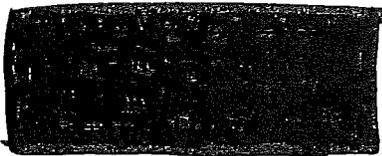


STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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Docket # 14-1162
Hearing Date: October 9, 2014

Date: November 14, 2014



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and agency policy reference(s) were the matters before the hearing:

DHS POLICY MANUAL: MEDICAL ASSISTANCE
SECTION: 0399.04.01 Institutional Long-Term Care
SECTION: 0399.05 Eligibility Requirements
SECTION: 0354.40 Resource Reduction
SECTION: 0354.40.05 Date of Eligibility

The facts of your case, the agency policy, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: Your son (Power of Attorney/POA), and Agency representatives: Joy Thibodeau-Moore, Bonita D'Abreu, Denise Tatro, and Deborah Castellano.

Present at the hearing were your son and his wife, and the Agency Representative Joy Thibodeau-Moore.

ISSUE: Is the appellant eligible for retroactive Medical Assistance (MA) coverage for the month of January 2014?

DHS POLICIES:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Department of Human Services Policy Manual.

DISCUSSION OF THE EVIDENCE:

The agency representative provided the following testimony

- He (the appellant) was at the Greenville Center and paying privately in December.
- Initially, the Greenville Center Nursing facility faxed the DHS-1 part of the application on February 5th (2014).
- The DHS-1, signed and completed allows DHS to hold the date of February 5th going forward. We allowed for February eligibility although the application was not fully completed by the family until March.
- Eligibility was assessed and approved for February.
- The facility let DHS know that monies were due for January, and upon reviewing the assets the Agency determined that the appellant was over assets, taking into consideration any medical expenses they could use.
- The assets used for January were the two bank accounts which showed \$3754.92 in savings, and \$608.09 in a money market account totaling, \$4363.01.
- This amount exceeds the \$4000.00 limit.
- We cannot do the resource reduction which would have been assessed if the application was submitted in January, because policy indicates that an applicant cannot utilize resource reduction in a retroactive period.
- The month of eligibility for this application is February, and the reduction was needed in January-retroactively.

- The application was actually signed by the appellant on January 29, 2014, but it was not faxed to the DHS worker until February 5th.
- I worked in a nursing home, and in my experience with my specific home is that the facility generally assesses insurance upon admission, and assesses the level of expected care, and who was paying for it.
- Families often times get involved with the appellant to help him fill out forms, whether they have power of attorney or not.
- When someone goes to a Nursing home, financially they must meet a certain criteria for Medicare and supplemental insurance to pay for rehab (rehabilitation), and the first criteria would be a three day hospital stay-which he did not meet.
- Initially, this is why he started off as a private pay patient.
- The facility faxed the Agency on January 28th identifying they already had given the father the application, and there would be no need to have the Agency send one.
- The Agency notes that he went to the hospital from February 2 through February 20th, and then returned again on February 21, and returned to the Rehab. on March 1, 2014.
- In this case the facility did not fax the DHS-1 and eligibility did not take place until the month of receipt.
- DHS cannot change this, but facilities some time have an appeal processes as well.

The appellant's son (POA) and his wife provided the following testimony:

- On December 28, 2013 he (the appellant) went to Greenville Center following a brief hospitalization.
- The son obtained Power of Attorney (POA) in April, and could not legally get any information until then.
- He (the son) does not dispute the financial information being used by DHS to obtain eligibility.
- He does not dispute that the application was submitted in February.

- The family questions the father's (appellant's) faculties to sign this application, but we are happy it did get signed and sent in February.
- We were unaware of his financial status as he is very stubborn and closed and somewhat paranoid about his money, and did not want help.
- Although his home seemed in disarray, we could not intervene with his lifestyle unless safety became the issue.
- We visited with him regularly at his home, but we went over as early as late November, and he was beginning to see things in the air which he attributed to bugs, and we attributed to down feathers, but later realized it might have been hallucinations.
- He drove his car, and shopped in the community into December, and was functioning.
- He began falling and having difficulty getting out of bed, and agreed that something was wrong, and agreed as well to go to the hospital on December 24th (2013).
- At the hospital, he complained of electricity in his arms which was a result of the pinching in his neck-the spinal stenosis diagnosis which the family was unaware of.
- The doctor discharged him, and he stumbled on the way out, but was released to home.
- In the following days he had great difficulty with his walking as well, appeared to worsen, and we returned to the hospital again.
- The case manager recommended a short period of rehabilitation (rehab) at the nursing home, and made all the arrangements as well.
- The family transported him, and they had to pay cash, initially \$3000.00, and they understood this was a short stay.
- There were no discussions about Medicaid, but the discussion centered on more community supports upon his release such as elderly assisted living.
- He (the appellant) did not get better but kept getting worse in rehab. and, finally could not hold his fork and returned to Miriam Hospital in early February.
- Major surgery was performed as the physical issue and pinching became serious.
- The nursing home mentioned spending his money down below \$4000.00, but the family did not understand the reasoning, and he (the son) could not access his father's money until April when they got power of attorney.

- The family did not know when the diagnosis of dementia had taken place, but the father had not mentioned anything about the spend down.
- The father had gone from Miriam to rehabilitation, and back to Miriam twice, once for the operation, and once for the subsequent Pneumonia.
- There was no other money, and the family gave the hospital his initial pension monies.
- There were no other discussions around monies again, but the son did not ever think his father would remain.
- The father was extremely active and aggressive in rehab. and, although he has gotten much worse now, there was no understanding on the part of the family that he was not going home.
- He (the son) feels some responsibility for not asking questions and not being aggressive about his father's long term plan, but no one ever came to him and discussed this with him.
- The nurses did refer the son to someone in the hospital to speak with, but he didn't follow through as he felt his father was getting good services, and he was not realizing they were considering long term care.
- Perhaps the lack of communication about monies and the long term plan resulted from the poor relationship between him and the Nursing home business manager.
- Her brusqueness sometimes seemed as if she was yelling at you, and she was giving him lots of things to do, and then expressed her frustration with him, stating she had been considering throwing him out of the office.
- So, at one point, she had alluded to the \$4000 spend down, and she had left all sorts of Post-It notes for him (the son), but communication was poor and the son did not want to follow up with any questions for her.
- His father was diagnosed with dementia in the nursing home on January 28, 2014 when he first went in, and this was a surprise to the family.

FINDINGS OF FACT:

- A notice dated June 25, 2014 informed the appellant that his Retroactive Medical Assistance request has been denied for the month of January 2014. It further states

that his resources in the amount of \$4363 are \$363.01 in excess of the standard. The same notice allowed eligibility for Medical Assistance to begin on February 1, 2014.

- The appellant's son and Power of Attorney (POA) filed a timely request for hearing received by the Agency on July 21, 2014.
- A hearing was held on October 9, 2014.
- The Agency received the appellant's application for Medical Assistance on February 5, 2014.

CONCLUSION:

The issue to be decided is whether the appellant is eligible for retroactive Medical Assistance (MA) coverage for the month of January 2014.

Under the Medical Assistance RI Global Waiver policy the appellant was found eligible for access to institutional long-term care services beginning on February 1, 2014. Per policy, in order to qualify for Medicaid funded long-term care, an individual must meet general and financial eligibility as well as certain clinical eligibility. Policy further identifies that if found ineligible at the first moment of the month due to an excess of countable resources, some expenditures are allowable in order to reduce those resources and establish eligibility retroactively.

There is no dispute that the appellant's resources for the month of January 2014 were more than the allowable standard resource limit of \$4000. Financial evidence submitted also supports this. There is no dispute between the Agency and the appellant that the application for Medical Assistance was received in February by the DHS representative.

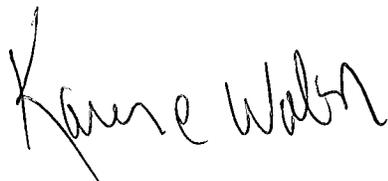
The appellant's son testified that the appellant entered the Greenville Center on December 28, 2013 following one brief hospital stay in late December, a return home, a second voluntary return to the hospital, and a discharge to the Greenville Center for a short term rehabilitation period. The appellant further testified that the family paid privately as their father had not remained in the hospital for three days, a time frame which might have allowed other Medicaid and supplemental assistance. The son testified that his father progressed in the rehabilitation program initially, and the facility and the family discussed community supports, as well as the likelihood that the father (the appellant) would be returning home. In early February the father's physical condition worsened and he was admitted to the hospital from February 2 through February 20, 2014 for surgery, and again February 21 through March 1, 2014 as a result of complications. The appellant's son had not discussed the father's financial situation with the facility prior to this time except in general terms. He identified that the facility had on several occasions suggested he meet to discuss the financial concerns, but he was unaware that there was any consideration for long term services, and he did not follow through at that time. Additionally, the son testified that he had difficulty with one of the

financial managers and was possibly not proactive for his father as a result of the poor communication between himself and the facility. The son did not get power of attorney until April, and he identified that his father was not forthcoming about his financial situation prior to this time. The son requests that the Agency should consider allowing retroactive spend down for the month of January due to the many difficulties the family encountered.

The Agency argues that they could not assess the father's resources for the month of January as they did not receive any application from the father until February. They further testified that they allowed the February application to hold the February date, although the family did not complete their application until much later due to difficulties obtaining financial information, as well as the time frame needed to obtain Power of Attorney, which the son completed in April 2014. The Agency cited policy which did not allow retroactive consideration prior to the date of application. Exploration of that policy supports this assessment. It reads in part, that "in no event shall the first day of eligibility be earlier than the first day of the month of application".

In summary, the appellant's application was sent to the DHS office in early February 2014. Neither the appellant nor the Agency disagreed on the date of submission, nor did they disagree that the appellant was over resources at that time. The appellant's son enumerated several reasons which acknowledged that he had not pursued financial discussions with the Nursing facility prior to February, and that the application was submitted by his father with the assistance of the facility. The credible and undisputed testimony and evidence presented found that the appellant was not eligible for retroactive coverage for January, as a direct result of policy which does not allow eligibility to be determined prior to the first day of the month of application.

After a careful review of the Agency's policies, as well as the evidence and testimony given, the Appeals Officer finds that the appellant's request for retroactive MA coverage is not allowable. The appellant's request for relief is denied.

A handwritten signature in black ink that reads "Karen E. Walsh". The signature is written in a cursive style with a large initial 'K'.

Karen E. Walsh
Appeals Officer

APPENDIX

0399.04.01 Institutional Long-Term Care

REV:07/2009

Beneficiaries that meet the applicable clinical eligibility criteria may access institutional long-term care services in the following facilities:

a) Nursing Facilities (NF). A beneficiary is eligible to access Medicaid-funded care in a nursing facility when it is determined on the basis of a comprehensive assessment, as defined in Sections 0399.05.01.02 and 0399.11, that the beneficiary has the highest level of care needs (See Section 0399.12.01).

b) Intermediate Care Facility for the Mentally Retarded (ICF/MR). A beneficiary qualifies for an ICF/MR level of care if the beneficiary has been determined by the MHRH to meet the applicable institutional level of care. Rules governing such determinations are located in: "Rules and Regulations Relating to the Definition of Developmentally Disabled Adult and the Determination of Eligibility as a Developmentally Disabled Adult, by MHRH" and may be obtained at http://www.mhrh.ri.gov/ddd/pdf/MHRH_1746.pdf or by contacting the agency.

c) Long-term Acute Care Hospital - Eleanor Slater Hospital (ESH). A beneficiary qualifies for a long-term acute care hospital stay if the beneficiary has been determined to meet an institutional level of care by the MHRH and by the DHS.

Beneficiaries residing in an NF, ICF/MR and ESH are considered to be in an institution for the purposes of determining eligibility. The Medicaid payment for institutional care is reduced by the amount of the beneficiary's income after certain allowable expenses are deducted. Other rules applicable to institutional care and services are located

in the Sections of 0378.

0399.05 ELIGIBILITY REQUIREMENTS

REV:07/2009

To qualify for Medicaid-funded long-term care services under the Global Waiver, a person must meet the general and financial eligibility requirements as well as meet certain clinical eligibility criteria. The general eligibility requirements for Medicaid are set forth in Sections 0300.25 and 0300.25.20.05 respectively. Income and resource eligibility rules for Medicaid eligible persons who are likely to be residents of an institution (as specified in Section 0399.04.01) for a continuous period and who have a spouse living in the community are found in Sections 0380.40-0380.40.35 and 0392.15.20- 0392.15.30. See also the applicable income and resource provisions in the long-term care Sections from 0376 to 0399.

Clinical eligibility is determined by an assessment of a beneficiary's level of care needs. Under the Global waiver, the income and

eligibility rules in these Sections will apply to persons who are likely to receive home and community-based core services for a continuous period. That is, persons meeting the highest or high level of care who reside in the community.

In Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30, all references to institutionalized spouses and continuous periods of institutionalization will include those institutionalized spouses receiving home and community-based services in lieu of institutional services.

0354.40 RESOURCE REDUCTION

REV:01/2002

If an applicant or recipient is found to be ineligible due to excess countable resources as of the first moment of the month, s/he is notified that eligibility does not exist via the InRHODES Eligibility Notice. Included within the Notice is a description of the possibility of resource reduction.

An applicant whose countable resources exceed the basic resource limitation may establish eligibility on the basis of resources if:

- o S/he incurs (or has incurred) outstanding allowable medical bills or other allowable expenses that equal or exceed his/her excess resources; AND,
- o S/he reduces the excess resources to the appropriate resource limit by actually paying the allowable expenses or fees, and submitting verification thereof within thirty days of the date of the rejection or closing notice. Both the expenditure of the resource and submission of verification of the expenditure and the reduced resource must occur within the thirty day time period.

The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of an application that is eventually approved. Allowable bills, which the applicant has paid and used to reduce resources, may not be the same bills that have been used to meet an income spenddown.

The agency representative must see the receipts for bills that have been actually paid in order to verify that resources have been properly reduced.

0354.40.05 Date of Eligibility

REV:06/1994

An individual who reduces resources and is otherwise eligible will be eligible as of the date the incurred allowable expenses were equal to or exceeded the amount of his or her excess assets, subject to verification that the excess resource was actually expended on the allowable expense. In no event shall the first day of eligibility be earlier than the first day of the month of application. An applicant cannot establish eligibility by resource reduction in the retroactive period.

The applicant will be required to verify that:

- o S/he incurred the necessary amount of expenses; and,
- o His or her excess resources were reduced to the allowable resource limit by expenditure of the excess resource on the allowed expense.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.