



Rhode Island Executive Office of Health and Human Services  
Appeals Office, 57 Howard Ave., LP Building, 2<sup>nd</sup> Floor, Cranston, RI 02920  
Phone: 401-462-6827 / Fax: 401-462-0458

February 20, 2015

Docket # 14-2389  
Date of Hearing: 02-18-15

**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 regulations reference(s) were the matters before the hearing:

**THE DHS POLICY MANUAL: Medical Assistance**

- Section: 0399.05.01.02 Needs-based LTC Determinations
- Section: 0399.06 Assessment and Coordination Organization

The facts in your case, the Agency regulations, and the complete administrative decision 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: You (the appellant) your Power of Attorney and Agency representatives Michelle Szylin, and Tom Conlon.

Present at the hearing were: Your daughters and Agency representative: Michelle Szylin.

**ISSUE:** Was the appellant's monthly budget for the Personal Choice Program reduced per Agency Policy?

EOHHS Rules and Regulations: Please see the attached **Appendix** for pertinent excerpts from the RI Executive Office of Health and Human Services Code of Administrative Rules.

**APPEAL RIGHTS:**

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

**DISCUSSION OF THE EVIDENCE:**

**The Agency representatives testified that:**

**DISCUSSION OF THE EVIDENCE:****The Agency representatives testified that:**

- The appellant was active on a Personal Choice Waiver.
- The last assessment of the appellant's needs was completed on December 8, 2014 the budget was \$2668.29.
- A new assessment was completed decreased the budget by \$ 256.62.
- TRI-Town did the assessment with the appellant's family.
- A physician's statement was also used.
- The number of times she needed help showering a week changed.
- Care for bowel changed from moderate to minimum.
- The assessment is based on what the appellant tells the Agency they need and what the assessor observes.
- The appellant was to use her budget to pay care workers to give the care and for her needs.
- There have been rule changes on how much time the tasks should take and how much you are paid to do them.

**The Appellant's daughters testified:**

- Their mother had been active on the Personal Choice Waiver program.
- They did get a new assessment.
- The budget did go down so they filed an appeal.
- She needs help with almost everything.
- She is old and frail.
- It takes a lot of time to care for her.
- She does not want to go to a nursing home.
- They did not know there were changes in the regulations.
- They feel that the social worker did a proper assessment.

**Findings of Fact:**

- The appellant was active in the Personal Choice Waiver program.
- The Agency did send a notice on December 12, 2014 that her monthly budget was re-evaluated.
- The appellant's monthly budget was reduced by \$256.62 a month.
- She did file for a timely hearing.
- The hearing took place on February 18, 2015.

**CONCLUSION:**

The issue to be decided is whether the appellant's budget for the Personal Choice Waiver program was decreased per Agency Regulations.

A review of Agency regulations regarding the Personal Choice program reveals that the Personal Choice program provides the individual with the opportunity to receive self-directed home and community based services using a "cash and counseling" model.

The recipient has the ability to hire and manage their own Personal Care Assistants and the options to purchase goods and services that are not otherwise covered by Medicaid.

An applicant must meet a clinical level of care for this program. The level of care level for this program is high or highest. The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The entities that conduct the assessments work in coordination with staff of the Medicaid Agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

There is no argument that the appellant meets the level of care and the financial guidelines for the Personal Choice program. The appellant's daughters feel that in order to continue to receive the hours their mother needs due to her they will need to have her previous budget restored.

The appellant needs a lot of care with personal needs. She also needs help with meals.

The Agency argued that the Personal Choice Waiver has been reviewed under the Global Waiver to insure all Long-term Care consumers are receiving access to the same quality care.

The Agency uses an assessment of activities of daily living and the applicant's level of needed assistance with these activities to help determine a monthly budget. The comprehensive

assessment used to determine clinical eligibility and additional information provided by the beneficiary and/or family members is used by the responsible agency to develop an individualized care plan, identifying the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. When the assessment is completed the number of activities a recipient needs assistance with and how often determines units of time needed for these activities. Each activity such as toileting, grooming, dressing and mobility among others is assessed for how much time is used to complete the activity, how many times a day or week it is needed and the cost of each activity. This is also based on how much assistance the individual needs with each activity. (Moderate, minimum or total)

The EOHHS Office of Medical Review is responsible for reviewing and approving the aggregate cost neutrality of the home and community based long-term care system on an annual basis. To meet cost neutrality, the average per capita expenditures for home and community-based services cannot exceed one hundred percent (100%) of the average per capita expenditures of the cost of institutional services if the individuals had been institutionalized.

The EOHHS uses these average monthly costs to Medicaid to assist in determining whether home and community-based services are cost effective as required under Title XIX of the Social Security Act.

In this case it was determined by the Agency, after completion of a new assessment, that the time it took a caretaker to complete the appellant's Activities of Daily Living, as they would be completed by a majority of healthcare aides employed by Agencies. The Agency adjusted the amount they pay for each Activity of Daily Living completed by the appellant's caretaker and lowered the budget accordingly. The budget was lowered \$256.62.

The appellant has the right to work with her case manager to determine what changes she can make to have the needed care provided within the budget. The appellant determines who cares for her, how much they are paid and how many hours they are paid for. The Agency allocates enough funds per month to insure the appellant can pay for the help she needs to complete her Activities of Daily Living needed to remain in the community, not solely for the supervision of the appellant. It is up to the appellant and her case manager to determine how her budget can be used most effectively.

In this case the appellant's budget was based on her need for assistance in almost all activities of daily living and the fact that she is frail and has some cognitive issues which allows her more time than others for completing tasks; however the Agency did revise the cost of certain activities and the amount of time it should take to complete these tasks. The only areas that the extent of help needed was lowered were in grooming; however one area of grooming was also added.

After careful review of Agency Regulations and the evidence and testimony presented this Appeals Officer finds that the appellant's budget was reduced appropriately and is consistent with Agency Regulations; therefore her request for relief is denied.



Geralyn B. Stanford  
Appeals Officer

APPENDIX

## 0398.40.15 Eligibility Criteria

REV:03/2006

The Personal/Choice Program is designed to assist individuals who are either aged (age sixty five (65) years and older) or have a disability and are at least eighteen (18) years old who are Medical Assistance eligible (or would be if institutionalized) and who:

- Require the level of care provided in a Nursing Facility
- Are eligible as Categorically or Medically Needy
- Have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care;

## 0398.40.20 Services

REV:03/2006

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal Medical Assistance services, eight (8) special services are provided under the Waiver.

In some cases, the individual may be responsible for a portion of the cost of the Waiver services.

Waiver services are:

- SERVICE ADVISEMENT

The Service Advisor team consisting of the Advisor, an RN and Mobility Specialist focus on empowering participants to define and direct their own personal assistance needs and services. The Service Advisor guides and supports, rather than directs and manages, the participant through the service planning and delivery process.

- FISCAL INTERMEDIARY SERVICES

Fiscal Intermediary services are designed to assist the participant in allocating funds as outlined in the Individual Service and Spending Plan and to facilitate employment of personal assistance staff by the participant.

- PERSONAL CARE ASSISTANCE

Personal Care Assistance services provide direct support, in the home or community, to individuals in performing tasks that due to disability they are functionally unable to complete independently, based on the Individual Service

and Spending Plan.

o PARTICIPANT DIRECTED GOODS AND SERVICES

Participant Directed Goods and Services are services; equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Service and Spending Plan (including improving and maintaining the individual's opportunities for full membership in the community).

o HOME MODIFICATIONS

Equipment and/or adaptations to an individual's residence to enable the individual to remain in his/her home or place of residence, and ensure safety, security, and accessibility.

o HOME DELIVERED MEALS

The provision of a meal delivered to the waiver recipient's residence.

o PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency.

o SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized Equipment and Supplies are devices, controls, or appliances specified in the Individual Service and Spending Plan, which enables the participant to improve their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

**0398.40.25 Eligibility Determinations**

REV:03/2006

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated (if any) to the cost of care. Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, that the recipient must pay toward the cost of Waiver services.

Eligibility determinations for applicants of Waiver services are conducted as if the applicant were institutionalized.

### **0398.40.30      Confirming MA Eligibility Status**

REV:03/2006

Prior to providing services under the Waiver program, and at each reassessment, the Service Advisement agency and Fiscal Intermediary agency must confirm that the candidate is eligible for Medical Assistance and has an active case number by utilizing the Recipient Eligibility Verification System (REVS) ..

### **0398.40.35      Redetermination of Eligibility**

REV:03/2006

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

### **0399.04.02      Home and Community Based Long-Term Care**

REV:07/2009

The Global Waiver authorizes the state to offer an array of home and community-based services to beneficiaries as an alternative to institutionalization. Home and community-based long-term care services and supports (HCB/LTC Services) are in addition to the services otherwise provided under the Medicaid program.

#### **0399.04.02.01      Core and Preventive HCB/LTC Services**

REV:07/2009

1) Core HCB/LTC services include the following broad categories of services:

- |   |  |
|---|--|
| * Homemaker   | * Adult Companion Services                   |
| * Environmental Modifications                         | * Personal Care Assistance Services          |
| * Special Medical Equipment                           | * Respite                                    |
| * Home Delivered Meals                                | * Day Supports, including Adult Day Services |
| * Personal Emergency Response                         | * Supported Employment                       |
| * Licensed Practical Nurse Services (Skilled Nursing) | * Shared Living                              |
| * Community Transition Services                       | * Private Duty Nursing                       |
| * Residential Supports                                | * Supports for Consumer Direction            |
| * Participant Directed Goods and Services             | * Case Management                            |

\* Assisted Living

\* PACE

Assisted Living, PACE and Shared Living are defined in greater detail in Sections 0399.20.01, 0399.21 and 0399.20.02.

2.) Preventive Services: These services are available, as needed, to beneficiaries eligible for Medicaid long-term care.

In addition, persons who are eligible for Community Medical Assistance but who have been determined to meet a preventive level of care, have access to the following services: Homemaker Services, Minor Environmental Modifications, and Personal Care Assistance Services.

### **0399.05.01.02 Needs-based LTC Determinations**

REV:07/2009

The processes for determining clinical eligibility are based on a comprehensive assessment that includes an evaluation of the medical, social, physical and behavioral health needs of each beneficiary. The assessment shall be tailored to the needs of the beneficiaries services and, as such, may vary from one process to the next. Based on this assessment, the needs of the beneficiary are classified as "highest" or "high" to reflect the scope and intensity of care required and the range of services available. Beneficiaries already eligible for community MA who do not meet the highest or high level of care but are at risk for institutionalization may access certain short-term preventive services. There are two general types of services available to beneficiaries - core and preventive (see description in section 0399.10.20). An individual care plan is then developed that identifies the LTC core and preventive services and settings appropriate to meet the beneficiary's needs within the specified service classification.

The scope of services accessible to a beneficiary varies in accordance with individual needs, preferences, availability, and the parameters established in the Global Waiver and/or federal and state regulations, rules or laws. For example, a beneficiary with the highest need may be able to obtain the full range of services he or she needs at home or in a shared living arrangement, but may choose, instead, to access those services in a skilled nursing facility. Community-based care includes PACE and accessing services through a self-directed model. A beneficiary determined to meet the high need may have access to care in the home and community based setting - including PACE -- and self-directed care, but does not have the option of nursing facility care.

### **0399.06 ASSESSMENT & COORDINATION ORGANIZATION (ACO)**

REV:07/2009

The Assessment and Coordination Organization (ACO) is a set of four (4) processes established across the health and human service departments that assist applicants/recipients and their families in gaining access to and navigating the LTC system. In this respect, the ACO is not a separate and distinct entity, but a set of interrelated activities from across the departments that serve the goal of rebalancing the long-term care system.

The four processes included in the ACO are as follows:

a) Information and Referral. The State provides information and referrals about publicly-funded LTC to individuals and families through a variety of sources across agencies. The ACO is responsible for enhancing and coordinating these resources to ensure that every person seeking Medicaid-funded LTC services has access to the information they need to make reasoned choices about their care. The Department of Human Services shall enter into inter-agency agreements with each entity identified or designated as a primary source of information/referral source for beneficiaries of long-term care.

b) Eligibility Determination. Through the ACO, the Department of Human Services determines financial eligibility for long-term care services provided across agencies. Clinical eligibility is based on a comprehensive assessment of a person's medical, social, physical and behavioral health needs. Responsibilities for clinical eligibility are as follows:

- \* Clinical eligibility to receive services in a nursing facility or community alternative to that institution will be determined by DHS, utilizing needs-based criteria.
- \* Clinical eligibility to receive services in a long-term care hospital or community alternative to the institution will be determined by DHS and MHRH, as appropriate, utilizing an institutional level of care.
- \* Clinical eligibility to receive services in an intermediate care facility or community alternative to that institution will be determined by the Department of Mental Health Retardation and Hospitals, using an institutional level of care.
- \* The entities that conduct the assessments work in coordination with staff of the Medicaid agency, as appropriate, to ensure the eligibility determination process is coordinated and to preserve program integrity.

c) Care Planning. The comprehensive assessment used to determine clinical eligibility and additional information provided by the beneficiary and/or family members is used by the responsible agency to develop an individualized care plan, identifying the scope and amount of services required to meet the beneficiary's needs as well as the full array of service/care setting options. ACO care planning activities include establishing funding levels for the care and/or the development of a budget for self-directed services or the provision of vouchers for the purchasing of services.

d) Case management/evaluation. The activities of the various agencies and/or their contractual agents designed to ensure beneficiaries are receiving scope and amount of services required to optimize their health and independence. The broad range of services includes periodic review of service plans, coordination of services with the beneficiary's acute care management entity (Rhody Health Partners, Rite Care, or Connect Care Choice), and quality assurance. Depending on the agency and the population served, this may be performed by multiple entities working in collaboration or a single entity.

**RI Department of Human Services/ Medical Assistance Program 7/1/09**  
**Medicaid Long Term Care- Level of Care Categories**

**Highest Level of Care**

Individuals who meet the criteria for the **Highest** Level of Care needs and the financial eligibility criteria for Medicaid Long Term Care may be eligible to receive (1) nursing facility care or (2) home and community-based care. The home and community-based services are listed under the High Level of Care description.

Only individuals who qualify for the **Highest** Level of Care are eligible to receive nursing home care paid for by Medicaid.

**High Level of Care**

Individuals who meet the criteria for the **High** Level of Care needs and the financial eligibility criteria for Medicaid Long Term Care may be eligible to receive the following home and community-based services:

- Homemaker/ CNA services
- Environmental modifications
- Special medical equipment
- Meals on Wheels Personal Emergency Response Systems
- Case Management Senior Companion Assisted Living
- Personal care services (Self-directed care)
- Respite
- Minor home modifications

**Personal Choice Program**

**Program Description**

The Personal Choice Program provides individuals over age 65 or individuals with disabilities the opportunity to receive self-directed home and community-based services using a "cash and counseling model." This gives participants the ability to hire and manage their own Personal Care Assistants and the option to purchase goods and services not otherwise covered under Medicaid.

**Eligibility**

To be eligible, an individual must be at least 18 years old, meet financial guidelines and a clinical Level of Care (Highest or High).

**Covered Services**

- Personal Care Assistants
- Environmental Modifications
- Specialized Equipment
- Personal Emergency Response System (PERS)
- Home Delivered Meals
- Other Goods and Services that will support independence
- Service Advisement
- Fiscal Advisement

*Service advisement services* are provided by PARI and Tri-Town. Service Advisors assess, enroll, train and assist consumers with developing and monitoring services.

*Fiscal advisement services* are provided by PARI & OPTIONS Program. The fiscal intermediary provides the consumer with financial advice on plan development, funds RI Department of Human Services 11/4/09

## PERSONAL CHOICE REFERRAL/INTAKE/ENROLLMENT PROCESS

**1. Referral:**  
—Can come from DHS,  
Community Agencies,  
family/friend;  
**Point of Entry is:**  
Advisement Agency...

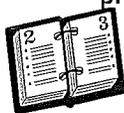
**ADVISEMENT AGENCY:**  
**2. First contact with consumer  
involves providing information re:  
program. (by an Advisor)**

- A. Screen for Appropriateness by Advise ment Agency/ Advisor
- a. Medicaid eligible/LongTermCare active?
  - b. Meets Level of Care for program?
  - c. Ability to Self-Direct or Representative available
  - d. Willingness to participate in the program.
- B. Send participant packet of Program information and list of Approved Providers.

If referral appears appropriate for PersonalChoice and not currently LTC active, refer to appropriate LTC office to begin Medicaid application process. Assist with application as needed.

If Referral is not appropriate for Personal Choice, proceed by investigating other community program options. Personal Choice Enrollment process ends here.

**3. Advisor Schedules Appointment for Home Visit**  
A. **If participant will be utilizing a Representative ensure they will be present during home visit.**



**4. Contact DHS/Project Coordinator to inform of referral.**  
A. **Project Coordinator mails Agency Choice Form and info re: each agencies and requests participant choose which agency they want for Advise ment and Fiscal Intermediary Services.**

**5. Prior to Home Visit-Advisor**  
A. **Calls participant to confirm receipt of Program Information and List of Approved Providers.**  
B. **Confirm desire to continue with the process with current agency.**

- 6. During Initial Home Visit with Advise ment Agency**
- A. **Assess participant utilizing PersonalChoice Functional Assessment and PersonalChoice UCAT Supplemental Assessment; also screen for Self-Direction utilizing Self-Direction Assessment.**
  - B. **If Representative is requested, screen potential Representative utilizing Representative Screening Tool and have Participant and Representative sign Designation of Authorized Representative form; and have Representative complete BCI check approval form.**
    - a. **If participant still appears appropriate and interested in program, obtain signature on form CP-12 (DHS Community Services Choice form)**
    - b. **Review Rights and Responsibilities document with Participant and Representative (if applicable) and obtain signatures.**
    - c. **Ensure Participant has completed and submitted LTC**

### 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.