

**STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
DEPARTMENT OF HUMAN SERVICES  
APPEALS OFFICE  
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October 2, 2014

Docket # 14-981  
Date of Hearing: August 19, 2014

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**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:

**THE DHS POLICY MANUAL: Medical Assistance**

Section: 0399.05.01.02 Needs-based LTC Determinations  
Section: 0399.06 Assessment and Coordination Organization  
Section: 0399.10.01 Agency Responsible  
Section: Personal Choice Program

The facts in your case, the Agency policy, 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) Agency representative Michelle Szylin and the Policy Unit.

Present at the hearing were: You, representatives from Tri-town and agency representative Michelle Szylin.

**ISSUE:** Did the agency correctly assess the appellant's Personal Choice Program monthly budget?

DHS POLICIES: Please see the attached **Appendix** for pertinent excerpts from the Department of Human Services Policy Manual.

**APPEAL RIGHTS:**

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

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

- The appellant is active on the Personal Choice Program Waiver. The agency notified him by notice dated May 30, 2014, that the re-assessment submitted by his Service Advisement Agency, Tri-Town, was reviewed and a new budget amount of \$3154.08 was approved. The agency re-assessment requirement is per agency policies 0399.05.01.02 & 0399.10.01. The agency representative stated that the changes made to the prior assessment were written on the notice. (Copy of the May 30, 2014 notice submitted).
- The agency representative submitted copies of the appellant's old budget and copies of the new budget that he has appealed. The appellant's initial budget was completed during April of 2012. At that time the appellant's budget was approved for \$3702.81.
- The agency representative stated that during August 2012 changes were made to the agency Personal Choice Program assessment and budget rules. The agency reviewed the times required for tasks and the multipliers and those were adjusted resulting in changes to some recipient's budgets.
- The agency representative stated that for some individuals if the need was for total assist or extensive assist the allotment was less and the budgets went down accordingly.
- In the past some individuals needing minimal assist were allowed comparable budgets to those needing maximum assist.
- The agency representative stated that there were some changes to the appellant's assessment and also some changes from total to extensive and from extensive to minimum.
- The agency representative stated that there are 6 levels of assistance including set up, which would be supervision of a specific activity, minimum assist is assistance with about 25% of an activity such as dressing, moderate assist is when half to 75% of the activity requires assist, and total assist is when the activity cannot be completed without assistance.
- The assessment also reviews functional characteristics which take into account certain tasks which would increase the dollar amount if applicable. For example if an individual has spasticity they would get extra help because it is more difficult to dress or shower them. An individual with an illness such as Alzheimer's disease may qualify for additional activity assistance.
- The agency representative stated that the most recent assessment was submitted to the agency from Tri-Town on April 18, 2014. The new budget is affected by the August 2012 rule change.
- The new assessment indicated changes from the April 2012 assessment. The appellant's need with eating changed from extensive assistance to minimum

assistance. His need for mobility assistance changed from total assistance to extensive assistance. His need for shopping assistance changed from total assistance to moderate assistance.

- The new assessment notes that the client requires minimum assistance with eating and shopping. The assessment notes that the client goes on shopping trips occasionally and uses the Ride van. He relies on family and caregivers to assist with grocery shopping.
- The latest assessment notes the changes which resulted in the budget decrease. (Copies of the 2012 assessment submitted). The new assessment is determined based on how much assistance the individual requires. The dollar amount is calculated based on a unit time depending on the amount of assistance.
- The agency representative stated that there are formulas used to determine the dollar amount. The agency does not pay for supervision hours but only for actual hands on assistance.
- The new assessment was done in April 2014 and the appellant's level of assistance decreased from his previous assessment. In addition the formulas changed because the rules changed.
- The new rule changes required the agency to use a new formula when determining the budget amount. Individuals requiring less assistance will see a decrease in their budget. The agency representative submitted a copy of the new rules indicating activity and time allotment schedules.
- The appellant's budget using the new rules was determined to be \$3154.08. The new budget has not gone into effect pending the outcome of the hearing.
- The agency representative stated that a caseworker from Tri-Town went to the appellant's home to assess the appellant's needs. The caseworker assessed each activity and how much time each requires. The assessment is based on the assistance required by a recipient per each task and each task is assigned a time.
- Once a monthly budget is calculated it is up to the individual to determine how the budget is to be spent. The agency does not determine the number of hours, the agency determines the budget and it is up to the recipient to determine how to allot the money.
- The individual is given a score when the needs assessment is completed based upon their level of need, ranging from independent to total assistance.
- Based upon the level of need the time is allotted by the percentage of the task the client is able to do.
- The agency evaluates an individual's daily tasks. The agency pays for task-oriented needs and does not pay for supervision or companionship time.
- The budget is a total dollar amount and the client determines how the budget is spent. The appellant is allowed to contact Tri-Town at any time if his assistance needs change and that agency will do a new assessment.
- The agency representative submitted a copy of the agency Provider Medical Statement dated April 25, 2014 that was completed by the appellant's physician.
- The appellant's physician noted that the appellant is independent with eating, and medication management.

**The appellant testified:**

- He stated that he is able to feed himself but he needs assistance in food preparation. He questioned whether or not his hours have been reduced since his last budget.
- He stated that his medical condition has remained about the same as when his last assessment was done in 2012. He stated that he does need more total hours than he presently receives.
- He stated that he will submit additional information from his doctor about his current functional ability.

**Findings of Fact:**

- The appellant is active with the agency Personal Choice Waiver program.
- The agency sent a notice to the appellant dated May 30, 2014 notifying him that his monthly budget was re-assessed and his new budget in the amount of \$3154.08 was approved.
- The appellant testified that he requires additional hours for home care as he believes his current hours are not sufficient.
- This record of hearing was held open through September 22, 2014 at the appellant's request to allow him to submit additional information from his doctor.

**CONCLUSION:**

The issue to be decided is whether the agency correctly assessed the appellant's monthly budget for the Personal Choice Waiver program.

A review of Agency Policy regarding the Personal Choice Program determines 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 contracted agency 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 dispute that the appellant meets the level of care and the financial guidelines for the Personal Choice program. The appellant submits that the agency

adjusted and decreased the budget available to him based on his needs, which have not decreased but if anything he needs additional home care hours.

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/caregivers 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 bathing, grooming, dressing and transfers is assessed for how much time is used to complete the activity, the level of assistance and how many times a day or week it is needed and the cost of each activity.

The DHS 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 i.e. a nursing facility.

The DHS 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 during April 2014, that the time it took a caretaker to complete the appellants Activities of Daily Living, as they would be completed by a majority of healthcare aides employed by Agencies and Nursing facilities, was less than the time that had been allocated in the appellants previous budget plan. The Agency then adjusted the hours that the appellant needed to have his Activities of Daily Living completed by his caretakers and lowered the budget accordingly.

According to agency policy and the testimony of the agency representative the appellant has the right to work with his case manager to determine what changes he can make to have the needed care provided within the budget. Policy allows that the appellant determines who cares for him, how much they are paid and how many hours they are paid for. The Agency is required to allocate enough funds per month to insure the appellant can pay for the help he needs to complete his Activities of Daily Living needed to remain in the community.

The policy and the agency representative emphasize that funds are not to be allocated solely for the supervision of the appellant. It is up to the appellant and his case manager to determine how his budget can be used most effectively.

Review of the assessment plan from April 2014 submitted by the agency determines that the following ADL's are addressed and allotted time for extensive assistance with: mobility. The appellant is allotted total assistance time for: bowel, dressing, grooming, showering, skin care, urinary and transfers. The appellant is

allotted minimum time for eating. The agency policy allows for adjustment of hours and the reimbursement rate in calculating the allotted budget.

The change in the appellant's previous assessment decreased his allotted time for eating, mobility, and shopping. The appellant testified that he needs more hours as he needs total assist for most activities.

This record of hearing was held open through September 22, 2014 to allow the appellant to submit medical information from his doctor or other care providers. The appellant did not submit any additional information to this record or to the agency representative.

The appellant is advised that any changes in care needs that have occurred since the April 2014 assessment should be brought to the attention of the Tri-Town assessment caseworker.

Based on review of the agency policy, the testimony and evidence submitted it is determined that the appellant has been allotted an appropriate time in his April 2014 Personal Choice budget to maintain his independence. The appellant is advised that agency policy requires a periodic review of a recipient's service plan. The appellant is advised to review his periodic assessment time frame with his case manager as needed.

The appellant's request for relief is denied.



Michael J. Gorman  
Appeals Officer

## APPENDIX

### **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.

### **0399.05.01.02 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.

Agency Respons for Determining Level of Care 0399.10.01  
REV: 07/2009

Beginning on July 1, 2009, beneficiaries determined to have a potential need for Medicaid-funded long-term services and supports in a nursing facility or in the community are referred to the Assessment and Coordination Organization (ACO) processes administered by the Department of Human Services (DHS). Those applying for state-only funded services and supports are referred to ACO processes administered by the Department of Elderly Affairs (DEA). The agency entities authorized to carry out these ACO processes are responsible for:

- a) Coordinating related activities with the Medicaid financial eligibility staff;
- b) Conducting assessments that determine level of care needs;
- c) Developing service plans with the active involvement of beneficiaries and their families;

Agency

Respons for Determining Level of Care 0399.10.01

- d) Establishing funding levels associated with care plans developed for each beneficiary;
- e) Reviewing service plans on a periodic basis; and
- f) Working in collaboration with the beneficiary's care management plan or program (Connect Care Choice; PACE; Rhody Health Partners) to ensure services are coordinated in the

most effective and efficient manner possible.

Financial eligibility for Medicaid-funded long-term care is conducted by the DHS field staff in accordance with Sections 0380.40-0380.40.35 and 0392.15.20-0392.15.30. Determinations of clinical level of care needs for nursing facilities are made by the DHS Office of Medical Review (OMR) nurses for both DHS and DEA beneficiaries.

#### Personal Choice Program

The Personal Choice Program provides 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. 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 include:**

- 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 allocation, hiring Personal Care Assistants, etc.

RI Department of Human Services 9/14/09

### **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.