



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

May 13, 2015

Docket # 14-1349  
 Hearing Date 1/20/15 & 05/13/15

### **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 policy reference(s) were the matters before the hearing:

**Executive Office of Health and Human Services**  
 Medicaid Code of Administrative Rules  
 SECTION: 0392 Post-Eligibility Treatment of Income

The facts of your case, the Agency Regulations, 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: You and Agency representatives Cynthia Lopes, Daniel Ballirano, Deborah Castellano and Tom Conlon.

Present at the hearing were: your mother, your Physician, Jody Feldman and Agency representatives Cynthia Lopes, Daniel Ballirano and Heather Mincey.

**ISSUE:** Did the Agency calculate the recipient's share of medical expenses correctly in July 2014?

**EOHHS Rules and Regulations:** Please see the attached **Appendix** for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules. (MCAR)

### **APPEAL RIGHTS:**

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

### **DISCUSSION OF THE EVIDENCE:**

**DISCUSSION OF THE EVIDENCE:****The Agency representative testified:**

- The appellant was active on a Long Term Care MR (mentally retarded) Waiver.
- She has a share amount.
- The appellant receives \$1494.90 in RSDI income.
- The appellant's share of the cost of her medical expenses was calculated to be \$397.50 per month.
- The Agency calculated the share amount using the appellant's income.
- The Agency gave the correct deductions, part B Medicare payment of \$104.90 and the personal needs deduction of \$992.50 per regulations.
- The Agency calculates each recipients share this way.

**The Appellant's Mother testified:**

- The appellant is active on a MR Waiver.
- To pay a share will be too much of a financial hardship.
- The appellant was unaware that there was a cost share.
- She receives SSDI because her father passed away.
- Her mother has to pay for her home and her food and a lot of medical treatments her daughter requires that are not covered by Medicaid.
- She cannot go to a day program because she has very special needs and refuses to go.
- Her mother sends her for swim lessons and to the YMCA for exercise.
- She needs a lot of one to one time.
- If they have to pay a share, how will they still give her everything else she needs?
- Her doctor agrees that she needs these specific treatments.

**FINDINGS OF FACT:**

- The appellant is active on an MR waiver.
- The Agency issued a written notice of Share of Medical Expenses on April 27, 2014.
- The appellant has been billed for her Share Amount since August 2014.
- The appellant filed a request for hearing received by the Agency on August 20, 2014.
- The Hearing was scheduled for November 17, 2014. The appellant requested and was granted a re-schedule.
- The hearing was heard at the appellant's home on January 20, 2015.
- The hearing was to reconvene with representatives from BHDDH.
- The hearing was scheduled for February 16, 2015 and March 17, 2015. These hearings were rescheduled.
- The hearing was reconvened on May 13, 2015.

**Conclusion:** The issue to be decided is whether or not the appellant's Applied Income was calculated per EOHHS Regulations.

A review of EOHHS Regulations reveals that many individuals who require the level of care provided in an institutional setting may be able to receive such services at home.

Programs that provide home and community-based services to persons who would otherwise require institutional care require special waivers of the normal Medicaid rules. These Waiver Programs must be approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The state Agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver services for all Waiver services recipients who are subject to the post-eligibility process.

The calculation starts with the individual's full, gross income, including amounts which were disregarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be defined to be part of the applicant's gross income in the determination of Medicaid financial eligibility. The deductions allowed by MCAR are the maintenance needs allowance and a deduction for medical insurance premium deduction.

In this case the appellant has been active on an MR Waiver. The Agency representative testified that she calculated the appellant's cost of care amount by starting with her gross SSDI income of \$1494.90, and then subtracted the maintenance needs allowance of \$992.50 and her Part B Medicare payment of \$104.90 determining that \$350.20 would be her share of cost of medical expenses.

The appellant's mother argued that her daughter's income is not the enough to meet her care needs and that she needs her full income to continue with her programs. She also argued that the only reason her daughter receives that money from SSDI is because her father passed away and having to pay a share of her medical expenses will be a financial hardship.

The Agency indicated that there are some medical expenses that are Medically Necessary, but not covered by Medicaid that may be deductions from the Cost Share. Subsequent to the initial hearing the appellant has been given a deduction for Dental expense. The Agency and the appellant's mother and physician agreed to look into other expenses to see if they are qualified medical deductions.

Although the appellant's mother argues that the system is broken and that it does not meet the needs of the people it is supposed to serve, this Appeals Officer's only jurisdiction is whether or not the Agency followed Rules and Regulations when determining the appellant's share of the cost of care.

After careful review of Agency Rules and Regulations and the evidence and testimony presented this Appeals Officer finds that the appellant's share of cost of medical expenses was calculated per Agency Regulations; therefore her request for relief is denied.



Geralyn B. Stanford  
Appeals Officer

APPENDIX

### **0396.05 Overview of Waiver Programs**

REV: April 2014

Many individuals who require the level of care provided in an institutional setting may be able to receive such services at home.

Programs that provide home and community-based services to persons who would otherwise

require institutional care require special waivers of the normal Medicaid rules. These Waiver

Programs must be approved by the Health Care Financing Administration of the U.S. Department of

Health and Human Services.

Home and community-based services are a humane, cost-effective, and generally preferable way of

providing institutional levels of care to eligible individuals. The Medicaid agency provides Home

and Community Based Services to eligible aged and disabled individuals under a Waiver Program

operated by the Long Term Care/Adult Services unit (see Section 0398.05).

The Medicaid agency also operates Waiver Programs in conjunction with other agencies to serve

the needs of certain target populations. These jointly operated programs are the following:

□ **The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals**

**(BHDDH) program for developmentally disabled individuals ("MR Waiver" - see Section**

**0398.10);**

□ The Division of Elderly Affairs (DEA) program for individuals in the community or seeking

to return home from nursing facilities ("DEA Waiver" - see Section 0398.20);

□ The Division of Elderly Affairs (DEA) program for aged and disabled individuals in specified Residential Care/Assisted Living Residences ("Assisted Living Waiver" - see Section 0398.30).

State agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and

redeterminations of financial eligibility for Medicaid for all waiver recipients. Since categorically

needy individuals receive a greater scope of services, waiver recipients must be determined to be

eligible as categorically needy whenever possible.

Case managers at BHDDH, DEA, and for the Personal Choice Program assist in the determination of eligibility for the Waiver Programs by forwarding information to the state agency LTC/AS unit, and by communicating directly with their applicants and recipients regarding eligibility and income allocation matters.

The Waiver Programs differ in:

- Target populations;
  - Special home and community-based services provided to eligible recipients;
  - Eligibility level required for participation (Categorically Needy or Medically Needy);
- and

- Procedures.

This section contains the policies that generally pertain to all Waiver Programs, including determinations of eligibility, post-eligibility treatment of income, and determinations of costeffectiveness.

Exceptions are listed, where applicable, in the following sections specific to each Waiver Program.

### **0396.10 Determination of Eligibility**

REV: April 2014

Eligibility determinations conducted for individuals applying for or receiving services under a

Waiver Program are conducted as if the individual were actually institutionalized.

Policies

contained in Sections 0376 through 0392 are generally applicable to individuals applying for

Medicaid eligibility and services under a Waiver Program. This means that:

- Deeming of spousal resources and/or income does not apply after the month of separation due to institutionalization;
- Deeming of parental income and/or resources does not apply to a child under 18 after the month in which the child is determined to be separated due to institutionalization;
- All transfers of assets made within sixty (60) months prior to, or any time after, the individual applies for services under the Waiver Program must be evaluated under transfer provisions contained in Section 0384. Trusts established within sixty (60) months immediately prior to, or any time after, the individual applies for services under the Waiver Program must be evaluated under trust and transfer provisions contained in Section 0382. Resource transfers may render an individual ineligible for payment of Waiver-specific services.

**0396.10.05 Persons Eligible**

REV: April 2014

Individuals potentially eligible for Waiver Programs include Supplemental Security Income (SSI)

recipients and non-SSI recipients.

**SSI RECIPIENTS**

SSI recipients (and former SSI recipients who are determined eligible for Medicaid by SSA under

section 1619(b)) are automatically eligible for Categorically Needy Medical Assistance and thus

potentially eligible for Waiver services unless the individual has transferred an asset with a resulting

uncompensated value. See Section 0384 for specific information about the penalties related to

transfer of assets, and Section 0382 for information about trusts and portions of trusts which are

treated as a transfer of assets.

SSA transmits a list of individuals who have transferred resources to the LTC Unit at CO. These

transfers must be evaluated when a request for Waiver services is made.

**NON-SSI RECIPIENTS**

Eligibility for non-SSI recipients is determined as if the applicant were entering or in an institutional

setting. The applicant must meet the technical, characteristic, and financial requirements of the

Medicaid program.

**0396.10.10 Technical Eligibility Requirements**

REV: 06/1994

Technical requirements which must be met are:

- Level of care;
- Residency;
- Enumeration;
- Citizenship/Alienage;
- Assessing potential income and resources;
- Cooperation in making resources/income available;
- Transfer of assets.

**0396.10.10.05 Institutional Level of Care**

REV: April 2014

In order for an individual to be eligible for home-based services under a Waiver, s/he must require the level of care provided in an institutional setting. Case managers recommend the appropriate level of institutional care for each Waiver applicant, subject to the review and approval of the State's Office of Medical Review (OMR).

Policy and criteria for establishing levels of care are found in Section 0378, prior authorization.

Each Waiver Program's targeted population is a specific subset of the overall population requiring institutional services. The appropriate level of care for eligibility varies with each Waiver Program.

#### **0396.10.15 Characteristic Requirements**

REV: 06/1994

The characteristic requirements are those of the SSI program: Age (65 years or older); Blindness; or Disability. Only aged individuals can be served under the Waiver Program for Deinstitutionalizing the Elderly (DEA Waiver).

#### **0396.10.20 Financial Requirements**

REV: 12/2000

For categorically needy eligibility to exist, the applicant's resources must be within the categorically needy limits set forth in Section 0380, and the applicant's gross income must not exceed the federal cap set forth in Section 0386.05.

The Waiver Programs requiring Categorically Needy eligibility are:

- Waiver for Aged and Disabled Individuals (Section 0398.05); and
- Waiver Program for Aged and Disabled Individuals in Assisted Living (Assisted Living Waiver) (Section 0398.30).

For medically needy eligibility to exist, the individual's resources may not exceed the Medically

Needy resource limits set forth in Section 0380. The applicant's countable income must be less than the Medically Needy income limit for an individual set forth in Section 0386.05; OR the individual

must incur each month allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy income limit.

The Waiver Programs in which an individual may be either Categorically Needy or Medically

Needy are:

- Waiver Program for the Severely Handicapped (PARI Waiver) (Section 0396);
- Waiver Program for Aged Individuals (DEA Waiver) (Section 0398.20);

Waiver Program for Developmentally Disabled Individuals (Section 0398.10).

#### **0396.10.25.05 Cost Neutrality Requirement**

REV: April 2014

The Medicaid agency is responsible for reviewing and approving the aggregate cost neutrality of each Waiver Program on an annual basis. To meet cost neutrality, the average per capita expenditures under a waiver cannot exceed one hundred percent (100%) of the average per capita expenditures for the appropriate level(s) of care that would have been made in that year had the waiver not been granted.

#### **0396.10.25.10 Cost Neutrality - Level of Care Costs**

REV: April 2014

The average monthly costs to Medicaid by level of care are:

##### **Level of Care Cost**

Nursing Facilities \$6,388.

Intermediate Care Facilities for the Developmentally Disabled (ICF-MR)  
\$20,461.81

Hospitals \$24,195.00

#### **0396.15 Average Cost of Care**

REV: April 2014

The post-eligibility treatment of income applies to those individuals who are:

- Categorically Needy by virtue of having resources within the Categorically Needy limits, and income within the federal cap; and
- Medically Needy.

SSI RECIPIENTS: SSI recipients and individuals receiving Categorically Needy Medical Assistance by virtue of 1619(b) status are NOT subject to the post-eligibility process.

The SSI payment itself is invisible in the allocation process, and for Waiver Program recipients who are also

SSI recipients, NONE of the other income of an SSI recipient is subject to the post-eligibility process.

The state agency Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver

services for all Waiver services recipients who are subject to the post-eligibility process. The calculation starts with the individual's full, gross income, including amounts which were disregarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be defined to be part of the applicant's gross income in the determination of Medicaid financial eligibility.

#### 0396.15.05 Post-Eligibility Treatment of Income

REV: April 2014

The following is a list of allowable deductions in the order they are to be deducted:

**Maintenance Needs Allowance**

The Maintenance Needs Allowance is nine hundred and ninety-two dollars and fifty cents (\$992.50) per month.

This amount is in lieu of the Personal Needs Deduction and the Home Maintenance

Deduction available to other institutionalized (non-Waiver) individuals.

For employed individuals eligible under the Waiver for the Developmentally Disabled (Section 0398.10), the Maintenance Needs Allowance is equal to nine hundred and ninety-two dollars and fifty cents (\$992.50) plus all gross earned income per month, an amount not to exceed the federal cap. To qualify for this expanded Maintenance Needs Allowance, the individual's employment must be in accordance with the plan of care.

**Spouse/Dependent Allowance**

This deduction is an allowance for the support of a spouse and any dependents. The basic

allowance for a spouse is equal to the monthly medically needy income limit for an individual, less

any income of the spouse.

If there are also dependent children to be supported, the Medically Needy Income Limit for the number of children is used.

**Medical Insurance Premiums**

This deduction is insurance premiums paid by the individual, such as Medicare and Medigap policies such as Blue Cross and Plan 65.

**Allowable Costs Incurred for Medical or Remedial Care**

This deduction is reasonable costs for medical services recognized under state law but not covered in the scope of the Medicaid Program. Any balance of income remaining after these expenses are deducted is allocated toward cost of home-based services according to the plan worked out with the Case Manager.

#### **0396.15.10 Allowable Income Deductions**

REV: April 2014

Beginning with the second (2nd) month in which the individual receives services, income is allocated toward the cost of home-based services in the manner indicated below. The LTC/AS staff will calculate costs for individuals receiving services under the Aged and Disabled Waiver.

##### **0396.15.10.05 Calculation of Income Allocation**

REV: 01/2012

From the full gross income of a single individual the following amounts are deducted in order:

- Maintenance Needs Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan developed with the Case Manager.

##### **0396.15.10.10 Individual With Community Spouse/Dependent**

REV: 01/2012

When an eligible individual lives with a spouse (or a parent in the case of a child with an ineligible parent), the individual is considered to be a single individual.

The spouse's (or parent's) income is not considered in determining the amount the individual must pay for the cost of services.

Deduct from the applicant's full, gross income the following amounts, in the order presented:

- Maintenance Needs Allowance
- Spousal and Dependent Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

##### **0396.15.10.15 Medicaid Payment for Waiver Service**

REV: April 2014

The Waiver services recipient is responsible to pay the income allocation toward cost of home based services according to the plan worked out with the Case Manager. The Medicaid payment for Waiver services is reduced by the amount of the income allocation each month.

#### **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