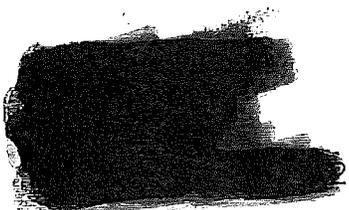


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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF HUMAN SERVICES
APPEALS OFFICE
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May 29, 2015

Docket # 15-369
Date of Hearing: April 2, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided. 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 representatives Michelle Szylin, Linnea Tuttle and the Policy Unit. Present at the hearing were: You, your parents, a representative from Tri-town and agency representative Linnea Tuttle.

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 her by notice dated February 3, 2015, that the re-assessment submitted by her Service Advisement Agency, Tri-Town, was reviewed and a new budget amount of \$3830.53 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 February 3, 2015 notice submitted).
- The agency representative submitted copies of the appellant's old budget and copies of the new budget that she has appealed. The appellant's initial budget was completed during October of 2014. At that time the appellant's budget was approved for \$4339.57. She stated that the new budget has not been approved because the appellant requested a hearing within 10 days of the agency notice.
- The agency representative stated that the Tri-Town caseworker did an assessment during October of 2014 and did a re-assessment during February of 2015. During that time period the caseworker noted some changes in terms of the appellant's abilities.
- The agency representative stated that the assessments are based on hands on assistance and each activity has an amount of time assigned to it and that is why the budget changed.
- The agency representative stated that when an activity goes from one time to two times or conversely from two times to one time the budget will decrease or increase depending on the change.
- The budget is also based on how much help is needed. Each level of care is provided with a dollar amount. She stated that the agency policy explains how services are determined and how a dollar amount is assigned to the assessment.
- The agency representative stated that each level of assistance has a particular amount of time assigned. If there is a functional characteristic noted such as behavioral issues, limited range of motion, then additional cost is added to how the budget is determined.
- The agency representative that multipliers are used to add to each task from total assistance to no assistance. She stated that the appellant's assessment went down because there were considerable changes according to what was reported to the caseworker in February 2015 that decreased the budget.
- The agency representative stated that dressing assistance was one of the changes. The appellant went from having minimum assistance to independent because it was reported that the appellant could sit and do most of the dressing herself.

- The agency representative stated that there were also other changes. The number of times requiring assistance with transfers went down and the number of times required with help toileting also decreased. She stated that all of these changes added up to result in a budget decrease.
- The agency representative stated that as the appellant's condition changed the original thought was that walking with a cane would strengthen her and increase her independence. Those changes were noted in the assessment.
- The agency representative stated that there is also a Provider Medical Statement from the appellant's doctor from April of 2014. The statement lists the appellant's needs and terms of assistance needed. The statement matches very closely with the assessment that was completed in February 2015. The budget is based on the medical information and the most recent assessment from February 2015.
- The agency representative stated that the program is not designed to provide payment for every single service. The appellant's parents provide assistance to their daughter such as transfers, which the program is not intended to pay for.
- The agency representative stated that a goal of the program is to help people become as independent as possible. She stated that is close to the time for a 3 month assessment and she will review that new assessment and determine if there are changes to the budget.
- The agency representative stated that in 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 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 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 Tri-Town representative testified:

- He stated that the assessment that was done in October 2014 was done by request because the appellant's doctor told the appellant's parents at that time the appellant would be transitioning from the walker to the cane.
- He stated that at that time the appellant's doctor was concerned about the appellant's lower body strength as she had been using her arms too much

with the walker. He stated that the assessment done in February 2015 was the annual scheduled re-assessment date.

The appellant' mother testified:

- She stated that her daughter's initial assessment was in October 2013 as Tri-Town hired a new caseworker at that time and the lady that worked with her daughter before was no longer working at Tri-Town.
- She was contacted by the new Tri-Town caseworker and he came out to see her daughter in March of 2014. The family was subsequently contacted by the Tri-Town caseworker in October 2014 who informed them that a new assessment was needed at that time, which was actually the annual assessment.
- She stated that at the time of the October 2014 assessment her daughter had switched from the walker to the cane per her doctor and therapist suggestion because she was using all upper body and not weight bearing with her legs.
- She stated that her daughter is not independent with the cane because she has vision loss and fear of falling. Her daughter has anxiety as her leg and arm do not work so someone has to hold her hand while she uses the cane.
- She stated that the Tri-Town caseworker contacted the family to arrange an assessment visit in February 2015. The caseworker told the family that there had been a budget increase because her daughter needed more assistance with the cane.
- She stated that she does everything for her daughter but she was told by the caseworker that she had to put a number on the assistance. The assessment indicates that bowel assist went from 7 days to 5 days per has decreased the budget. Her point is that most people move their bowels every day.
- She stated that at the time of the February assessment her daughter told the caseworker that she can dress herself. Her daughter is able to put her clothes out but she is unable to put her socks on, her brace on, and she cannot put her shoes on. Her daughter is unable to comb her hair. In her mind dressing independently is the ability to get dressed alone and going out the door.
- She stated that she is required to shower her daughter because her daughter must hold on to the shower bar while she showers. She dries her off and does her hair.
- She stated that her daughter's right leg has lymphedema, it is swollen, and it is the leg that was affected by the hemorrhagic bleed. She has a spot on her foot that must be checked every day and she is unable to check it herself.
- She stated that every transfer that her daughter does is with assistance either from her or her husband.
- She does not understand how the assessment determined the urinary/menses activity changed from 4x7 to 1x7. She stated that on a scale of 0% to 100% the assistance provided for dressing her daughter would be 50%.
- She stated that Tri-Town gives her personally 5 hours on weekends. She cares for her daughter 24 hours per day. The goal is to have her daughter become independent. The agency does not consider all of the other daily tasks that she does for her daughter such as laundry and meal preparation.

- She stated that her daughter sees her Neuro-Rehabilitation doctor on a regular basis.

Findings of Fact:

- The appellant is active with the agency Personal Choice Waiver program.
- The agency sent a notice to the appellant dated February 3, 2015 notifying her that her monthly budget was re-assessed and her new budget in the amount of \$3830.53 was approved.
- The appellant's representatives testified that the appellant requires additional hours for home care as her current hours are not sufficient.
- This record of hearing was held open through May 4, 2015 at the appellant's request to allow her to submit additional information from her 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 conducts the assessment 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 her based on her needs, which have not necessarily decreased but if anything she 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 February 2015, 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 her Activities of Daily Living completed by her 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 her case manager to determine what changes she can make to have the needed care provided within the budget. Policy allows that the appellant determines who cares for her, 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 she needs to complete her 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 February 2015 submitted by the agency determines that the following ADL's are addressed and the appellant is allotted time for extensive assistance with: showering, moderate assistance with: bowel, grooming, sponge bath, transfers, urinary/menses, total assistance with: mobility, skin care, set – up assistance with: eating, independent with: dressing. 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 from October 2014 decreased the appellant's allotted time for bowel from 1x7 to 1x5, dressing from minimum assistance to independent, grooming from 2x7 to 1x7, transfers from 10x7 to 8x7, urinary/menses from 4x7 to 1x7.

The appellant's representatives testified that the appellant continues to require the same amount of assistance for bowel, dressing, grooming, transfers, and urinary/menses.

The record contains a letter dated March 27, 2015 from the appellant's Rehabilitation Physician Rocco A. Chiappini, MD. The letter states that, "the appellant is a 22 year old woman who has a chronic disability since a hemorrhagic stroke caused by a ruptured arteriovenous malformation which occurred in December 2011. She has right sided weakness and spasticity in both the arm and leg since the stroke. She also had visual impairment which makes moving around in her environment less safe. Due to the above issues she has anxiety and a fear of falling. She uses a cane and a brace for all mobility, but even with these she is at risk of falling. The appellant continues to be disabled from the stroke and requires assistance on a consistent and daily basis."

This record of hearing was held open through May 4, 2015 to allow the appellant to submit medical information from her doctor or other care providers. The appellant's doctor completed a Provider Medical Statement dated April 14, 2015. The statement indicates that the appellant is diagnosed with hemorrhagic stroke due to arteriovenous malformation and spastic hemiplegia. The appellant has physical and speech therapy 2x's per week. The statement indicates that the appellant is independent with bed mobility, eating, and medication management. The appellant requires extensive assistance with dressing, bathing, ambulation, and transfers. The appellant requires supervision with toileting

The agency representative reviewed the April 14, 2015 provider Medical Statement and responded to this record that at this time there does not appear to be any significant changes between the most current assessment and the new Level of Care. The assessment was also reviewed with the Tri-Town caseworker who also felt that the assessment matched the Level of Care.

Based on review of the agency policy, the testimony and evidence submitted it is determined that the appellant has not been allotted appropriate time in her February 2015 Personal Choice budget to maintain her independence. The appellant's physician and her representatives have provided sufficient testimony and evidence to determine that her assistance requirements should be amended.

The appellant's level of assistance with dressing is to be changed from independent to minimum, transfer from 8x7 to 10x7, and urinary/menses from 1x7 to 4x7. The appellant is advised to review her periodic assessment time frame with her case manager as needed.

The appellant's request for relief is granted.

ACTION FOR THE AGENCY:

The agency is to make the above cited adjustments to the appellant's budget and notify the appellant of those changes within 30 days of this decision.


Michael J. Gorman
Appeals Officer

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.

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.