STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVCES
NOTICE OF PUBLIC COMMENT

SECTION 0396: WAIVER PROGRAMS & PROVISIONS

In accordance with Rhode Island General Laws (RIGL) Chapter 42-35, notice is hereby given that the Secretary of the Executive Office of Health & Human Services (EOHHS) has under consideration amendments to the Medicaid Code of Administrative Rules ("MCAR") Section #0396 ("Waiver Programs and Provisions"). Effective April 1, 2015, this Medicaid rule was amended by an "emergency" filing to reflect the 2015 changes in the Federal Poverty Level [FPL] guidelines that were cited in the January 29, 2015 *Informational Bulletin* from the Centers for Medicare and Medicaid Services. These rules are also being amended to reflect 2015 cost of care figures. The State is adopting these amended rules to set forth these provisions in a timely manner in order to prevent wrongful denial, discontinuance, or interruption of benefits for Medicaid applicants and beneficiaries.

These regulations are being promulgated pursuant to the authority contained in Rhode Island General Laws Chapter 40-8 (Medical Assistance) as amended; Rhode Island General Laws Chapter 40-6 ("Public Assistance"); Title XIX of the Social Security Act; Chapter 42-7.2 of the Rhode Island General Laws, as amended; and Chapter 42-35 of the Rhode Island General Laws, as amended.

In accordance with RIGL 42-35-3, an oral hearing will be granted if requested by twenty-five (25) persons or by an agency or association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

In the development of these proposed Regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

These proposed rules are accessible on the R.I. Secretary of State's website: **http://www.sos.ri.gov/ProposedRules/** and the EOHHS website **www.eohhs.ri.gov** or available in hard copy upon request (401 462-1575 or RI Relay, dial 711). Interested persons should submit data, views, written comments, or a request for a hearing **by Friday, June 19, 2015** to: Elizabeth Shelov, Office of Policy and Innovation, RI Executive Office of Health & Human Services, Louis Pasteur Building, 57 Howard Avenue Room #142, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.

Original signed by

_____

Elizabeth H. Roberts, Secretary
Signed this 19th day of May 2015

0396 Waiver Programs, Provisions

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 PersonalChoice 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 cost-effectiveness. 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~~ May 2015

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

Level of Care	Cost
Nursing Facilities	~~$6,388.~~ $6,510.00
Intermediate Care Facilities for the Developmentally Disabled (ICF-MR)	~~$20,461.81~~ $21,932.94
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 2015~~ May 2015

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)~~ one thousand dollars and eighty-three cents ($1,000.83) 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)~~ one thousand dollars and eighty-three cents ($1,000.83) 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.

*NOTE: To qualify as Medically Needy, an individual must have income within the Medically Needy income limit or incur 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.

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.

0396.20 Repealed April 2014

0396.20.05 Repealed April 2014

0396.20.10 Repealed April 2014

0396.20.15 Repealed April 2014

0396.20.20 Repealed April 2014

May 19, 2015
0396proposedmay2015