

## **0396**

## **WAIVER PROGRAMS, PROVISIONS**

### **0396.05**

### **OVERVIEW OF WAIVER PROGRAMS**

REV:04/2007

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 Medical Assistance 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 Department of Human Services 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).

DHS also operates Waiver programs in conjunction with other agencies to serve the needs of certain target populations. These jointly operated programs are the following:

- o The Department of Mental Health, Retardation and Hospitals (MHRH) program for developmentally disabled individuals ("MR Waiver" - see Section 0398.10);
- o The Department of Elderly Affairs (DEA) program for individuals in the community or seeking to return home from nursing facilities ("DEA Waiver" - see Section 0398.20);
- o The Department of Elderly Affairs (DEA) program for aged and disabled individuals in specified Residential Care/Assisted Living Facilities ("Assisted Living Waiver" - see Section 0398.30).

DHS Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of financial eligibility for Medical Assistance 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 MHRH, DEA, and for the PersonalChoice Program assist in the determination of eligibility for the Waiver Programs by forwarding information to the DHS LTC/AS unit, and by communicating directly with their applicants and recipients regarding eligibility and income allocation matters.

The Waiver programs differ in:

- o Target populations;

- o Special home and community-based services provided to eligible recipients;
- o Eligibility level required for participation (Categorically Needy or Medically Needy); and,
- o 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: 08/2008

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 Medical Assistance eligibility and services under a Waiver program. This means that:

- o Deeming of spousal resources and/or income does not apply after the month of separation due to institutionalization;
- o 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;
- o All transfers of assets made within sixty (60) months prior to, or anytime 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 anytime 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 Who May Be Eligible**

REV:12/2000

Individuals potentially eligible for Waiver programs include SSI recipients and non-SSI recipients.

#### **SSI RECIPIENTS**

SSI recipients (and former SSI recipients who are determined eligible for Medical Assistance 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 Medical Assistance program.

### **0396.10.10      Technical Elig Requirements**

REV:06/1994

Technical Requirements which must be met are:

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

#### **0396.10.10.05      *Institutional Level of Care***

REV:06/1994

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 Long Term Care Unit at CO.

The instruments for establishing the appropriate level of care are the CP-1 and the CP-1.1. 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 NEEDED eligibility to exist, the applicant's resources must be within the Categorically Needed 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 Needed eligibility are:

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

For MEDICALLY NEEDED eligibility to exist, the individual's resources may not exceed the Medically Needed resource limits set forth in Section 0380. The applicant's COUNTABLE income must be less than the Medically Needed 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 Needed Income Limit.

The Waiver Programs in which an individual may be either Categorically Needed or Medically Needed are:

- o Waiver Program for the Severely Handicapped (PARI Waiver) (Section 0398.15);
- o Waiver Program for Aged Individuals (DEA Waiver) (Section 0398.20);
- o Waiver Program for Developmentally Disabled Individuals (Section 0398.10).

## **0396.10.25.05 Cost Neutrality Requirement**

REV:05/2002

The DHS Center for Adult Health 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:03/2008

The average monthly costs to Medical Assistance by level of care are:

O	Nursing Facilities	\$ 5,566.00
O	Intermediate Care Facilities for the Developmentally Disabled (ICF-MR)	\$16,913.92
o	Hospitals	\$22,977.00

## **0396.15 Average Cost of Care**

REV:06/1994

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

- o Categorically Needy by virtue of having resources within the Categorically Needy limits, and income within the Federal Cap; and,
- o 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.

DHS 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 MA financial eligibility

## **0396.15.05 POST-ELIG TREATMENT OF INCOME**

REV:03/2008

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

- o Maintenance Needs Allowance

The Maintenance Needs Allowance is eight hundred eighty six dollars and sixty-seven cents (\$886.67) 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 eight hundred eighty six dollars and sixty-seven cents (\$886.67) 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.

O 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.

O Medical Insurance Premiums

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

This information will have been previously entered and identified on the STAT/INSU and STAT/MEDI panels.

O 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 Medical Assistance Program. Examples of such items would be hearing aids, chiropractic expenses, or ambulance charges.

These items are entered on the InRHODES Medical Expense (MEDX) Panel.

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:06/1994

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. The LTC/AS staff will review and approve CP-3 and CP-4 forms submitted by Case Managers from other agencies on each individual.

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

REV:03/2008

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

- o Maintenance Needs Allowance

- o Medical Insurance Premiums
- o 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.

EXAMPLE: Mr. Alonzo applies, is found eligible to receive home based services, and is Categorically Needy with income under the Federal Cap. He lives alone. His sole income from RSDI is \$1,134 per month. He has Medicare, but no other health insurance.

His monthly allocation to the cost of services is as follows:

RSDI Benefit	\$1,134.00
Maintenance Needs	- 886.67
Balance	246.33
Medicare Premium	- 96.40
Income Allocation	\$150.93

\*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:01/2009

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:

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

EXAMPLE: Mrs. Quackenbush has been found eligible for home-based services as a Categorically Needy individual with income under the Federal Cap. She has income from RSDI of \$989.40, and a private pension of \$449.80, for a total income of \$1,439.20 monthly. Her husband has income of \$515.40 from RSDI. Each

has Medicare and pays an SMI premium of \$96.40 monthly. Each also has Blue Cross Plan 65 at a monthly cost of \$117.47. Mrs. Quackenbush's monthly income allocation is as follows:

Total Gross Income	\$1,439.20
Maintenance Needs	- 886.67
Spouse Allowance	- 284.60
Mrs. Q's premiums	- 213.87
Income Applied to the Cost of Services	\$ 54.06

\*The Spouse allowance is calculated as follows: MNIL \$800.00 less Mr. Q's gross income of \$515.40 results in a spousal allowance of \$284.60. Note that the gross amount of Mr. Q's income is deducted from the MNIL. There is no recognition of Mr. Q's medical insurance premiums.

### **0396.15.10.15 MA Payment for Waiver Service**

REV:06/1994

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 Medical Assistance payment for Waiver services is reduced by the amount of the income allocation each month.

### **0396.20 FORMS UNIQUE TO WAIVER PROG**

REV:06/1994

Listed below are several of the forms used in more than one Waiver program, the programs for which each is used, and a description of their use. Specific procedures are found in the policies relating to each Waiver program.

### **0396.20.05 Patient Assessment Form**

REV:06/1994

The CP-1 and CP-1.1 may be completed only by staff trained in the use of these forms, and delegated the responsibility for recommending the appropriate care. Case Managers for all Waiver programs have been delegated this responsibility. The CP-1 cover sheet is used as an authorizing document to establish the need for NF care for services under a Waiver. The original and one copy of page 1 are sent to the LTC Unit, Division of Medical Services at Central Office for review and approval. One copy is retained in the case record.

### **0396.20.10 AND Activity Log**

REV:06/1994

The CP-2 is used in the aged and disabled Waiver. It is the chronological log of the Case Manager's activity for each individual receiving services under the Waiver. The form is retained in the case record. All contacts (face-to-face, telephone, or mail) with the individual, family, provider or others should be

entered briefly. A column is provided on the right side of the sheet for appropriate file instructions.

## **0396.20.15          AND Worksheet**

REV:06/1994

The CP-3 worksheet (see the InRHODES SERV panel) is designed to help the Case Manager compile the monthly cost of the individual plan of care. Informal providers of service need not be listed on the CP-3. The service costs calculated on the CP-3 are for Homemaker Services, Adult Day Care Services, Home Health Aide Services, Minor Modifications to the Home, and Minor Assistive Devices.

COLUMN 1:

Each deficit identified in the assessment should be specified.

For example, "cooking main meal weekdays," or "laundry."

COLUMN 2:

The type of provider whose service will compensate for the identified deficit rather than specific agency is entered here.

For example, "Homemaker Services," or "Day Care Services."

COLUMN 3:

Enter the number of hours per day for Homemaker Services required to complete the task. This column is used only for Homemaker Services.

COLUMN 4:

Enter the number of days per week the service will be delivered.

This column is used for Homemaker Services, Day Care Services and Home Health Services paid by Medical Assistance.

COLUMN 5:

Enter the unit cost of the service. Provider rates will be found on the CP-20. For minor modification in the home and minor assistive devices, (including the installation charge for PERS), divide the total cost by 12 and add to the dividend the monthly cost of PERS, if provided. Enter the total in column #6.

COLUMN 6:

Enter the monthly cost of each service and total the monthly cost for all services. Enter this figure on the CP-4, line 11.

## **0396.20.20          Case Mngr Financial Worksheet**

REV:06/1994

LINE 1:

Enter the consumer's total monthly gross income, excluding only the SSI payment, and the amount of the SMI premium, if any.

LINE 2-8:

Calculate exactly as if the individual were in a nursing facility.

Instructions for the allocation of income toward the cost of a nursing facility are in DHS MANUAL, Sec. 0396.

LINE 9:

Enter the average gross monthly cost of care in a nursing facility.

This amount is updated each year, and is found in DHS MANUAL, Sec.

0394.

LINE 10:

Subtract line 8 from line 9.

LINE 11:

Enter the consumer's total monthly gross income, excluding only the SSI payment and the amount of the SMI premium, if any.

LINE 12:

Enter the Medically Needy Income Limit (MNIL) for ONE for the consumer's maintenance needs. See Sec. 301.3.

LINE 13:

Enter the amount of any medical insurance premiums paid by the consumer (other than SMI).

LINE 14:

Enter the amount necessary for the support of a spouse who lives with the consumer. This is the MNIL for ONE less the spouse's gross income. If dependent children under 18 are present in the home, this amount is the MNIL for the total number of dependents to be supported (including the spouse), less any gross income of the dependents.

LINE 15:

Enter the cost of medical or therapeutic services provided for under state law but not covered by Medical Assistance (e.g., chiropractic services).

LINE 16:

Add lines 12, 13, 14 and 15.

LINE 17:

Subtract line 16 from line 11. If eligible, this is the amount for which the consumer will be responsible.

LINE 18:

Enter the total cost of Waiver services from the CP-3, or the Master Authorization form, as appropriate.

LINE 19:

Subtract line 17 from line 18.

The cost to Medical Assistance for home based services cannot exceed the cost of care in a Nursing Facility.