0376 OVERVIEW OF MA

0376.05 MANUAL ORGANIZATION

REV: 06/1994

Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to INSTITUTIONALIZED INDIVIDUALS.

Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.

The remainder of this section, OVERVIEW OF MA, describes who is considered to be institutionalized for the purpose of determining MA eligibility and the sequence of determinations. This section also lists the terminology for institutionalized persons, the coverage groups and Waiver programs to which they may belong, and services for the relocation of institutionalized individuals;

Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE, sets forth the provisions governing prior authorization for institutionalized care, which is a requirement for MA payment of care in certain medical facilities;

Section 0380, RESOURCES GENERALLY, contains general provisions which apply to an institutionalized individual's resources - resource limits, definitions, distinguishing resources from income, determining the countable resources of an institutionalized individual with a community spouse or dependents, resource reduction, and deeming of resources;

Section 0382, EVALUATION OF RESOURCES, sets forth the First Moment of the Month Rule (FOM) and the policies for evaluating specific types of resources;

Section 0384, RESOURCE TRANSFERS, defines resource transfers and when a prohibited transfer may result in a period of ineligibility for MA payment of long term care;

Section 0386, INCOME GENERALLY, contains general provisions which apply to an institutionalized individual's income -- limits, deeming considerations, definitions, and when income is counted;

Section 0388, TREATMENT OF INCOME, describes the various income exclusions and the evaluation of specific types of income such as rental property income and VA payments.

Section 0390, FLEXIBLE TEST OF INCOME, contains the policies governing the spenddown of excess income to achieve Medically Needy eligibility;

Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME, describes how the amount of income that an institutionalized individual must allocate to the cost of his or her care is determined;

Section 0394, SSI-RELATED COVERAGE GROUPS, describes the eligibility requirements and other provisions of the specific SSI- related coverage groups to which an institutionalized individual may belong;

Section 0396, WAIVER PROGRAMS - GENERAL PROVISIONS, contains the eligibility

requirements and other common provisions governing home and community-based services; Section 0398, SPECIFIC WAIVER PROGRAMS, describes the program goals, eligibility requirements, and services of the specific Waiver programs.

0376.10 ELIGIBILITY REQUIREMENTS

REV: 07/2006

The rules regarding determinations of eligibility for institutionalized individuals differ from the rules for community residents with respect to:

- Income limits;
- Consideration of the income of an institutionalized individual with a community spouse;
- The procedures utilized in the flexible test of income;
- Evaluation of the resources of an institutionalized individual with a community spouse; and
- The impact of resource transfers.

In addition to income and resource eligibility, institutionalized applicants for MA must meet the technical and characteristic requirements of the program and require an institutionalized level of care.

The technical requirements for eligibility are:

- Level of care;
- Residency;
- Enumeration;
- Citizenship/Alienage;
- Identity;
- Accessing potential income and resources; and
- Cooperation in making income/resources available.

An individual must have a characteristic. The characteristics are:

- Age (65 years or older);
- Blindness;
- Disability; and/or
- An AFDC-related characteristic.

The Long Term Care Unit within the Division of Medical Services at CO and Long Term Care/Adult Services (LTC/AS) field staff are responsible for determinations involving institutionalized individuals who apply for MA. An institutionalized individual who receives SSI or FIP is automatically Categorically Needy and receives the full scope of services. However, if an eligible institutionalized individual has made a prohibited transfer of resources, the transfer may render the individual ineligible for MA payment of nursing facility care for up to thirty (30) months.

Once eligibility for Medical Assistance and eligibility for payment of nursing facility services is determined, LTC/AS staff evaluate the individual's income to determine the amount the individual must pay toward the cost of care in the institution.

0376.15 CONSIDERED INSTITUTIONALIZED

REV: 06/1994

For purposes of determining eligibility for Medical Assistance, the following individuals are considered to be institutionalized from the first day in the medical institution:

- Individuals who receive care, or who are likely to receive care for at least thirty (30) consecutive days in nursing facilities, i.e., Skilled Nursing Facilities, Intermediate Care Facilities (SNF/ICFs), Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), or public medical facilities such as the Eleanor Slater Hospital and Zambarano Hospital;

- Individuals in acute care hospitals who are likely to be in the hospital (or another medical institution) for at least thirty (30) consecutive days, and have applied for nursing or public medical facility placement;

- Individuals in acute care hospitals who are likely to be in the hospital (or other institutional setting) for at least thirty (30) consecutive days, who no longer require acute care and for whom Administratively Necessary Day (AND) payment has been requested by the hospital;

- Individuals who entered the acute care hospital setting from a nursing or public medical facility to receive acute care and who plan to return to a nursing or public medical facility subsequent to the episode of acute care hospitalization. The following individuals are also considered to be institutionalized for the purpose of determining MA eligibility:

    - Individuals who receive home and community-based services under a Waiver; and

    - Children under age eighteen who require an institutional level of care, but who receive services at home (Katie Beckett children).

0376.20 SEQUENCE OF DETERMINATIONS

REV: 06/1994

Prior to Medical Assistance payment for the cost of institutional care, it must be determined that the individual requires care in an institutional setting, and that the specific institution is appropriate for that individual's needs. (See Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE).

Three separate financial determinations must be made in order to determine the Medical Assistance benefits for individuals who are institutionalized. The financial determinations are made in the following order:

- First, a determination of eligibility for Medical Assistance as either Categorically or Medically Needy is completed. Because of the broader scope of benefits, a determination of eligibility for the Categorically Needy Program is completed first. If the individual is not eligible as Categorically Needy, a determination of Medically Needy eligibility is completed;

- Second, the impact of resource transfers is evaluated. Eligibility for nursing facility payment (or an equivalent level of care) may be effected by a resource transfer which occurs on or after 10/1/89. (See Section 0384, RESOURCE TRANSFER);

- Third, if eligibility for both Medical Assistance and nursing facility payment exists, the institutionalized individual's income is evaluated to determine how much income must be used to help pay for the cost of care in the nursing facility or public medical facility. The Medical Assistance payment for care in these institutions is reduced by the amount of the institutionalized individual's applied income. This determination is known as the post-eligibility treatment of income. (See Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME).

0376.25 NOTICE OF AGENCY ACTION

REV: 06/1994

Each application for Medical Assistance results in a determination of eligibility or ineligibility. If eligible, the scope of services to be provided is determined, i.e. Categorically Needy, Medically Needy, restricted services only for aliens, non-payment for nursing facility services due to resource transfers, etc.

Applicants must be notified of agency decisions regarding:

- Medical Assistance eligibility and the effective dates thereof, including the months of eligibility/ineligibility resulting from the application;

- The scope of services, including eligibility for payment for nursing facility services;

- The amount of income to be applied to the cost of care, and how it was calculated, including the income allocation to the community spouse and/or dependents; and

- The amount of resources attributed to an institutionalized spouse and to his/her community spouse.

0376.25.05 TIMELINESS

REV: 06/1994

Applicants must receive adequate notice at the time the decisions pertinent to their applications are made. Unless the timely decision time frame has been extended by consent of an individual who is rebutting the presumption of ownership of a joint account, decisions on applications for disabled individuals are made within sixty (60) days. Decisions on applications for all others are made within thirty (30) days.

Recipients must receive adequate and timely (10-day) notice of decisions which result in an adverse action. Adverse actions include closing, reduction in the scope of services, and ineligibility for payment of institutional care services.

0376.25.10 NOTICE STRUCTURE

REV: 06/1994

LTC/AS cases frequently require a complex series of decisions relating to eligibility date(s), resource determinations, income to be applied to the cost of care, and allocations to community spouses. A series of attachments supplements the system- generated notices of the Medical Assistance program.

The LTC/AS staff utilize the additional special notices:

- Individuals must be notified of the results of the initial determination of total joint resources for couples when the evaluation is conducted in advance of the eligibility determination;
- Applicants must be notified of the attribution of resources between the institutionalized and community spouses at the time of application;
- Applicants must be notified that there may be a period of ineligibility for Medical Assistance as a result of a resource transfer. Recipients must be notified of the period of ineligibility for payment for nursing facility care that results from a prohibited transfer.

0376.30 TERMINOLOGY

REV: 06/1994

The following terms, which are listed alphabetically, are used in determining MA eligibility and payment for services:

ADVANCED DETERMINATION OF SPOUSAL SHARE: The determination of the Spousal Share of a couple's Total Joint Resources, conducted prior to the MA application and on the first day of the month in which one member of a couple begins a Continuous Period of Institutionalization.

COMMUNITY SPOUSE: The spouse of an individual in a medical institution whose separation from the institutionalized spouse is due solely to the spouse's institutionalization. For a spousal relationship to exist, there must be a legal marriage under Rhode Island law. A legal marriage may be a ceremonial marriage, or a common-law marriage. For a common-law marriage to exist under Rhode Island law, the following conditions must be met:

- Both parties must be of age;
- Both parties must be otherwise free to marry;
- The parties must hold themselves out to the community to be married; and
- The parties must have cohabited at some point.

COMMUNITY SPOUSE RESOURCE ALLOWANCE: The amount of a couple's combined Total Joint Resources which is attributed to the Community Spouse at the time Medical Assistance

eligibility is determined for the Institutionalized Spouse.

CONTINUOUS PERIOD OF INSTITUTIONALIZATION: A period of institutionalization which lasts (or is expected to last) at least thirty (30) consecutive days. A continuous period of institutionalization ends when the institutionalized individual is absent from an institutional setting for thirty (30) consecutive days.

DEPENDENT: For purposes of determining the post-eligibility allocation of income, a dependent is defined as:

- The financially dependent minor child of either the institutionalized or community spouse;
- The financially dependent parent of either the institutionalized or community spouse;
- The financially dependent sibling of either the institutionalized individual or the community spouse.

Financial dependency is established if the sibling, parent or child meets the criteria for dependency for federal income tax purposes for either the institutionalized or the community spouse. The dependent must reside with the community spouse in order to receive a dependent's allocation.

INSTITUTIONALIZED SPOUSE: An individual who is in a medical institution and who is married to a spouse who is not in a medical institution or nursing facility.

SPOUSAL SHARE: One half (1/2) of the couple's Total Joint Resources computed as of the beginning of a Continuous Period of Institutionalization. The Spousal Share remains fixed until the institutionalized spouse is determined to be eligible for Medical Assistance, regardless of any changes in the resources of either the institutionalized spouse or the community spouse. At the time of eligibility determination, the Spousal Share is used as one component in the calculation of the Community Spouse Resource Allowance.

TOTAL JOINT RESOURCE: The combined resources of the Community Spouse and the Institutionalized Spouse owned jointly and/or severally, to the extent that either has an ownership interest in the resource(s). Total Joint Resources are normally calculated at two points in the eligibility determination process as follows:

- The first evaluation (referred to as Advance Determination) is conducted as of the first day of the month in which the institutionalized spouse begins a Continuous Period of Institutionalization. The Total Joint Resources are those existing on the first day of the month in which the Continuous Period of Institutionalization begins, regardless of when the evaluation is actually conducted. The Total Joint Resources of the couple (as of the first day of the month in which a continuous period of institutionalization begins) are divided in half to determine the Spousal Share;
- The second calculation of Total Joint Resources occurs at the point the institutionalized spouse applies for Medical Assistance. At the time of application, as part of the eligibility determination process, the Total Joint Resources of the couple are established as they exist on the first day of the month(s) for which eligibility is being determined.

0376.35 COVERAGE GROUPS

REV: 04/2007

The following is a summary listing of the Medical Assistance coverage groups applicable to institutionalized individuals.

Following each listing is a reference to the section where the requirements of that specific coverage group may be found:

- Institutionalized Individuals - SSI Eligible in Community (0394.05)
- Institutionalized Individuals - Not SSI Eligible in Community (0394.10)
- December 1973 Residents of Title XIX Facility (0394.15)
- Continuing Eligibility - Short Term Confinement (0394.20)
- Employed Individuals Receiving SSI under Section 1619 - Institutionalized in State Operated Facilities (0394.25)
- Institutionalized Individuals AABD Eligible in December, 1973 (0394.30)
- Qualified and Specified Low-Income Medicare Beneficiary (0394.35)
- Qualified Disabled Working Individual (0394.40)
- Disabled Children Receiving Care at Home (Katie Beckett - 0394.45)

Coverage groups also include individuals receiving home and community- based services under one of the following Waiver programs approved by the Centers for Medicare and Medicaid (CMS) of the U.S. Department of Health and Human Services:

- Home Based Services for the Elderly and Disabled (A&D Waiver) (See Section 0398.05)
- Home Based Services for the Mentally Retarded (MR Waiver) (See Section 0398.10)
- PersonalChoice Program (See Section 0398.40)
- Home Based Services for Deinstitutionalizing the Elderly (DEA Waiver) (See Section 0398.20)
- The Assisted Living Waiver (See Section 0398.30.05)
- The Habilitative Waiver (See Section 0398.35.05)

0376.40 RELOCATION OF INSTIT IND

REV: 06/1994

The LTC/AS staff has the responsibility to:

- Determine initial and/or continuing eligibility of applicants and/or recipients who reside in a Long Term Care (LTC) facility or who reside in the community under Long Term Care

Alternatives (see Section 0396, WAIVER PROGRAMS);

- Provide required medical and social facts to Division of Medical Services for providing care to such recipients; and,
- Report to the LTC/AS Unit Supervisor any questions of quality of care or any indicated deviations from the standards set by the Licensing Authority.

The LTC/AS workers have an ongoing responsibility to provide service to recipients in nursing facilities and individuals receiving home-based services under the Long Term Care Alternatives Program.

Individuals receiving services under Long Term Care Alternatives are Group I and Group II. Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a nursing facility through Home Maker Services, and meet the financial and non- financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to Group I. Group II is individuals who qualify for nursing facility care, meet the financial and non-financial criteria for Categorically Needy MA and the criteria for Long Term Care Alternatives Program, and who choose home-based services in lieu of institutional care. When home-based care is no longer needed, it is the responsibility of the LTC/AS worker to plan with the recipient concerning his/her discharge from the home.

0376.40.05 INVOLUNTARY RELOCATION

REV: 06/1994

The relocation of patients necessitated by the decertification of a nursing or ICF/MR facility for Title XIX funds requires detailed social service planning in order to minimize the disruptive effect of the transfer. The Department will, upon request, provide social services necessary to plan and complete relocation. Every effort must be made to achieve a solid plan based on the patient's individual needs. The planning considers several factors. These factors include nursing facility and ICF/MR vacancies, location of the facility, the patient's medical condition, and proximity to visiting relatives and friends. Relevant planning data should be consolidated from all potential authority, relatives, etc.

The following activities occur:

- The patient and patient's family must be notified in writing immediately as to the status of the facility with respect to decertification. The letter should indicate the inability of DHS to pay for the care thirty days following decertification, and also inform the patient and family that LTC staff will provide service for relocation at any time during the thirty day period that the patient and/or family requests it.

- Since the patient's case record contains all current and pertinent medical and social data, it must be carefully reviewed to identify all factors necessary for a sound relocation plan. If it is determined from this review, from consultation with the patient, the patient's family or attending physician that a change in level of care is appropriate, the LTC/AS supervisor will request that the case be re-evaluated by the DHS Review Team.

- Sufficient casework service will be provided to reduce as much as possible the anxiety

level of the patient and assure that the patient understands to his/her capacity the necessity for relocation. Staff must be sensitive to the potential impact of the relocation on the patient. The patient's attending physician will be notified of the pending relocation and requested to provide information regarding any special medical considerations related to the relocation. Involvement of the patient, and the patient's family is paramount. The significance of the family's involvement in the planning should be emphasized. At least one contact, or as many as necessary to effect the relocation plan, will be made with the patient's family, where available. In most instances where the patient is competent and wishes that the family not be involved, the patient's wish is to be honored.

- Care should be taken to sensitize the staffs at the current and prospective facilities to the seriousness of the impact of relocation. They should be encouraged to provide whatever additional support the patient may require in dealing with the stress of uncertainty about the future.

- The caseworker should prepare the patient by providing as much information about the new facility as the patient needs and/or can absorb. Information may include the prospective facility's policies with respect to personal needs, money, laundry, visiting hours, etc. If brochures or photographs are available, they should be shown to the patient. In those instances where a group of patients from a decertified facility will all be transferring to the same facility, group meetings can be held to answer questions about the new facility.

- To the maximum extent possible, the prospective facility selected should be in close geographical proximity to the decertified facility, to avoid disrupting visiting patterns of the patient's relatives and friends. Every effort will be made to relocate together patients who wish to be placed in the same facility.
- Planning for mentally retarded patients must be coordinated with appropriate MHRH field staff in order to ensure that no disruption of other related special services occurs.

- All activities with respect to relocation, including date, time, place and details for planning must be included in the case record.

- LTC staff will undertake the activities set forth in the preceding bulleted paragraphs before concluding that the patient has knowingly refused to accept relocation planning from LTC staff.

- If medically feasible and if a family member or other appropriate person is available to bring the patient for an on-site visit, it can be very helpful in reducing the patient's anxiety.

- Several appropriate alternatives for transporting patients to the new facility are available. The responsible attending physician should be consulted to determine if the patient requires an ambulance. Voluntary transportation resources in the community should be mobilized, where appropriate, to effect the actual move. Suitable plans for a relative or other appropriate person to transport the patient can be arranged. Unusual problems with

transportation should be referred to the Supervisor of LTC services for resolution.

- Appropriate follow-up casework service, after the transfer, is imperative. The social worker must provide whatever support is necessary to ensure adjustment to the new facility.

- Before planning begins, each patient should be notified of the planning process and informed that, if s/he is dissatisfied with any aspect of the contemplated plan, s/he has a right to appeal through the fair hearing process.

0376.40.05.05 INVOLUNTARY RELOCATION RESTRICTIONS

REV: 06/2000

The Nursing Home Resident Protection Amendments of 1999 prohibit the transfer or discharge of residents from a nursing facility as a result of the facility's voluntary withdrawal from participation in the Medicaid Program.

Individuals residing in a nursing facility on the day before the effective date of the facility's withdrawal from MA participation may not be transferred or discharged as a result of the facility's withdrawal. This includes residents receiving MA benefits at the time, as well as individuals who are residents but not yet eligible for MA.

To continue receiving MA payments, the nursing facility must comply with all Title XIX nursing facility requirements related to treating patients residing in the facility in effect at the time of its withdrawal from the program.

Involuntary relocation of a resident patient is permitted when the basis for discharge or transfer is:

- to meet the resident's welfare and that welfare cannot be met in the facility;
- the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- the safety of individuals in the facility is endangered;
- the health of individuals in the facility would otherwise be endangered;
- the resident has failed, after reasonable and appropriate notice, to pay (or have paid by Medicare or Medical Assistance) for a stay at the facility; or
- the facility ceases to operate.

Individuals admitted to the nursing facility on or after the effective date of the facility's withdrawal from the MA program must be provided with notice that:

1) the facility no longer participates in the MA program with respect to that individual; and,

2) the individual may be discharged or transferred if unable to pay the facility's charges

even though the individual may have become eligible for MA.

This information must be provided to the individual both verbally and in a prominent manner in writing on a separate page at the time of admission. A written acknowledgment of the receipt of the notice, signed by the individual (and separate from other documents signed by the individual) must be obtained.

0376.40.10 NF PATIENT APPEAL RIGHTS

REV: 06/1994

Section 1919 (e) (3) of the Social Security Act requires States to provide appeal hearings for all nursing facility residents who wish to challenge their transfers or discharges. By statute, the appeals process cannot be limited to only Medical Assistance eligible nursing facility residents. Therefore, DHS will conduct administrative hearings for any NF resident who wishes to appeal a transfer or discharge from the facility, whether Medical Assistance or Medicare eligible, or private pay.

0376.40.10.05 TRANSFER DISCHARGE CRITERIA

REV: 06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- The health of individuals in the facility would otherwise be endangered.

The basis of the transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.10 DOCUMENTATION REQUIREMENTS

REV: 06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- The health of individuals in the facility would otherwise be endangered;

The basis or transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.15 PRE-TRANSFER/DISCHARGE NOTICE

REV: 06/1994

Before effecting a transfer or discharge of a resident, a nursing facility must:

- Notify the resident (and, if known, an immediate family member or legal representative of the resident) of the transfer or discharge and of the reasons for the move; and
- Record the reasons in the resident's clinical record (including any required documentation).

The nursing facility must notify the resident by use of a PRE- TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF) at least thirty (30) days in advance of the resident's transfer or discharge. At the time the patient receives the Pre-Transfer or Pre-Discharge Notice, s/he receives at the same time a NOTICE OF YOUR TRANSFER AND DISCHARGE RIGHTS (DHS-200NF) and a copy of REQUEST FOR A HEARING (DHS-121NF).

Thirty (30) day advance notice is not required under the following circumstances:

- In the event of danger to the safety or health of the individuals in the facility;
- When the resident's health improves sufficiently to allow a more immediate transfer or discharge;
- Where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;
- When the resident has not resided in the facility for a period of at least 30 days.

In the case of such exceptions, notice must be given as many days before the date of the move as is practicable, and include:

- The right to appeal the transfer or discharge through the administrative appeals process;
- The name, mailing address, and telephone number of the State long-term care ombudsman.

In the case of residents with developmental disabilities, the pre- transfer or pre-discharge notice must include:

- The mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

The resident must request an appeal within thirty (30) days of the date of the pre-transfer/discharge notice.

0376.40.10.20 Adminis Appeals Process
REV: 06/1994

The Department of Human Services will conduct administrative hearings for any nursing facility resident who wishes to appeal a transfer or discharge from the facility. The patient or patient's representative may request a hearing by completing Sections I and II of DHS form, REQUEST FOR A HEARING (DHS-121NF). The hearing request form should then be routed promptly to the Department of Human Services, Hearing Office, Hazard Building, 74 West Road, Cranston, RI 02920. Upon receipt, the Hearing Office will date stamp the form and send a copy with a letter to the nursing facility instructing the facility to complete Section III and return the form to the Hearing Office within seven (7) days.

The request for a hearing must be submitted within 30 days of the date of the PRE-TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF). If the request is submitted within 10 days of the date of the PRE- TRANSFER OR PRE-DISCHARGE NOTICE (DHS-100NF), the patient will remain in the facility pending the decision of the Hearing Officer.

The administrative hearing generally will be conducted at the resident's nursing facility unless otherwise requested by the patient or the patient's representative. Official notice of the hearing is sent to all parties involved at least five (5) days prior to the scheduled hearing date.

September 10, 2015
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