



RHODE ISLAND GOVERNMENT REGISTER

PUBLIC NOTICE OF PROPOSED RULEMAKING

AGENCY: Executive Office of Health and Human Services

DIVISION: Medicaid Policy Unit

RULE IDENTIFIER: 210-RICR-50-00-8 ERLID # TBD This proposed rule, when adopted, will supersede the Medicaid Code of Administrative Rules, Section #0392, "Post-Eligibility Treatment of Income" ERLID # 8415 and #0396, "Waiver Programs and Provisions" ERLID # 8143.

REGULATION TITLE: Medicaid Long-Term Services and Supports (LTSS) Post-Eligibility Treatment of Income (PETI)

RULEMAKING ACTION: Regular promulgation process

Direct Final: N/A

TYPE OF FILING: Adoption

TIMETABLE FOR ACTION ON THE PROPOSED RULE: Public comment will end on **Monday, June 18, 2018.**

SUMMARY OF PROPOSED RULE: This Part pertains to the post-eligibility treatment of income or "PETI" process and the determination of beneficiary liability. To ensure the beneficiary and/or spouse remaining at home (the "community" spouse) and the dependents of the LTSS beneficiary (the "institutionalized" spouse) have sufficient income and resources to thrive, Congress established a process to prevent spousal impoverishment. One important aspect of this process is a re-evaluation of the beneficiary's income – known as PETI – to determine what, if any, amount remains and available to be applied to the LTSS cost of care after certain amounts are set aside or "protected" to meet the financial needs of the beneficiary, spouses and/or dependents. The amount a beneficiary must pay toward the cost of care for Medicaid LTSS coverage is referred to hereinafter as "beneficiary liability."

COMMENTS INVITED:

All interested parties are invited to submit written or oral comments concerning the proposed regulations by **Monday, June 18, 2018** to the address listed below.

ADDRESSES FOR PUBLIC COMMENT SUBMISSIONS:

All written comments or objections should be sent to the Secretary of EOHHS, Eric J. Beane, c/o Elizabeth Shelov, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services

Mailing Address: Virks Building, Room 315, 3 West Road, Cranston, RI 02920

Email Address: Elizabeth.Shelov@ohhs.ri.gov

WHERE COMMENTS MAY BE INSPECTED: Mailing Address: Executive Office of Health & Human Services, Virks Building, Room 315, 3 West Road, Cranston, RI 02920

PUBLIC HEARING INFORMATION:

If a public hearing is requested, the place of the public hearing is accessible to individuals who are handicapped. If communication assistance (readers/ interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call (401) 462-6266 or RI Relay 711 at least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.



ALTERNATIVE PUBLIC HEARING TEXT:

In accordance with R.I. Gen. Laws § 42-35-2.8, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within ten (10) days of this notice.

FOR FUTHER INFORMATION CONTACT: Elizabeth Shelov, Interdepartmental Project Manager, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services, Virks Building, Room 315, 3 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov

SUPPLEMENTARY INFORMATION:

Regulatory Analysis Summary and Supporting Documentation:

Societal costs and benefits have not been calculated in this instance. To be in conformity with federal law, regulations, guidance and state law, the state has little discretion in promulgating this rule. For full regulatory analysis or supporting documentation see agency contact person above.

Authority for This Rulemaking: Title XIX of the U.S. Social Security Act provides the legal authority for the RI Medicaid program. Federal Authorities: Federal Law: Title XIX, of the federal Social Security Act at: 42 USC § 1396a, 42 USC § 1396b, 42 USC § 1396k; Federal regulations: 42 CFR §§ 435.700 – 435.735; 435.800-435.832; 460.184, Parts I through G, including §§435.733, §435.735 and 484.10(e). The RI Medicaid State Plan and the Title XIX, Section 1115 (a) Demonstration Waiver (11-W-00242/1), effective through December 31, 2018. State Authorities: Among other statutes, R.I.G.L. §40-8, 40-8.9, and 40-8.10.

Regulatory Findings:

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

The Proposed Adoption: This proposed rule, when adopted, will supersede the Medicaid Code of Administrative Rules, Section #0392, “Post-Eligibility Treatment of Income” and #0396, “Waiver Programs and Provisions.” Medicaid LTSS beneficiaries are required by federal law and regulations, the State Plan, and the Section 1115 waiver to contribute income toward the Medicaid cost of care, irrespective of whether LTSS is provided in a health care institution or a home or community living arrangement. Only persons eligible for Medicaid LTSS on the basis of the Modified Adjusted Gross Income “MAGI” methodology – the ACA adult expansion – are not required to pay toward the cost of care under federal regulations in effect as of March 1, 2018. This Part pertains to the post-eligibility treatment of income or “PETI” process and the determination of beneficiary liability.



STATE OF RHODE ISLAND EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

PUBLIC NOTICE OF PROPOSED RULE-MAKING

Section 210-RICR-50-00-8

“Medicaid Long-Term Services and Supports: Post-Eligibility Treatment of Income”

The Secretary of the Executive Office of Health and Human Services (EOHHS) has under consideration the adoption of a Medicaid regulation entitled, “Medicaid Long-Term Services and Supports: Post-Eligibility Treatment of Income” - Section 210-RICR-50-00-8. This proposed rule, when adopted, will supersede the Medicaid Code of Administrative Rules, Section #0392, “Post-Eligibility Treatment of Income” and #0396, “Waiver Programs and Provisions.”

These regulations are being promulgated pursuant to the authority contained in R.I. Gen. Laws Chapter 40-8 (Medical Assistance); R.I. Gen. Laws Chapter 40-6 (“Public Assistance”); R.I. Gen. Laws Chapter 42-7.2; R.I. Gen. Laws Chapter 42-35; and Title XIX of the Social Security Act.

In accordance with R.I. Gen. Laws 42-35-2.8(c), an opportunity for a hearing will be granted if a request is received by twenty-five (25) persons, or by a governmental agency, or by an association having not less than twenty-five (25) members, within ten (10) days of this notice that is posted in accordance with R.I. Gen. Laws 42-35-2.8(a). A hearing must be open to the public, recorded, and held at least five (5) days before the end of the public comment period.

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/>, 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, or written comments by **Monday, June 18, 2018** to: Elizabeth Shelov, Medicaid Policy Office, RI Executive Office of Health & Human Services, Virks Building, 3 West Road, Room 315, 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.

The EOHHS in the Virks Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the EOHHS at (401) 462-6266 (hearing/speech impaired, dial 711) at least three (3) business days prior to the event so arrangements can be made to provide such assistance at no cost to the person requesting.

Original signed by:

Eric J. Beane, Secretary
Signed this 16th day of May 2018

210-RICR-50-00-08

Title 210 - Executive Office of Health and Human Services

Chapter 50 – Medicaid Long-Term Services and Supports (LTSS)

Subchapter 00 – N/A

Part 8 –Post-Eligibility Treatment of Income (PETI)

8.1 OVERVIEW

- A. Medicaid LTSS beneficiaries are required by federal law and regulations, the State Plan, and the Section 1115 waiver to contribute income toward the Medicaid cost of care, irrespective of whether LTSS is provided in a health care institution or a home or community living arrangement. Only persons eligible for Medicaid LTSS on the basis of MAGI – the ACA adult expansion – are not required to pay toward the cost of care under federal regulations in effect as of March 1, 2018.
- B. To ensure the beneficiary and/or spouse remaining at home (the “community” spouse) and the dependents of the LTSS beneficiary (the “institutionalized” spouse) have sufficient income and resources to thrive, Congress established a process to prevent spousal impoverishment. One important aspect of this process is a re-evaluation of the beneficiary’s income – known as the post-eligibility treatment of income or “PETI” – to determine what, if any, amount remains and available to be applied to the LTSS cost of care after certain amounts are set aside or “protected” to meet the financial needs of the beneficiary, spouses and/or dependents. The amount a beneficiary must pay toward the cost of care for Medicaid LTSS coverage is referred to hereinafter as “beneficiary liability. This section pertains to the PETI process and the determination of beneficiary liability.

8.2 LEGAL AUTHORITY AND SCOPE AND PURPOSE

A. Federal Authorities:

1. Federal Law: Title XIX, of the federal Social Security Act at: 42 USC § 1396a, 42 USC § 1396b, 42 USC § 1396k;
2. Federal regulations: 42 CFR §§ 435.700 – 435.735; 435.800-435.832; 460.184, Parts I through G, including §§435.733, §435.735 and 484.10(e).
3. The RI Medicaid State Plan and the Title XIX, Section 1115 (a)Demonstration Waiver (11-W-00242/1), effective through December 31, 2018.

- B. State Authorities: Among other statutes, R.I. Gen. Laws §§ 40-8, 40-8.9, and 40-8.10.
- C. The PETI process is conducted by the State with verified information subsequent to the determination of income and resource eligibility, the assessment of clinical need and the pre-authorization of services. Only the amounts set aside for the purposes set forth in this rule may be protected. All the beneficiary's remaining income must be used to reduce the Medicaid payments for LTSS coverage. A beneficiary's income, protected amounts, and allocation to the cost of care are computed monthly to account for changes in income, the scope of services provided, and the cost of care, as appropriate.

8.3 EXCLUSIONS AND EXEMPTIONS

- A. There are certain beneficiaries receiving Medicaid LTSS coverage that are either excluded from the PETI or are exempt in certain circumstances, as indicated below:
1. Children and Youth Up to Age 19 – Children receiving Medicaid LTSS, irrespective of eligibility pathway, are not subject to PETI. Although there are some differences in the way beneficiary liability is determined by setting, the same general rules in this section apply irrespective of eligibility pathway or whether LTSS is provided in a health institution or at home or in the community.
 2. SSI Beneficiaries – 1619 (b) status – Irrespective of LTSS living arrangement, Medicaid beneficiaries who are working and have SSI 1619 (b) status are exempt from the PETI process. Earned income is treated as invisible in the allocation process.

8.4 DEFINITIONS

- A. For the purposes of this section, the following definitions apply:
1. "Authorized representative" means a person whom the applicant or beneficiary has designated to act on his or her behalf on matters related to LTSS Medicaid.
 2. "Beneficiary liability" means the LTSS beneficiary's financial obligation toward the Medicaid LTSS cost of care, as determined monthly.
 3. "Community spouse housing allowance" means the monthly housing allowance set by the federal government each year as the minimum amount that must be protected to cover the non-LTSS spouse's shelter expenses for his or her principal place of residence.

4. "Family allowance" means a deduction in the computation of a beneficiary's liability for the needs of dependent family members who are residing with the non-LTSS spouse or guardian.
5. "Family maintenance of needs allowance" means a deduction in the computation of beneficiary liability for the needs of dependent family members when there is no non-LTSS spouse and the dependent resided with the LTSS beneficiary immediately preceding the admission to a health care institution or LTSS community residence or is residing with the LTSS beneficiary at home.
6. "Family member" means a natural, adoptive, step-child, parent, or sibling of the LTSS beneficiary who is under age 19 and is claimed as a dependent by the LTSS beneficiary, non-LTSS spouse, or the couple for the most recent federal tax year, or, if a tax return was not filed, could be claimed as a dependent.
7. "Financially responsible relative" means a spouse or, if the person is a minor or older youth with a disability, the person's parent.
8. "HCBS maintenance needs allowance" means a required deduction in the income of a beneficiary liability to cover the costs of living needs of a Medicaid beneficiary requesting or receiving LTSS in a home or community-based living arrangement.
9. "LTSS beneficiary" means a person who meets all the general, clinical/functional, and financial eligibility requirements for LTSS, or a person receiving Medicaid LTSS of any type regardless of living arrangement. The LTSS beneficiary was previously referred to as the "institutionalized" individual.
10. "Maximum monthly maintenance of need allowance" means the amount established by the federal government as the maximum amount of income the State must protect to meet the maintenance of needs requirements of beneficiary's spouse living in the community when determining beneficiary liability.
11. "Minimum monthly maintenance of needs allowance" means the amount established by the federal government as the minimum amount of income that the state must protect to meet the maintenance of needs requirements of beneficiary's spouse living in the community when determining beneficiary liability. Based on 150 percent of the FPL for a family of two.
12. "Monthly spousal allowance" means the amount of a Medicaid LTSS beneficiary's income that is set aside to meet the monthly maintenance of need expenses of a non-LTSS spouse.

13. "Non-LTSS spouse" means the spouse of an LTSS applicant or beneficiary regardless of LTSS living arrangement. It includes the spouses of anyone requesting or receiving Medicaid LTSS in a health care institution – NF, ICF-ID, or hospital – or in the home and community-based setting. When both spouses in a married couple are seeking or receiving Medicaid LTSS, neither is considered a non-LTSS spouse, irrespective of whether they reside together or separately.
14. "Personal needs allowance" means a required deduction in the computation of beneficiary liability for needs of the LTSS beneficiary and includes the federally mandated amount as well as State-only personal needs allowance, paid through the optional State supplement program.
15. "Service plan " means the scope of Medicaid LTSS, including the types of services to be furnished, the amount, frequency and duration of each service and the type of provider to furnish each service.
16. "Standard utility allowance" means an amount that is used in lieu of the actual amount of utility costs. The standard utility allowance is applicable if the non-LTSS spouse is responsible for payment toward the cost of gas, electric, coal, wood, oil, water, sewage, or telephone for the residence and is updated annually, in conjunction with the Supplemental Nutrition Assistance Program (SNAP) in the RI Department of Human Services' Administrative Code at 218-RICR-20-00-01.

8.5 INCOME FOR POST-ELIGIBILITY PURPOSES

- A. PETI Income. During the post-eligibility review process, income is treated differently than during earlier steps in the LTSS eligibility sequence.
 1. General Rules – The treatment and availability of income in the PETI is conducted in accordance with the following:
 - a. Only the income allocated to the LTSS beneficiary is considered available in the beneficiary liability determination.
 - b. During any month in which a Medicaid LTSS beneficiary is receiving covered services, the income of beneficiary's spouse is treated as unavailable.
 - c. In the case of an LTSS beneficiary who has no spouse, only the income of the beneficiary is considered in determining beneficiary liability.
 - d. Spouses separated by a continuous period of LTSS, regardless of living arrangement, are considered for PETI purposes to be living apart starting in the month the LTSS beneficiary begins to receive Medicaid LTSS.

2. Income Ownership – When determining the income ownership in the PETI process, the following rules apply and preempt any State laws that might otherwise govern community property or the division of marital property:
- a. Non-trust property. Non-trust property is all property not subject to a trust. The instrument which provides income is reviewed to identify the specific provisions related to payment and the availability of income for the LTSS beneficiary and spouse. If the instrument providing the income lacks specific provisions relating to payment and availability of income, the following provisions apply:
- (1) If payment of income is made solely in the name of the LTSS beneficiary or the spouse, the income must be considered available only to the spouse;
 - (2) If payment of income is made in the names of the LTSS beneficiary and the spouse, one-half of the income is considered available to each member of the couple;
 - (3) If payment of income is made in the name of the LTSS beneficiary, spouse or both, and to another person, the income is considered available to each spouse in proportion to that spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest is considered available to each spouse.
 - (4) In the case of income that is not derived from a trust in which there is no instrument establishing ownership, one-half of the joint interest is considered available to the LTSS beneficiary and one-half to the spouse.
- b. Trust property. In the case of a trust, income is considered available to each spouse as provided in the trust or, in the absence of a specific provision in the trust, as follows:
- (1) If payment of income is made solely to the LTSS beneficiary or the spouse, the income is considered available only to the spouse;
 - (2) If payment of income is made to both the LTSS beneficiary and the spouse, one-half of the income is considered available to each member of the couple;
 - (3) If payment of income is made to the LTSS beneficiary or the spouse, or both, and to another person or persons, the income is considered available to each spouse in proportion to the spouse's interest. If payment is made with respect to

both spouses and no such interest is specified, one-half of the joint interest is considered available to each spouse.

3. Rebutting Income Ownership --The provisions regarding non-trust property may be superseded to the extent that an LTSS beneficiary can establish, by a preponderance of the evidence that the ownership interests in income are other than as provided in this Part.

B. Recalculation of Income. The first step in the PETI process is the determination of gross income of the LTSS beneficiary by adding all earned and unearned income without including any disregards or exclusions that apply for eligibility purposes. Once gross income has been established, federal law mandates that certain types of income must be excluded from gross income in the PETI calculation. They are as follows:

1. German reparation payments, Austrian social insurance payments, and Netherlands reparation payments, in accordance with the Nazi Persecution Victims Eligibility Act, Pub. L. No. 103-286 (20 C.F.R. § 416.1236(a)(18)); or provisions of the Austrian General Social Insurance Act, paragraphs 500 through 506.
2. Japanese and Aleutian restitution payments, under the provisions of section 105 of Pub. L. No. 100-383 (50a U.S.C. § 1989b et seq.) by persons of Japanese ancestry.
3. Agent Orange settlement payments under the provisions of the Agent Orange Compensation Exclusion Act, Pub. L. No. 101-201 (42 C.F.R. § 416.1236) received on or after January 1, 1989.
4. Radiation exposure compensation payments under the provisions of the Radiation Exposure Compensation Act, Pub. L. No. 101-426 (42 U.S.C. § 2210).
5. U.S. Veterans Administration pensions of up to the amount of ninety (90) dollars per month for LTSS beneficiaries residing in a health care institution (NF, ICF-ID, H). Applies to surviving spouses of veterans requesting or receiving Medicaid LTSS.
6. U.S. Veteran's Aid and Attendance (A&A) and housebound allowances (VHA) are reduced to and included in the \$90 exclusion indicated in (5) above when residing in a health care institution. When the LTSS beneficiary is residing at home or in a community-based LTSS arrangement, the portion of the A&A or VHA payment allocated by the VA for room and board is excluded. The pension portion of the payment is included in the calculation of gross income and is considered when determining beneficiary liability unless specifically allocated for a spouse/dependents. See:

http://www.benefits.va.gov/pension/current_rates_veteran_pen.asp for pension amounts.

7. Seneca Nation Settlement Act of 1990 payments under the provisions of the Seneca Nation Settlement Act of 1990, Pub. L. No. 101-503 (25 U.S.C. § 1774) (as in effect January 1, 2014), received on or after November 3, 1990.
 8. As indicated in § 8.3 of this Part, SSI cash benefits received under authority of Sections 1611(e)(1)(E) and (G) of the SSA (42 U.S.C. § 1382), Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (42 U.S.C. § 1396a) are excluded for LTSS beneficiaries during the first three (3) full months of Medicaid LTSS in a health care institution. The EOHHS re-determines beneficiary liability retroactively if an SSI-eligible LTSS beneficiary's actual stay exceeds the expected stay of ninety (90) days or less.
 9. Optional State Supplement Payments paid to LTSS beneficiaries residing in health care institutions. State supplement program cash assistance is as State-only payment that is considered to be a component of the beneficiary's personal needs allowance or HCBS special maintenance needs allowance and is identified herein as the State only personal needs allowance.
 10. Payments received under the provisions of a State "Victims of Crime Program" for a period of nine months beginning with the month following the month of receipt.
 11. Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al, per section 4735 of the Balanced Budget Act of 1997, Pub. L. No. 105-33 (42 U.S.C. § 1396u).
 12. Payments made from any fund established pursuant to a class action settlement in the case of "Factor VIII or IX concentrate blood products litigation."
- C. Sequence of Deductions. Once all required exclusions are applied, deductions are made in the income of the person seeking or receiving LTSS in a specific sequence. In general, the sequence functions as follows: the beneficiary's personal need allowance (identified as 1 through 2(b) in the table below), and then spousal and family allowances (3 and 4 in the table). If necessary, the personal needs allowance is adjusted to ensure that the allowances for spouses and family members are adequate. From this point forward, allowances for health costs, incurred expenses and, if appropriate, home maintenance are deducted. Both the nature of the deduction and the amount may vary by LTSS family structure and living arrangement:

<u>Sequence of Deductions for PETI Allowances by Type</u>		
	<u>Applicability by Setting</u>	
<u>Allowances</u>	<u>Institutional – NF, Hosp, ICF/ID</u>	<u>HCBS</u>
<u>1. Personal Need Allowance -federally mandated.</u>	<u>Yes</u> <u>For Non-Veterans total = \$30</u>	<u>Yes</u>
<u>a. State Only -Personal needs allowance State-only</u>	<u>Yes</u>	<u>Yes -Amount varies by living arrangement</u>
<u>b. Veterans Improved Pension</u>	<u>Veteran LTSS beneficiaries in nursing facilities (NF) and other health care institutions only</u>	<u>No</u>
<u>c. Therapeutic Employment (TE) - Personal needs allowance</u>	<u>Yes</u>	<u>No</u>
<u>2. HCBS - Maintenance of Needs Allowance for the LTSS beneficiary, OR:</u>	<u>No</u>	<u>Yes</u>
<u>a. Intellectual and Developmental Disabilities - Special Maintenance Needs Allowance</u>	<u>No</u>	<u>For LTSS beneficiaries participating in the Medicaid HCBS habilitation program and integrated community employment support program for persons with developmental disabilities. See § 8.6 Part B 4</u>
<u>b. Assisted Living - Special Maintenance Needs Allowance -</u>	<u>No</u>	<u>For LTSS beneficiaries. See § 8.6 Part B 3</u>

<u>Sequence of Deductions for PETI Allowances by Type</u>		
	<u>Applicability by Setting</u>	
<u>Allowances</u>	<u>Institutional – NF, Hosp, ICF/ID</u>	<u>HCBS</u>
<u>Assisted/Supported Living</u>		
<u>3. Monthly Spousal Allowance – Amount protected for a beneficiary’s spouse</u>	<u>Yes</u>	<u>Yes</u>
<u>4. Family Allowance - Dependent family members when there is a non-LTSS spouse; OR</u>	<u>Yes</u>	<u>Yes</u>
<u>Family Maintenance of Need - Dependent family members, when there is NO non-LTSS spouse</u>	<u>Yes</u>	<u>Yes</u>
<u>5. Health Coverage and Expenses</u>	<u>Yes</u>	<u>Yes</u>
<u>6. Special Incurred Expenses – including legal guardianship fees</u>	<u>Yes</u>	<u>Yes</u>
<u>7. In Institution – Time Limited Home Maintenance Allowance</u>	<u>Yes</u>	<u>No</u>

D. PETI Standards – When determining the amount of an allowance in the PETI process the following standards apply:

<u>PETI Allowance Standards</u>	
<u>Standard</u>	<u>Monthly Amount and Basis</u>
<u>Personal needs allowance standard</u>	<u>Non-veterans = total federal minimum plus and State supplement program payment (\$50)</u> <u>Veterans = improve pension (\$90)</u>
<u>Therapeutic employment personal needs allowance</u>	<u>An additional \$85 plus one-half of earned income allowance, after deducting certain employment expenses and fees.</u>
<u>Minimum Monthly Maintenance of Need Allowance -- for non-LTSS spouse</u>	<u>Based on 150% of the FPL for a family of two -</u>
<u>Community Spouse Housing Allowance</u>	<u>Amount established by the federal government and the standard utility allowance for SNAP</u>
<u>Home and Community-Based Services - Maintenance of Needs Allowance</u>	<u>100% of the FPL for one + \$20</u>
<u>State only personal needs allowance for beneficiaries receiving the optional State supplemental payment to SSI</u>	<u>Varies by living arrangement</u>
<u>Assisted Living Special Maintenance of Need Allowance -- beneficiaries eligible for State supplement payment</u>	<u>Federal Benefit rate + State supplement payment for Category D or F, less State only - personal needs allowance, adjusted for single v. double room -- For beneficiaries with income up to 300% of the SSI income standard</u>
<u>I/DD-Special Maintenance of Needs Allowance – habilitation and developmental disabilities programs</u>	<u>HCBS maintenance of need allowance (100% of the FPL and a \$20 standard disregard) plus any earned income not to exceed 300% of the SSI income standard</u>
<u>Family Allowance</u>	<u>One-third of the minimum monthly maintenance needs allowance per dependent family member</u>

<u>PETI Allowance Standards</u>	
<u>Standard</u>	<u>Monthly Amount and Basis</u>
<u>Family Maintenance of Need</u>	<u>Medically needy income limit adjusted for family size. Medicaid LTSS beneficiary living with family members is included in family size. LTSS Medicaid beneficiaries residing in institutional living arrangements are NOT included in family size</u>
<u>Health Coverage and Expenses</u>	<u>Actual costs but only if not paid for or reimbursed by Medicaid or a third-party and allowable expenses otherwise not covered by Medicaid, including Medicare and other health insurance premiums</u>
<u>Special Incurred Expenses</u>	<u>Within applicable limits See § 8.6 A(2)(b)</u>
<u>In Institution – Time Limited Home Maintenance Allowance</u>	<u>Up to 100% of the FPL for one per month, based on expenses, for no more than six months</u>

8.6 PERSONAL AND FAMILY MAINTENANCE OF NEED ALLOWANCES

A. Personal Needs Allowances. In general, LTSS beneficiaries receiving services in a health care institution receive a monthly personal needs allowance to cover the costs of daily needs that are not covered by the facility such as grooming, reading materials, cell phone fees and the like. A personal needs allowance is also provided to LTSS beneficiaries living in community settings such as Medicaid-certified assisted living residences under certain circumstances – that is, when eligible to receive the optional State supplement payment for low-income beneficiaries. The amount of the personal needs allowance is also a function of whether the LTSS beneficiary was receiving a pension from the Veterans Administration and has no spouse or dependents or qualifies as a surviving spouse.

1. Personal Need Allowance - A personal needs allowance is provided to LTSS beneficiaries who reside in a health care institution. (The maintenance of need allowances set aside for Medicaid LTSS beneficiaries residing in certain HCBS living arrangements are set forth in paragraph (3) below.) The personal needs allowance amounts indicated below include optional State supplemental payments as well as required federal amounts, except as provided for veterans:

- a. Monthly Personal Needs Allowance of \$50. LTSS beneficiaries residing in a NF, ICF-ID, or hospital providing long-term services receive a personal needs allowance of \$50. The personal needs allowance consists of a mandated federal allowance of \$30 and the State only - personal needs allowance through State supplement payment of \$20 per month.
 - b. Veterans Personal Needs Allowance of \$90. The Veterans Benefit Act of 1992 entitles veterans who had received a pension to obtain what is known as the “veteran’s improved pension” of \$90 per month when residing in a health care institution. This \$90 benefit is treated as a personal needs allowance and is deducted from income when determining liability for veterans who are Medicaid LTSS beneficiaries. The \$90 veteran’s improved pension is available to Medicaid LTSS beneficiaries who are veterans and do not have a spouse or dependent child; or are the surviving spouse of a veteran who does not have a dependent child(ren). The improved pension is provided instead of the \$50 monthly personal needs allowance for non-veteran Medicaid LTSS beneficiaries.
2. Expanded - Personal Needs Allowance – The personal needs allowance of LTSS beneficiaries may be expanded in certain circumstances as indicated below:
- a. Therapeutic Employment – Personal Needs Allowance. LTSS beneficiaries may retain a higher personal needs allowance if they have earned income as result of therapeutic employment. The personal needs allowance is deducted from the total amount of earned income related to public or private employment. To be considered therapeutic, the employment must be part of a written plan developed by the Office of Rehabilitative Services, of the Department of Human Services, or a similar entity and be for the purpose of enhancing the beneficiary’s ability to achieve the highest level of independence. For these beneficiaries, the therapeutic employment - personal needs allowance is an additional \$85 plus one-half (1/2) the remainder of earned income per month, subsequent to deducting actual FICA tax withheld, transportation costs, employment expenses, such as tools and uniforms, and State and federal taxes if the person is not exempt from withholding. The total may be protected for personal needs. The maximum therapeutic employment - personal needs allowance will vary but may not exceed \$400 per month. See below for the expanded HCBS special maintenance needs allowance for employed LTSS beneficiaries with developmental disabilities residing at home.

b. Allowable fees. LTSS beneficiaries who incur expenses related to a guardianship or conservatorship, legal fees and/or tax assessments, court-orders or other legally binding instruments may receive an expanded personal needs allowance, or in the case of attachments or liens, a pre-emptive allowance to cover associated costs or legal obligations in certain circumstances when appropriate documentation is provided:

- (1) Guardianship/conservatorship. LTSS beneficiaries who have court-appointed guardians or conservators are allowed an expanded personal needs allowance to pay for certain court-approved or ordered fees. To be considered, the expense must be required for the LTSS beneficiary to make income or resources available, or to gain access to or consent for necessary medical treatment if the LTSS beneficiary does not have the capacity to make decisions on his or her own.
- (2) Requests and documentation – probate order and itemized bills – are reviewed by the EOHHS legal team and LTSS specialists. The total amount allowed must be reasonable based on applicable rates and fee schedules approved by the RI Supreme Court. Monthly deductions of up to one hundred twenty-five dollars (\$125) may be allowed for guardianship expenses. Monthly deductions up to one hundred twenty-five dollars (\$125) may also be allowed for related legal fees. An additional deduction from income of up to two hundred fifty dollars (\$250) is recognized for allowable expenses related to a guardian-ad-litem during the month in which the LTSS beneficiary pays the expense.
- (3) Legal Fees. LTSS beneficiaries who incur fees resulting from legal action to obtain income or resources for their support may retain income in the form of an expanded personal needs allowance to pay such fees. The maximum which may be deducted from income is the lesser of the actual fee, or one third of the settlement amount.
- (4) Tax Assessments. LTSS beneficiaries ordered by the federal Internal Revenue Service, the Rhode Island Department of Revenue or other State or municipal taxing authority to pay income taxes may retain an expanded personal needs allowance or a lump-sum of income for such purposes.
- (5) Legal Attachments or Obligations. LTSS beneficiaries who are court-ordered to pay all or a portion of income to address an outstanding debt, or obligation such as spousal or child support, receive an expanded personal needs allowance

equal to the amount due to meet that court ordered monthly obligation. The allowance may also be based on the terms of a settlement agreement that, although not court ordered, is legally binding. In instances in which this allowance absorbs all income, the State reviews the applicable legal documentation before proceeding with the cost of care calculation.

B. Home and Community-Based Services Maintenance of Need Allowance. Medicaid LTSS does not cover room and board when provided in a home or community-based living arrangement. To ensure LTSS beneficiaries opting for care in these settings have adequate resources to meet these and other person need expenses, a maintenance of need allowance has been established for those receiving HCBS. LTSS beneficiaries in HCBS living arrangements may qualify for the HCBS maintenance needs allowance only, a State-optional (SO) personal needs allowance and HCBS maintenance needs allowance, or special maintenance of need allowance based on setting or LTSS need addition to non-LTSS spousal and family allowances or a family maintenance of need allowance:

1. HCBS Maintenance Needs Allowance Only – The HCBS maintenance needs allowance is set at 100 percent of the FPL plus a \$20 personal needs allowance, for a family of one, and is taken as a deduction from the Medicaid LTSS beneficiary’s gross income subsequent to any required exclusions. Beneficiaries who qualify for the State optional supplement receive an additional payment, as indicated below. Although the HCBS maintenance needs allowance is protected income that cannot be included in the calculation of beneficiary liability, the income is available for room and board, personal effects, and any attendant health costs that are not covered by Medicaid. The HCBS maintenance needs allowance is based on a reasonable assessment of need provided in lieu of a home maintenance allowance, unless statutory requirements direct otherwise.
2. State Only - Personal Needs Allowance – R.I. Gen. Laws § 40-6-27 establishes the State’s optional supplemental payment and requires that a portion of the monthly cash payment provided to LTSS beneficiaries who are residing in certain living arrangements be set aside as a State-only personal needs allowance. Only beneficiaries with income at or below 300 percent of the SSI standard are eligible for this deduction. This State only - personal needs allowance is in addition to the HCBS maintenance needs allowance and varies in accordance with the State supplement payment category and/or type of residence:
 - a. Living in own household -- \$39.92 for an individual and \$79.36 for a couple
 - b. Living in the household of another -- \$51.92 for an individual and \$97.30 for a couple

- c. Medicaid certified assisted living residence, State supplement payment Category D – \$100 SPNA
 - d. Community Supportive Living Program residences, State supplement payment Category F – \$120 SPNA
 - e. Medicaid beneficiaries who qualify for Category D, but do not meet the eligibility requirements for long-term care, receive a State only-personal needs allowance of \$55.
- 3. Assisted Living -Special Maintenance Needs Allowance -- LTSS beneficiaries who qualify for the State supplement payment and reside in a Medicaid certified assisted living residence receive a set assisted living - special maintenance needs allowance which is equal to the federal benefit rate (FBR) for one plus the State supplement payment, less the state only - personal needs allowance. The amount of the assisted living - special maintenance needs allowance varies depending on whether the residence is certified to provide LTSS to beneficiaries with needs that qualify for State supplement payment in assisted living residences (Category D) or community supportive living arrangements authorized to provide enhanced/specialized services (Category F). (Category F includes assisted living residences licensed by the state to provide these enhanced/specialized services.)
- 4. All income above the assisted living - special maintenance needs allowance, less the applicable personal needs allowance, that is not allocated to a spouse or dependent is available to pay the cost of care, including the pension portion of Veteran's Administration Aid & Attendance payments. LTSS beneficiaries who do not qualify for the State supplement payment are treated as if they were living at home and are subject to subpart §1, related to HCBS maintenance needs allowance above unless they have a spouse, in which case Part C below also applies. The HCBS maintenance needs allowance is protected and allocated to room and board, except for the personal needs allowance of \$100. All remaining income is available to pay toward the cost of care. The State supplement payment is reduced by the non-pension portion of Aid & Attendance, which must be allocated for room and board or toward the spousal allowance:
 - a. The Assisted Living - Special Maintenance Needs Allowance LTSS Beneficiary-Category D. The assisted living - special maintenance needs allowance for a single room is \$982 and for a double room is \$857 after the State only - personal needs allowance of \$100 is deducted.
 - b. The Assisted Living - Special Maintenance Needs Allowance LTSS Beneficiary-Category F. The assisted living - special maintenance

needs allowance is \$1,427 for a single room and \$1,141 for a double room after the State only personal needs allowance of \$120 is deducted.

5. Intellectual/Developmental Disabilities -Special Maintenance Needs Allowance – LTSS beneficiaries participating in the RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) Development Disabilities (DD) Program or the EOHHS Habilitation Program who are employed are eligible for the intellectual/developmental disabilities - special maintenance needs allowance and an additional amount of earned income up to but not exceeding 300 percent of the SSI income standard.
 6. Exceptions - A beneficiary may receive an allowance that is above the maintenance of need allowance set by the State when:
 - a. Court-ordered. A court-order may require the allocation of a different portion of the beneficiary's income to a spouse or a dependent as indicated in § 8.6 A(b)(2)(5); or
 - b. EOHHS Hearing Decision. Upon presenting evidence of hardship in an EOHHS administrative fair hearing, the maintenance of need allowance for a beneficiary living at home may be increased if the amount provided is insufficient based on a reasonable assessment of need, as is required in 42 C.F.R. § 435.735(c)(1). Such an assessment must consider evidence that pertains directly to a beneficiary's need to maintain shelter including, but not limited to, rent or mortgage payments, property related taxes, fees and/or insurance, and utility costs. Hardships affecting home stability resulting from natural or human-made disasters such as a fire, weather damage, criminal acts may also be considered. The HCBS maintenance needs allowance increase may not exceed the minimum monthly maintenance of needs allowance in any given year.
- C. Monthly Spousal Allowances. The monthly spousal and family allowances are the principal mechanisms for assuring that the dependents of an LTSS beneficiary do not become impoverished as a result the obligation to pay income toward the Medicaid cost of care. The method for determining what type of spousal and family allowance and the amount also varies depending on family structure and living arrangements.
1. Monthly Non-LTSS Spousal Allowance – In instances in which the LTSS beneficiaries is married and the spouse is not requesting or receiving Medicaid LTSS, the monthly spousal allowance is established by:

- a. Determining gross income of the spouse. The gross income of a non-LTSS spouse is the total of earned and the unearned income, without applying the disregards and exclusions used when determining income eligibility.
- b. Calculating shelter costs. The shelter costs for maintaining the household of a non-LTSS beneficiary's principal place of residence are calculated by adding together monthly rental or mortgage payments (principal and interest), taxes and insurance, condominium or cooperative required maintenance charges, and the standard utility allowance, as applicable. The minimum is the Community Spouse Housing Allowance set annually by the federal government.
- c. The standard utility allowance. The standard utility allowance, as updated annually in 218-RICR-20-00-01 of the DHS Administrative Code for SNAP, serves as a proxy for utility costs when calculating shelter costs without respect to actual costs incurred by a non-LTSS spouse. This allowance is only included in the computation of shelter costs if the non-LTSS spouse is responsible for paying such expenses.
- d. Excess shelter allowance. To determine the excess shelter allowance, the sum of all shelter costs is deducted from the minimum monthly maintenance of need allowance. Any expenses above the standard constitutes the excess shelter allowance and is added to the minimum monthly maintenance of needs allowance and the determination proceeds as follows:
 - (1) If there is no excess shelter allowance or the sum of the excess shelter allowance and the minimum monthly maintenance of needs allowance are at or below the standard minimum allowance standard established for the year, the minimum monthly maintenance of needs allowance is used as the basis for determining the monthly spousal allowance.
 - (2) If the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance are above the standard but below the maximum monthly maintenance of need allowance, then the sum serves as the basis for determining the monthly spousal allowance.
 - (3) If the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance is at or above the standard maximum allowance, the maximum monthly

maintenance of need allowance serves as the basis for determining the monthly spousal allowance.

f. Monthly Spousal Allowance. To determine the monthly spousal allowance, the non-LTSS spouse's gross income is deducted from the sum of the excess shelter allowance and minimum monthly maintenance of needs allowance. The monthly spousal allowance is the amount remaining after this calculation and determines the amount of the LTSS beneficiary's income that is protected – available to the spouse – to meet the spouse's monthly needs and, as such cannot be included in the calculation of the LTSS beneficiary's liability toward the cost of care.

g. Exceptions. A non-LTSS spouse may obtain a monthly spousal allowance that exceeds the maximum monthly maintenance of need allowance standard when:

(1) Court-ordered. A court-order may require the allocation of a larger portion of the beneficiary's income to the spouse; or

(2) EOHHS Hearing Decision. Upon presenting evidence of hardship in an EOHHS administrative fair hearing, the monthly spousal allowance may be increased in certain circumstances.

2. No Monthly Spousal Allowance – If a Medicaid LTSS beneficiary does not have a spouse, there is no monthly spousal allowance regardless of LTSS living arrangement. Certain family allowances may apply however.

D. Family Allowances. The Medicaid LTSS beneficiary's income may be reduced by deductions for dependent family members. There are two types of family allowances that apply depending on whether there is a non-LTSS spouse. If there is a non-LTSS spouse, a family allowance is provided in addition to the monthly spousal allowance; if there is no spouse, a family monthly maintenance of need allowance is calculated. The family maintenance of needs allowance varies depending on whether the Medicaid LTSS beneficiary is residing with family members.

1. Family Allowance (FA)– A family allowance is determined when there is a non-LTSS community spouse residing with family members who are the dependents of the spouse or the LTSS beneficiary. The LTSS living arrangement of the beneficiary is not a factor in determining whether this allowance applies. The family allowance is the sum total of the allowances determined separately for each family member as follows:

a. Determination of gross income. The earned and unearned income for each family member is calculated without any disregards or exclusions.

- b. Family allowance standard. The minimum monthly maintenance of needs allowance standard is multiplied by one-third. The result of this computation is the family allowance standard that applies when determining the allowance for each family member.
 - c. Individual family member's allowance. The gross income of each family member is subtracted from the family allowance standard. The amount remaining from this calculation is the family allowance for that family member
 - d. Total Family Allowance. The individual allowances for each family member are added together to determine the total family allowance. The family allowance counts toward the maximum MMN allowance.
- 2. Family maintenance of need allowance – When the Medicaid LTSS beneficiary does not have a spouse, a family maintenance of need allowance is established that provides for a broader range of expenses than are considered when there is a monthly spousal allowance. This family maintenance of needs allowance is calculated in accordance with the following:
 - a. Determination of gross income. The earned and unearned income for each family member is calculated without any disregards or exclusions.
 - b. Family maintenance of need (FMN) standard. The gross income of each family member is added together and deducted from the FMN standard, which is the medically needy income limit based on family size.
 - (1) If the Medicaid LTSS beneficiary resides with family members in a HCBS living arrangement, he or she is included in the family when determining family size;
 - (2) If the Medicaid LTSS beneficiary is in a health care institution or does not reside with family members, family size is based on the number of family members only – that is, the LTSS beneficiary is not counted.
 - c. Family maintenance of needs allowance. The difference between the family maintenance of need standard and total gross income of the family members is the family maintenance of need allowance. The family maintenance of needs allowance counts toward the maximum monthly maintenance of need standard.

8.7 HEALTH EXPENSES

A. Health care and insurance. Additional amounts of the income of a Medicaid LTSS beneficiary may be protected to cover certain medical/health costs incurred by the beneficiary or financially responsible relatives, such as spouse, sibling, or adult child.

1. Health Coverage Costs – Health care premiums, co-payments and deductibles incurred by the Medicaid LTSS beneficiary that are not subject to payment by Medicaid or a third party may be deducted from income. This includes the beneficiary’s costs for Medicare, including Medicare Advantage and Part D plans, supplemental health insurance for dental and/or vision and long-term care insurance policy premiums. Only the portion of these costs that is for the Medicaid beneficiary are allowed.
2. Allowable Medical Expenses – Unpaid past expenses for medically necessary services may be deducted from available income in certain circumstances. For such expenses to reduce available income for beneficiary liability determination purposes, they must meet all the criteria to be considered allowable and exclude any costs of care already used to meet the beneficiary’s spenddown. A medical expense must be allowable under this section to be deducted in the LTSS income calculation. An allowable expense must meet the following conditions:
 - a. Medically necessary. The expense must be medically necessary. A necessary medical expense is an expense rendered --for any of these situations:
 - (1) In response to a life-threatening condition or pain;
 - (2) Treat an injury, illness or infection;
 - (3) Achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;
 - (4) Provide care for a mother and child through the maternity period;
 - (5) Prevent the onset of a serious disease or illness;
 - (6) To treat a condition that could result in physical or behavioral health impairment; or
 - (7) When such services are provided or ordered by a licensed health care professional or provider they are presumed to be medically necessary. In instances when such services are

provided by some other person or entity, documentation of medical necessity may be required.

- b. Non-Medicaid Service. The expense must not be covered by Medicaid. An expense cannot be deducted if it is a Medicaid-covered service and is incurred in a month in which eligibility may exist, including the month of application and the retroactive eligibility period. Exceptions are granted for Medicaid covered services only if the health costs were incurred for a medically necessary service provided prior to the retroactive eligibility period and are a legally binding debt obligation or attachment or lien as indicated in §8.6.A (b)(2). In addition:
- (1) An expense incurred in a month for which eligibility is approved is presumed to be a Medicaid covered service unless the applicant provides documentation that it is not.
 - (2) When an applicant for LTSS is receiving a service or set of services Medicaid pays for in a daily or bundled rate, the items and services included in that rate are not separate allowable expenses whether provided in an institution, such as a NF or hospital, or home and community-based setting, such as a DD group home, assisted living residence, etc.
- c. No Third Party Payment. An allowable expense must not be eligible for payment by a third party. For these purposes, a third party could be individuals, entities or benefits that are, or may be, liable to pay the expense including, but not limited to: other health care coverage, such as coverage through Medicare, private or group health insurance, long-term care insurance or through the Veterans Administration (VA) health system; automobile insurance; court judgments or settlements; Workers' Compensation.
- d. Allowed Expense Period. The expense must be incurred during a month in which the applicant/beneficiary is receiving Medicaid-funded LTSS or the retroactive period unless the exception for legally binding debt or attachments apply. The first day of the month an application for LTSS is filed, or a request for review of an expense is submitted is the start date for determining whether an expense qualifies, regardless of whether retroactive coverage is requested or approved.
- (1) An expense incurred during the three (3) month retro-period must be unpaid as of the date the agency received the request, unless it was incurred in a month that Medicaid LTSS coverage was active.

- (2) An expense incurred while Medicaid LTSS is active may be paid or unpaid.
- 2. Limits -- If all of the above conditions apply, the expense may still not be allowed in certain circumstances:
 - a. Expense in penalty period. An expense cannot be deducted for an LTSS service incurred during a penalty period in due to an uncompensated transfer. However, non-LTSS expenses, such as primary, acute or subacute care services incurred during a period of ineligibility, may be an allowable expense if all other conditions are met.
 - b. Used for other reductions. The expense must not have been treated as or paid:
 - (1) To reduce excess resources -- an expense paid by an applicant to meet resource eligibility limits cannot be deducted in the income calculation.
 - (2) As an income exclusion or deduction -- an expense previously used as a deduction in the income calculation cannot be used under this section.
- 3. Charges Not Allowed -- Under current federal regulations, the following services are not allowable expense deductions when provided to a Medicaid applicant:
 - a. Personal Items. Items such as shampoo, toothpaste or dental floss;
 - b. Elective or Expanded Services. Optional or elective features to services and supports that are not medically necessary, such as a motorized wheel chair, prescription sunglasses, elective treatments or procedures for non-medical purposes;
 - c. Provider travel. A charge for a provider to travel to an applicant's residence when no medical service is provided.
- 4. Deduction Timeline -- Allowable expenses are deducted in the LTSS income calculation for the month in which the expense is incurred. Expenses that were incurred in the three (3) months prior to the month the request for payment of LTSS services is submitted can be deducted beginning in the first month of eligibility.
- 5. Excess Carryover --The excess amount of an allowable expense can be carried forward and used as a deduction in future months when the amount of the expenses combined exceeds the amount of income remaining after all other deductions.

8.8 INSTITUTIONAL LIMITED HOME MAINTENANCE ALLOWANCE

- A. A home maintenance allowance is available for either a single LTSS beneficiary, in addition to the personal needs allowance, when residing in a health care institution and if there is an intent to return home. The allowance is equal to up to 100 percent of the FPL for a family size of one. The home maintenance allowance counts toward the maximum monthly maintenance of standard.
1. Access to the Home Maintenance Allowance – To obtain the home maintenance allowance, the following conditions apply:
 - a. Time limits. The deduction from income resulting from the home maintenance allowance cannot be allocated for more than six (6) months in any continuous period of Medicaid LTSS in a health care institution.
 - b. Certification. A licensed physician must certify that either LTSS beneficiary or both are likely to return to the home during the six-month period. The allowance ceases once a beneficiary is discharged and returns to the home.
 - c. Home Expenses. The LTSS beneficiary or beneficiaries has expenses that are required to maintain a residence (owned or rented) in the community including, but not limited to, taxes, rent, mortgage payments, utilities, and insurance; and
 - d. Other Resident Family Members. A spouse, dependent child or other person who is or could be claimed as a dependent for federal income tax purposes was not residing in the home at the time the beneficiary was admitted to the LTSS health care institution; or, if both spouses are LTSS beneficiaries, they were admitted to a health care institution on the same day.
 2. Application of the Allowance -- In instances in which LTSS beneficiaries qualify for the home maintenance allowance, it must be provided as follows:
 - a. One beneficiary only. The allowance is deducted from the income of only one LTSS beneficiary, even in cases in which both members are receiving Medicaid coverage in a health care institution. The determination of which spouse will receive the home maintenance allowance is based on an assessment of what is most advantageous to both members of the couple.
 - b. Restrictions. A Medicaid LTSS beneficiary residing in a health institutional arrangement is prohibited from receiving the home maintenance allowance and for the support of dependents at home.

8.9 DETERMINATION AND COLLECTION OF BENEFICIARY LIABILITY

A. PETI income is the amount of an LTSS beneficiary's income that is applied to the LTSS Medicaid cost of care after the deduction of all available allowances. If the beneficiary's gross income is depleted by the allowances deducted – PETI income is \$0 – there is no beneficiary liability and no payment toward the Medicaid cost of care is required.

1. Agency Responsibilities – In determining and applying PETI income for beneficiary liability purposes, the agency has the following responsibilities:

a. Calculation of beneficiary liability. In general, the determination of beneficiary liability is based on the income and resources of the applicant beginning on the eligibility date, which is the first day of the month in which an application is filed and date stamped as received by the agency. There is no beneficiary liability for services covered during the ninety-day retroactive period which begins in the month prior to the filing of the application.

b. Collection date. The obligation to pay beneficiary liability varies by type of LTSS when eligibility is determined by the State in a month after the application is filed irrespective of the eligibility date as follows:

(1) HCBS beneficiaries – Beneficiary liability begins on the first day of the month in which a determination of eligibility is made. If eligibility is determined in a month after the application was filed, beneficiary liability does not accrue retroactively back to the eligibility date, however. Therefore, collection of beneficiary liability for HCBS beneficiaries is always prospective and begins on the first day of the calendar month after eligibility is determined by the state.

(2) NF and other health institutions. LTSS beneficiaries residing in health institutions are obligated to pay what they can afford toward the cost of care beginning on the date of admission. Accordingly, for beneficiaries who were residing in such institutions on the date the application was filed, liability toward the cost of care begins on the eligibility date – the first day of the month in which an application is filed – irrespective of the date eligibility is actually determined by the State. Thus, beneficiary liability does accrue retroactively for LTSS beneficiaries residing in health care institutions.

b. Reductions. In instances in which the LTSS applicant has no spouse or dependents and has incurred LTSS costs during the

period an application is pending, liability for the cost of care may be reduced for the first month to take these additional costs into consideration.

c. Adjustments. In general beneficiary liability must be recalculated at any time there is a change in a factor that was used as the basis for an allowance including, but not limited to, the death of the non-LTSS spouse, sale of a home, change in living arrangement, income, or scope of benefits. Beneficiary liability is also adjusted prospectively, even in situations in which a beneficiary did not make a timely report of such a change. The only exceptions to prospective adjustments are as follows:

(1) Partial month eligibility. Beneficiary liability is adjusted when a LTSS beneficiary receives services for less than a full month due to death, discharge, or change in LTSS living arrangement, such as nursing facility to home.

(2) Beneficiary Overpayments. Retroactive adjustments are made when an agency system error resulted in an overpayment liability by a beneficiary for one month or more. The adjustments date back to the first of the month when the error was made. Retroactive adjustments are NOT made when beneficiary liability is understated.

d. Notice. Beneficiary liability may not be imposed without first providing prior notice to the beneficiary indicating the amount of the monthly payment and appeal rights. This requirement applies at the time of the initial eligibility determination in the benefit decision notice and Medicaid LTSS renewals as well as at any time there is reassessment of need indicating a change in living arrangement is required, such as the beneficiary no longer has the highest need for a NF level of care.

e. Provider notification. Notification is provided to the health care institution or HCBS provider if there are any changes to beneficiary liability.

3. Beneficiary Responsibilities – To ensure beneficiary liability is implemented in a fair and accurate manner, the LTSS beneficiary must:

a. Payment. The LTSS beneficiary must pay beneficiary liability in the amount required to the provider in accordance with § 8.9 (A) of this Part unless specifically notified otherwise. Upon confirming that a beneficiary has failed to make payment for three (3) consecutive months, the State may take action to resolve the debt or terminate services. Prior to taking an action, the State issues a notice

informing the beneficiary that Medicaid-funded HCBS will be terminated in thirty (30) days unless an appeal based on hardship is made in accordance with the requirements set forth herein. If an appeal is filed in a timely manner, Medicaid HCBS will continue until a final decision is rendered. The provider is not responsible for collecting the monthly payment during the appeal period. However, if no exception is granted, HCBS terminates until the debt to the State is settled or appropriate repayment arrangements are made as indicated by the EOHHS Hearing Officer. LTSS beneficiaries receiving SSI are exempt from the repayment and penalty requirements set herein.

- b. Notification of changes. The LTSS beneficiary must notify the agency of changes in any factor that served as the basis for an allowance/deduction, as set forth in this Part, within no more than ten (10) days from the date the change takes effect.
- c. Medicaid-certified LTSS Provider Responsibilities – The LTSS provider – whether a health care institution or HCBS provider must:

 - (1) Payment. Accept the liability amount from the LTSS beneficiary.
 - (2) Refunds. Overpayments of beneficiary liability must be refunded to the LTSS beneficiary, such as when retroactive adjustments are made.