RESPONSES TO ROUND THREE COMMENTS ON LTSS PROPOSED FINANCIAL ELIGIBILITY RULE AND RELATED SECTIONS -- §50-00-6, §50-00-2 and §40-00-3

1. **POC LTSS** – health institution. The language in §50-00-6.5.2 B (1) has been clarified to reflect the intent of the comment.

2. **POC LTSS – HCBS**. Pursuant to guidance from CMS, the point in which a continuous need for HCBS is established is when the State receives a completed application and has assessed or received documentation from a qualified provider (e.g., PM-1 or discharge summary) showing the results of an assessment that indicates one or more covered services is required or being provided. Accordingly, the language 50-00-6.5.2 B (2) on page 6 has amended to comport with CMS guidance.

> **Guidance from CMS**:
>
> **State Question** -- What is the minimum required for a person to be considered as needing the level of care for HCBS in terms of clinical eligibility and for evaluation of resources?
>
> ***CMS Answer --*** *In accordance current with 1915 (c) guidance [which applies for HCBS in a Section 1115 waiver], an applicant for HCBS waiver services must require, at minimum, one HCBS service at least monthly. The state has the discretion to determine on what basis this determination will be made. For example, the state may consider a provider evaluation or discharge notes as sufficient evidence pending completion of a full functional assessment. However, if the state chooses to require more than one waiver service as evidence of need, there must be a supporting plan of care or service plan. Additionally, the applicant may not be enrolled for HCBS to secure eligibility as a 217-look alike. Entrance to the waiver is contingent on the applicant requiring one or more waiver service to avoid nursing facility or other institutional care.*

3. **Medically Needy Income Pathway** – To be otherwise eligible, a person must meet all Medicaid LTSS requirements, including income, except for the penalty resulting from a disqualifying transfer. The income limit varies depending on categorical coverage category, in order from lowest to highest – SSI (75% of the FPL), low-income elder or adult with disability (100% of FPL), special income (300% of the SSI level) or MAGI LTSS (138% of the FPL). Anyone with countable income above these limits is considered "medically needy".

As indicated below in the response from CMS, the income cap for medically needy if a person is otherwise eligible is the average private pay rate set by the State for the applicable institutional level of care. This is, as CMS states, always the same as the penalty divisor. When LTSS medically needy, countable income must remain at or below this cap and incurred or paid allowable expenses must reduce countable income to the maximum medically needy income

limit each month, adjusted for family size. If not enrolled as LTSS medically needy, income and resources may fluctuate during the penalty period providing they are both at the applicable limits when the penalty period ends and LTSS coverage begins.

Note: Eligibility is essentially re-determined in Bridges, as it is whenever a change is made in a case, at the endpoint of the penalty period when services are authorized. At the time of this redetermination, financial eligibility is re-evaluated automatically based on both information known to the system and/or verified through electronic data sources on income and assets.

To comply with CMS guidance (see below), the following changes have been made in the applicable sections of each of the rules in play:

LTSS financial eligibility: §50-00-6	**SSI methodology: §40-00-3**	**LTSS Medically Needy: §50-00-2**
§6.4 C (3) (Clarification on eligibility limit and private pay rate – page 4)	§3.1.7 A (3) (b) and (d) – pps. 13 & 14	§2.3 A (5) (Definition added – page 2)
§6.6.1 B (2) (a) to (d) (Penalty, otherwise eligibility and LTSS medically needy requirements revised as requested --pps. 19-20)		§2.4 A (Clarification on eligibility limit added– page 2)
§6.6.1 D (2) (Penalty divisor definition clarified – page 20)		§2.4 B (1)-(4) (Process revised to eliminate ambiguity – pps. 2-4)
		§2.4 C Spenddown process clarified – page 4
		§2.4 C (1) penalty and MN eligibility revised – page 4
		§2.5 A beneficiary liability and spenddown clarified – page 5
		§2.6 A adds reference to penalty divisor -- page 8

Guidance from CMS:

State Question -- Another source of considerable confusion is the meaning of the term "otherwise eligible" relative to income in a medically needy LTSS case. If income is above the private pay rate projected forward at the time of eligibility, is otherwise eligibility applicable? Does the State have to track income and resource levels if the applicant chooses not to enroll as medically needy?

CMS Answer: The otherwise eligible period begins on the date that the applicant has met the general non-financial requirements and both income and resource requirements; functional

level of care criteria and PASRR as necessary. There must be a plan of care completed for HCBS when a penalty applies. Income for categorically eligible is the special income limit or 217 limit of 300% of the SSI level (1902 (a)(10)(A)(ii) (V). If above that, medically needy rules apply.

It is not an option to exclude long-term care costs during an LTSS medically needy penalty period. These costs are allowed under 42 CFR 435.811 but only at the state reimbursement rate, as discussed earlier. To be medically needy pursuant to 1902 (a)(10)(c) and 42 CFR 435.831 projected monthly, the applicant must meet all other requirements were it not for the penalty and have countable income at or below the projected monthly cost for the institution they are applying for -- this is the same number as the penalty divisor the state should be using in the institutional cost comparison. If income is above the divisor cap, there is no medically needy eligibility. If below the divisor, the applicant must show that they have spent down excess income to the MNIL on incurred or paid allowable expenses as of the first moment of the month of application, or later if a lump sum income or asset return. Once a denial on the basis of the penalty has been issued, otherwise eligibility continues until the end of the penalty period. The applicant is not in an eligibility status per se, so income may be in flux during this period as expenses go up or down.

However, if the applicant wants to enroll as medically needy during the penalty, the medically needy income spend down applies from month to month down to the MNIL and countable income has to stay at or below the projected monthly cost. Again, this is always the private pay rate for an ICF/ID, NF, LTAC or Psych under 21 or IMD over 65 the state uses as the penalty divisor. (The institutional comparison rate.)

The state cannot use the one-month projected cost with an amount other than the penalty divisor. The six-month ABD spenddown would apply in that case [if choosing not to use the divisor]. As we advised in our recent conversation, the reverse half loaf centers on monthly partial asset returns in RI. In many other states that allow the six- month spenddown, the partial return is a lump sum. Resources should stay at the limit on average. There is no cap using that pathway [six-month spenddown], but there is no eligibility until the spenddown has been met during the budget period and eligibility must be redetermined at the end of every budget period].

4. **Joint resources** – The language in this section has been modified as proposed in the comment, but in a slightly different organization for clarities sake. See §40-00-3.6.2 A (4) (b) (1)-(4), on pages 58-59.

5. **Asset returns** – The two provisions related to asset returns have been changed to reflect the intent of the language in 0384.35 and the applicable provisions in POMS. Asset returned to the person is located at §50-00-6.6 B (f) on page 16 and uses language consistent with other provisions in the section rather an exact duplicate of 0384.35 for consistency's sake; POMS language has been incorporated §50-00-6.6.1 F, page 22.

6. **Retirement funds** – Using actuarial tables other than those produced by the SSA requires a State Plan Amendment or waiver. Therefore, the newly added language in §40-00-3.6.2 A (2) (9) referencing a table was deleted to return to the current language in the rule now in effect which is silent. Also, §40-00-3.6.2 A (2) (9) on page 54 of the SSI rule and §50-00-6.5.3 B (5)

on page 13 of the LTSS financial eligibility rule have been amended to cross-reference and clarify the intent of the "living together" requirement as not applicable for a CSRA.

7. **Annuities** – No Change

8. **Long-term care insurance** – Requested clarification made in §50-00-6.4 F on page 4.

9. **Guardianship and conservatorship –** Provision is amended as recommended in §40-00-3.6.2 B (1) on pages 54-55.

10. **Spousal refusal** – Recommended amendment incorporated to clarify intent in §50-00-6.5.2 F, on page 9.

11. **Irrevocable trusts** – Missing sections restored at §50-00-6.11.2 B (2) (c), on page 34.