STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-01/12-01
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the calculation of her patient share under the Long-Term Care Medicaid program by the Department for Children and Families, Economic Services Division. The Department increased petitioner's patient share from zero to $522.13 per month.

Procedural History

The Human Services Board received petitioner's fair hearing request on January 5, 2012. The scheduled date for fair hearing on February 9, 2012 was converted into a status conference. The case was continued to allow petitioner to obtain representation and advice.

The fair hearing was held on March 12, 2012. Petitioner, due to her health, participated in the hearing by telephone. The Department offered the testimony of SL, a Long-Term Clinical Care Coordinator (LTCCC) by telephone. The petitioner offered the testimony of (1) AB, petitioner's son and personal care attendant, (2) PF, petitioner's case

manager, and (3) by telephone, Dr. PG, petitioner's treating physician.

The parties stipulated to the entry of the following exhibits:

1. August 17, 2011-Independent Living Assessment (ILA);
2. August 18, 2011-Home Based Service Plan (signed);
3. August 30, 2011-Home Based Service Plan (approved);
4. September 29, 2011-LTC Application;
5. October 6, 2011-Notice of Decision and Worksheet;
6. October 17, 2011-Letter from AB;
7. November 17, 2011-Verification Request;
8. November 29, 2011-288B Statement of Need;
9. November 11, 2011-288C Statement of Cost;
10. December 7, 2011-Statement of TM, RN, LTCCC;
11. December 7, 2011-Notice of Decision;
12. February 8, 2012-Letter from PG, MD;
13. February 27, 2012-Statement of Need from Dr. PG.

At the close of testimony, the record was kept open to augment the exhibits through (1) the prior year's

determination of petitioner's patient share[1], (2) the utilization review of petitioner's latest Choices for Care grant of services, and (3) the notes of the December 27, 2011 conversation between TM, a LTCCC, and Dr. PG.

In addition, the petitioner submitted Objections to the Recommendation of the Hearing Officer for the Board's consideration.

Issue

The issue is whether the petitioner has necessary medical or remedial care expenses recognized by Vermont regulations but not coverable under Vermont's Medicaid plan that should be allowed as a deduction in determining petitioner's patient share.

The decision is based on the stipulated records, the evidence adduced at hearing, and the argument before the Board.

FINDINGS OF FACT

1. The petitioner is a sixty-two-year-old woman who lives with her son, AB.

[1] The Department provided the determination for 2009 showing a patient share of $82.51 for month one and zero patient share thereafter due to medical expenses. The Department avers that it did not calculate the patient share for 2010.

2. The petitioner is disabled. Petitioner's primary diagnosis is multiple sclerosis. Her multiple sclerosis is steroid dependent and has worsened over time. Petitioner has decreased torso strength, decreased dexterity, increased weakness, and increased muscle contractures. Petitioner is also diabetic and is insulin dependent. Petitioner is status post colostomy and uses a superpubic (SP) catheter. The petitioner is depressed.

3. AB has been petitioner's primary care giver since 2001.

4. The petitioner became eligible for personal care services under the Choices for Care (CFC) program during 2004.

5. The Department of Disabilities, Aging and Independent Living (DAIL) administers the CFC program. DAIL determines clinical eligibility and determines the amount of personal care services covered under the regulations for each recipient in terms of Activities of Daily Living (ADLs), medication management, meal preparation, and Instrumental Activities of Daily Living (IADLs). Part of DAIL's calculations includes the unpaid time family members provide care for a recipient.

The Department determines financial eligibility for long-term care Medicaid with one exception. The Department uses the LTCCCs from DAIL to look at certain medical expenses set out in the Welfare Assistance Manual (W.A.M.) such as general supervision to see if those expenses should be deducted when determining patient share.

6. Each CFC recipient is assessed annually to determine if changes should be made to his/her service plan.[2] The first part of the reassessment is the completion of the Independent Living Assessment (ILA) by the recipient's case manager. DAIL's long-term care clinical coordinators (LTCCCs) then do a utilization review of the ILA and determine the amounts of service allowed in the service plan. After the initial eligibility determination, DAIL does a paper review of the ILA during annual reassessments.

Petitioner was last assessed on or about August 17, 2011. She requested 152.5 hours every two weeks and was approved for 115 hours every two weeks. DAIL based its decision on a finding that the petitioner's needs were consistent with the prior year.

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[2] If a significant change occurs before the annual reassessment, the recipient can ask for an Update due to significant change. Given the continuing decline in petitioner's condition and abilities, petitioner can ask for a clinical update for CFC services.

7. Patient share calculation was done by the Department on or about October 6, 2011. The Department determined petitioner's patient share to be $522.13 per month.

AB disagreed. Department Forms 288B and 288C were submitted on or about November 29, 2011 asking for a change to the patient share because the petitioner needed assistance with general supervision as well as assistance with her ADLs and because petitioner needed twenty-four hour care.

The Department had TM, a LTCCC, look at the petitioner's request for other medical expenses. TM advised the Department that she did not find documentation for general supervision or documentation for twenty-four hour care. The Department issued a Notice of Decision on or about December 7, 2011 that petitioner's patient share was $522.13 per month. The petitioner appealed that decision.

8. The petitioner disputes the calculation of other medical expenses, particularly general supervision, by the Department.

9. SL is a LTCCC. She is a registered nurse. Because TM retired, SL testified on behalf of the Department. Her testimony was based on a paper review of the documents in petitioner's file.

SL testified by telephone that the records did not indicate a need for general supervision because the petitioner is able to make decisions, able to use her lifeline[3], and does not engage in behaviors such as self-harm, refusing treatment, abusive behavior to others, etc. SL testified that the records did not indicate that petitioner's medical condition was unstable.

SL was asked what the standard is for general supervision. She pointed to the regulation that included individuals diagnosed with dementia or Alzheimer's or a condition with behavior similar to dementia or Alzheimer's. SL testified that she looks at whether the condition is unstable leading an individual to be at risk of harm to oneself or others. She noted that behaviors that place an individual at risk of harm are not knowing where you are, not being able to make decisions, being confused. She takes into consideration instability that impacts an individual's functioning.

10. PF works for the local area agency on aging and she is petitioner's case manager. PF has been a case manager for

[3] In terms of lifeline, SL based her testimony on her understanding that lifeline would not be approved as a service unless the recipient had the ability to use lifeline.

two years. PF has been petitioner's case manager for two years.

PF testified that petitioner's condition increased in severity over the past year. PF testified that petitioner needs more time with assistance of her ADLs because petitioner no longer has the torso strength or balance to assist her personal care attendant.

PF has observed petitioner become increasingly frustrated with her decreased abilities and her inability to do activities such as art that are important to her.

11. Dr. PG is an internist who has been in private practice for over ten years. Prior to that time, he was on the faculty of the UVM Medical School for approximately twenty years. He has been petitioner's treating doctor for eighteen years. He presently sees petitioner every three months in her home. Dr. PG testified by telephone.

Dr. PG testified that he has observed petitioner become increasingly disabled over the years due to her advanced MS. He has a framed pen and ink drawing that petitioner did eighteen years ago. Now petitioner cannot hold a spoon. Dr. PG stated that petitioner's MS significantly progressed over the past year.

Dr. PG testified that petitioner has painful contractures in her legs leaving her legs bent at the knee at ninety degrees. Over the past year, petitioner went from picking up her spoon to being unable to do so, from operating her scooter to no longer being able to do so, and to some movement in bed to no longer being able to do so.

Petitioner needs to be turned or repositioned every 45 minutes to two hours to prevent skin breakdown. Dr. PG noted that petitioner is 100 percent dependent for help with her ADLs. He doubts that petitioner can operate her lifeline.[4] Dr. PG testified that petitioner has a SP catheter due to an ostomy that needs to be checked overnight because of the potential for leakage.

Dr. PG noted that petitioner is depressed and they are treating her depression actively and that petitioner has some memory problems stemming from the depression.

12. AB concurred that the petitioner is declining and that the decline has been more rapid during the past two years. AB has been petitioner's primary care giver since 2001 or over ten years. He is a devoted to his mother and essentially provides care 24/7 for the petitioner.

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[4] Petitioner did not provide any direct testimony that she could not operate her lifeline if the need arose.

AB testified that as a result of her decline, petitioner is depressed and cries. Her ability to do art is taken away. Out of frustration, she says she does not want to live.

AB had a hard time isolating parts of his work to give examples of time spent on a particular ADL and time that may be considered general supervision.

AB testified that in the past, petitioner had a patient share of zero, leaving them with enough funds through petitioner's income and his wages from DAIL to meet their needs. Because the patient share was zero, they did not challenge DAIL's past decisions about coverage. AB believes that the reason the past patient share was zero was due to the Department allowing funding for general supervision.

13. The petitioner does not have dementia or Alzheimer's disease or any similar impairment that affects her cognitive functioning.

The petitioner's major disability is severe multiple sclerosis that has caused deterioration in her physical abilities to the extent that she needs total or extensive assistance with her ADLs, meal preparation, medication management and many IADLs. The extent of her impairments has led to depression.

Petitioner's need for assistance with her ADLs, in particular positioning to prevent skin breakdown and to relieve contractures, occur over the course of the entire day but not on a set schedule.

ORDER

The Department's decision is affirmed.

REASONS

The Department requires recipients of Long-term Care Medicaid to apply their available income to the cost of their care. W.A.M. § 4400. The specific requirements for patient share are found in W.A.M. §§ 4460-4463.3 and 4450-4452.

W.A.M. § 4460 states, in part:

> Once the department determines individuals are eligible for long-term care, including waiver and hospice services, it computes how much of their income must be paid to the long-term care provider each month for the cost of care (patient share). A patient share is computed for an individual in a medical institution or who qualifies for home-based waiver services as part of the special income group (rule 4202.3(b)) or a medically needy (rule 4203). The department determines the patient share amount at initial eligibility, eligibility redeterminations, and when changes in circumstances occur.
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> An individual's patient share is determined by computing the maximum patient share and deducting allowable expenses. Rules 4461-4461.2 describe how the department determines the maximum patient share. Rules 4462-4462.5 describe allowable deductions from the patient share.

. . .

> When monthly income and medical expenses are stable, the patient share remains constant. When deductions fluctuate, the patient share is likely to vary. When allowable deductions exceed the individual's income, the patient share is zero for as many months needed to exhaust the medical expenses against the patient's available income. The months when the remaining medical expense deductions no longer exceed the patient's income, the balance is the patient share payment for that month. (emphasis added.)

W.A.M. § 4462 lists allowable deductions to determine patient share and refers back to W.A.M. 4440-4453 regarding allowable medical expenses. The applicable part of W.A.M. § 4462(B) lists the allowable deductions in the following order:

1. a personal needs allowance or community maintenance allowance (rule 4462.1);

2. home upkeep allowance, if applicable (rule 4462.2);

3. allocations to community spouse or maintenance needs of family members living in the community, if applicable (rule 4462.3); and

4. reasonable medical expenses incurred, if applicable (rules 4440-4453).

The petitioner's case focuses on the deductions for reasonable medical expenses.

The sequence for medical expense deductions is found at W.A.M. § 4442:

> Eligible medical expenses are deducted from countable income in the following order:

A. Health insurance expenses (rule 4451).

B. Noncovered medical expenses (rules 4452-4452.4).

C. Covered medical expenses (rules 4453 and 4454) that exceed limitations on amount, duration or scope of services covered (rules 7201-7608).

D. Covered medical expenses (rule 4453 and 4454) that do not exceed limitations on amount, duration or scope of services covered and are incurred by the financial responsibility group. There must be deducted in chronological order of the date the services was received beginning with the oldest expense.

The question is whether a deduction for personal care expenses is allowable under W.A.M. § 4452C as a noncovered medical expense. W.A.M. § 4452.3 defines personal care services as:

> The department will allow a deduction for noncovered personal care services provided in an individuals own home or in a level IV residential care home when they are medically necessary in relation to an individuals medical condition.
>
> A. Deductible personal care services include those personal care services described in rule 7406.2 and assistance with managing money. <u>They also include general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimers disease or dementia or like debilitating diseases or injuries</u>. Room and board is not a personal care service.
>
> (emphasis added.)

General supervision is not covered by CFC services and is not covered by the Medicaid program. General supervision

falls within the type of medical service that can be a deduction for patient share provided the person meets the criteria for general supervision. In re Jean Brett, 2011 VT 28 (E.O. 2011)

The crux is whether petitioner meets the criteria for general supervision. Petitioner's main disability is MS, an autoimmune disorder that leads to partial or full paralysis and muscle contractures. Petitioner has seen her MS become increasingly debilitating over time.

The Department argues that general supervision is limited to those medical conditions that impact a person's cognition. The Department points to the naming of dementia and Alzheimer's disease in the regulation.

Dementia and Alzheimer's disease manifest their course through declines in cognitive and physical functioning. The cognitive decline is seen by confusion, wandering, becoming unaware of people, places, or objects, and, at times, to personality changes. The person becomes lost in the disease and needs general supervision to safeguard his/her physical and mental well-being. The Department looks to medical conditions that similarly affect cognitive functioning.

The petitioner argues that the Department interprets the criteria for general supervision too narrowly by limiting

general supervision to impairments that affect cognitive functioning rather than looking at whether a person's deteriorating physical functioning leads to a need for general supervision to keep the person safe. The petitioner argues that the Department's interpretation violates the antidiscrimination provisions of the federal Medicaid Act. 42 U.S.C. 1396a(a)(10)(B), Jacobus v. Department of PATH, 177 VT 496, 502 (2004).

The petitioner is correct that the Department's interpretation of W.A.M. § 4452.3(A) runs afoul of the antidiscrimination provisions of the Medicaid Act.

But, the question remains whether the petitioner has shown the need for general supervision or that her safety is at risk without general supervision. The evidence does not support a finding for general supervision; the evidence supports the need for additional time for ADLs.

Petitioner is looking for further assistance with her ADLs. Because petitioner did not appeal DAIL's last CFC decision, she sought redress against the Department by challenging the amount of her patient share. The problem is that petitioner receives covered Medicaid services through the CFC program. Her claim for additional time for ADLs does not fall within the noncovered medical services contemplated

in W.A.M. § 4442C. In re Jean Brett, supra. To the extent, petitioner seeks increased services that can be covered under Medicaid, these services cannot be considered noncovered under the regulations.

Petitioner has the option of asking DAIL to reassess her needs prior to her annual review because of the worsening nature of her illness and how that impacts the time needed for a personal care attendant to see to her needs. If she is dissatisfied with any decision by DAIL, she can appeal that decision.

Petitioner's case is compelling; her need for care is evident. But, petitioner seeks redress through the wrong mechanism. As a result, the Department's determination of patient share is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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