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MEMORANDUM

DATE: November 30, 2016

TO: Ms. Kimberly Xavier, DMMA  
Planning & Policy Development Unit

FROM: Ms. Jamie Wolfe, Chairperson  
State Council for Persons with Disabilities

RE: 20 DE Reg. 340 [(DMMA Proposed DDDS Waiver Participant Patient Pay Regulation (11/1/16)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMA's) proposal to amend its regulation regarding patient pay calculations. The proposed regulation was published as 20 DE Reg. 340 in the November 1, 2016 issue of the Register of Regulations.

As background, based on CMS regulations, DDDS waiver participants are subject to contributing a "patient pay" amount towards the cost of their waiver services. There are several deductions and exclusions in determining the "patient pay" contribution. See 42 C.F.R. §483.726 and DSSM §§20720, 20720.1, 20720.2, and 20720.3.

Historically, the patient pay amount has been paid to DDDS. See deleted sentence on p. 342. DMMA is proposing to change this approach as follows:

Individuals receiving Residential Habilitation funded by the DDDS waiver will submit their patient pay amount directly to the provider of Residential Habilitation.

No fiscal impact is contemplated. The proposal is intended "to be compliant with federal regulation". The citation to the federal regulation is not provided.

SCPD has two observations.

First, many DDDS waiver participants have one provider for residential habilitation and a different provider for day programming. Under the proposal, the residential provider would be paid 100% of the patient pay amount. The attached CMS regulation (42 C.F.R. §435.726) does not literally apportion the patient pay contribution exclusively to the residential habilitation provider. It only generally refers to "home and community-based services". DMMA may wish

to assess whether 100% of the patient pay contribution is required to be paid exclusively to the residential provider. If not, the proposed approach may be inequitable for day program providers.

Second, SCPD assumes part of the rationale for the proposal is reduction of the administrative burden of DDDS accounting/allocating the patient pay funds. However, DDDS is the representative payee for the SSI/SSDI monthly benefits for several hundred DDDS clients. Therefore, reciting that “(i)individuals receiving Residential Habilitation...will submit their patient pay amount directly to the provider” will ostensibly still result in DDDS (as representative payee) allocating patient pay funds to providers. Moreover, if an individual defaults in payment to the provider, SCPD assumes this should affect waiver eligibility which is within the province of DDDS, not the provider. Therefore, if this change in approach is not required by federal regulation, DMMA may wish to consider retention of the current approach.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: Mr. Stephen Groff  
Ms. Jill Rogers  
Mr. Brian Hartman, Esq.  
Governor’s Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

20reg340 dmma-ddds waiver participant patient pay 11-28-16

§ 435.726

42 CFR Ch. IV (10-1-11 Edition)

established under §435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under §435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income—*(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses—*

(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

**§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.**

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph

(c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48539, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37715, July 25, 1994]

**§ 435.733 Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care.**

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for Medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State