



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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The Honorable John Carney
Governor

John McNeal
SCPD Director

MEMORANDUM

DATE: December 18, 2017

TO: Ms. Nicole Cunningham, DMMA
Planning & Policy Development Unit

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

RE: 21 DE Reg. 475 [DMMA Proposed Medicaid LTC Limit on Medical Cost Submission
(12/1/17)]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance (DMMA) proposal to adopt a new long-term care Medicaid regulation. The proposed regulation was published as 21 DE Reg. 475 in the December 1, 2017 issue of the Register of Regulations.

As background, federal regulations authorize states to deduct certain expenses from the countable income of an institutionalized individual. For example, states may deduct medical expenses incurred in a period preceding Medicaid LTC eligibility not to exceed 6 months. See attached 42 CFR 435.725(a)(f). The current Delaware DMMA regulation currently authorizes a deduction for medical expenses incurred within 3 months of the beginning date of Medicaid eligibility. See 16 DE Admin Code 20620.2.3 (reproduced at 21 DE Reg 476-477).

The Division is now proposing to limit the time period for submission of proof of medical costs to “within one (1) year of the date(s) of coverage”. At 471.

The SCPD has the following observations.

While a 1 year time frame may appear reasonable on its face, it does not account for delays attributable to some common issues. For example, determination of a “final” medical cost may be delayed by several factors:

I. Processing of Insurance Claims

First, if the individual has multiple forms of insurance (e.g. Medicare; Medicaid; private insurance),

sequential claims may have to be submitted and processed based on the order of financial responsibility. This process can easily take several months to complete for even “clean” claims. Second, a medical provider may not issue a bill in timely fashion which delays the processing of insurer claims and identification of the individual’s final financial responsibility. Third, if the individual has invoked internal and/or external appeals of insurer denials, that process could easily take several months to resolve. Consider the following timetables for health insurer determinations covered by the Delaware Department of Insurance: 1) the health insurer can delay issuing a claim decision by requesting more information (18 DE Admin Code 1310.6.0; 2) once a patient eventually receives the “final” insurer decision, the patient can request mediation or, within 4 months of the final insurer decision, request IHCAP review which takes another 45 days (18 DE Admin Code 1301.4.0, 5.1, and 5.7); and 3) in lieu of IHCAP review, the patient can opt for arbitration with the Insurance Department within 60 days of an insurer’s final decision and, subject to continuances, expect a decision within 45 days (18 DE Admin Code 1315.3.1 and 13.15.6.1).

II. Beneficiary Capacity

Second, the institutionalized Medicaid LTC patient will often have compromised health and cognitive capacity resulting in delayed processing of medical cost determinations and submission of such information to DMMA.

The bottom line is that a “no-exceptions” 1-year time period may result in injustice. DMMA could consider alternative revisions to mitigate the potential for an unjust result:

A. The following sentence could be added to proposed §20620.2.3.1: “This limitation may be extended for good cause (e.g. significant delay in final cost determination due to insurer processing or appeals).”

OR

B. DMMA could adopt a longer submission period. For example, the Division could substitute “18 months” for “one (1) year” in the regulation.

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

cc: Mr. Steve Groff, DMMA
Mr. Brian Hartman, Esq.
Governor’s Advisory Council for Exceptional Citizens
Developmental Disabilities Council

21reg475 dmma medicaid ltc limit on medical cost submission 12-11-17

42 CFR 435.725 - Post-eligibility treatment of income of institutionalized individuals in SSI States: Application of patient income to the cost of care.

§ 435.725 Post-eligibility treatment of income of institutionalized individuals in SSI States: 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 SSI or AFDC who are eligible for Medicaid under § 435.110 or § 435.120.
- (2) Individuals who would be eligible for AFDC, SSI, or an optional State supplement except for their institutional status and who are eligible for Medicaid under § 435.211.
- (3) Aged, blind, and disabled individuals who are eligible for Medicaid, under § 435.231, under a higher income standard than the standard used in determining eligibility for SSI or optional State supplements.

(c) *Required deductions.* In reducing its payment to the institution, the agency must deduct the following amounts, in the following order, from the individual's total income, as determined under paragraph (e) of this section. Income that was disregarded in determining eligibility must be considered in this process.

- (1) *Personal needs allowance.* A personal needs allowance that is reasonable in amount for clothing and other personal needs of the individual while in the institution. This protected personal needs allowance must be at least -
 - (i) \$30 a month for an aged, blind, or disabled individual, including a child applying for Medicaid on the basis of blindness or disability;

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(ii) \$60 a month for an institutionalized couple if both spouses are aged, blind, or disabled and their income is considered available to each other in determining eligibility; and

(iii) For other individuals, a reasonable amount set by the agency, based on a reasonable difference in their personal needs from those of the aged, blind, and disabled.

(2) Maintenance needs of spouse. 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 beneficiaries under § 435.230; or

(iii) The amount of the medically needy income standard for one person 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 -

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- (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]

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