

Community Living Exchange Collaborative: A National Technical Assistance Program

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Expediting Medicaid Financial Eligibility

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Expediting Medicaid Eligibility Determinations

Background

Federal law requires that states designate a Single State Medicaid Agency (SMA) to administer all state responsibilities under Title XIX of the Social Security Act. SMAs may be an umbrella agency, a department or a division within a larger agency. Designating an umbrella agency allows the SMA to delegate specific activities such as financial eligibility determination to a department or division within the umbrella agency. Medicaid responsibilities can be administered solely by the SMA or delegated to other government entities such as another state agency or a unit of county government. Several states operate state supervised/county administered programs under which a local government agency determines financial eligibility.

Historically, financial eligibility has been delegated to the agency that determines financial eligibility for TANF benefits due to long standing ties between Medicaid and income maintenance programs. Financial eligibility staff generally process applications for all Medicaid eligibility groups. Individuals seeking long term care services are considered along with other groups in most states and often include eligibility for food stamp benefits. Because states are penalized for food stamp program errors above a threshold, there is a clear financial incentive to give priority to these applications. Aged, blind and disabled individuals account for 25% of all Medicaid beneficiaries¹ and eligibility workers receive far more applications for women and children. Applications from individuals seeking long term care are often more complicated than those from women and children and may take longer to process.

States also have an incentive to expedite applications from individuals seeking long term care services although the incentive may be less apparent to the staff and managers responsible for these determinations. Long term care accounted for 38% of all Medicaid spending in 2004.² Aged, blind and disabled individuals account for 70% of all Medicaid expenditures. The average expenditures for elderly beneficiaries in 2002 was \$12,764 a year, most of which was spent on long term care services, while average expenditures were \$1,475 for children and \$1,948 for adults.

Individuals being discharged from a hospital or who are facing a crisis in the community may apply for admission to a nursing facility or for home and community based service waiver programs. The eligibility process may not always reflect the importance of long term care in the overall scope of the Medicaid program. Determinations must be made for the individual's financial eligibility for Medicaid and their functional eligibility for the waiver program. Federal rules require determinations of financial eligibility for Medicaid must be made within 45 days from the date of application and up to 90 days when a disability determination must be made. However, service plans for people in crisis often depend on the availability of home and community based services when the person leaves a hospital or has a crisis. State officials and case managers often contend that a delay in determining financial eligibility may dictate whether a person remains in a community setting or enters a nursing facility.³

¹ The Medicaid Program At A Glance. Kaiser Commission on Medicaid and the Uninsured. Washington, DC. January 2004.

² Ibid.

³ Rosemary Chapin, Ph.D., et. al. "Expedited Service Delivery Pilot Evaluation Final Report." School of Social Welfare, University of Kansas. Lawrence, KS. 1999.

A report to CMS from the Medstat Group, Inc. on presumptive eligibility reported that almost half of all nursing home residents are admitted from hospitals and another 11 percent are admitted from other nursing homes. Just under 30% come from private or semi-private residences.⁴ Delays in determining Medicaid eligibility may affect the decision about where services may be available. Nursing homes are more willing to admit individuals while their Medicaid application is pending. Residents who are found ineligible, or their families, can be charged for services delivered and expected to pay. Nursing homes are able to measure the resident's income and resources and judge whether they will become a Medicaid beneficiary or remain private pay.

Community service agencies have less experience with Medicaid eligibility criteria and less assurance that individuals who are found ineligible will be able to pay for services. Uncertainty about Medicaid eligibility and a source of payment means that community agencies are less willing to accept a referral while the Medicaid application is processed. Therefore, individuals who are not able to pay privately for in-home or residential services are more likely to enter a nursing home.

Federal law recognizes the importance of determining financial eligibility quickly for certain categories of beneficiaries such as pregnant women, children under the age of 19 and breast or cervical cancer patients.⁵ Regulations allow states to provide Medicaid covered services these groups of beneficiaries because delays in approving access may affect their health status and outcomes, especially for pregnant women and women with cancer. Federal policy allows states to receive federal reimbursement for services provided between the date of "presumed" eligibility and the actual determination of eligibility even when the presumption was determined to be in error.

Current Federal policy does not allow states to receive reimbursement for services delivered to applicants while their eligibility is being decided. President Bush has proposed legislation to allow presumptive eligibility for individuals who are being discharged from a hospital to a Medicaid home and community based waiver program. While Federal policy does not provide for the same financial reimbursement for individuals applying for long term care services, the timeliness of a decision is equally as important. States recognize the importance of determining financial eligibility quickly. At least two states, Oregon and Washington, assigned responsibility for determining Medicaid eligibility for individuals applying for long term care services to the same agency that manages Medicaid long term care services. This organizational arrangement gives the agency responsible for all long term care policy and management responsibility better and more timely control over eligibility determinations and therefore access to services.

In addition to streamlined organizational structure, several states have implemented processes that include the actual presumption of eligibility, despite the lack of Federal reimbursement for erroneous decisions, or reduce the time it takes to process the application. Both processes are sometimes referred to "fast track."

⁴ David Stevenson, Joanne McDonald and Brian Burwell. "Presumptive Eligibility for Individuals with Long Term Care Needs: An Analysis of a Potential Medicaid State Option." Prepared for CMS, CMSO, DEHPG by the Medstat Group, Inc. August 23, 2002.

⁵ Ibid.

Presumptive eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible and to initiate services before the official determination has been made by the eligibility staff.

Expedited processes address the factors that are most likely to cause delays – fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing home and community based services, helps the individual or family member complete the application and attach sufficient documentation of income, bank accounts, and other assets to allow the financial eligibility worker to make a decision. Expedited processes reduce the time it takes to complete a financial application using the normal channels. Staff responsible for making the decision does not change.

A review of selected fast track practices found several variations. Applicants may be presumed eligible by the care coordinator staff responsible for conducting an assessment, determining level of care and authorizing home and community based waiver services. In other programs, care coordinators are familiar with Medicaid eligibility criteria and assist the applicant but do not presume eligibility. The presumption is made by the staff responsible for financial eligibility. Programs that allow care coordinators to presume eligibility require additional training.

Eligibility in Michigan and Ohio is presumed by Area Agencies on Aging without an arrangement with the State Medicaid Agency. In Ohio, the practice was designed by the Department of Aging and the AAAs. In these instances, there is no risk to Medicaid since inaccurate decisions are the responsibility of the Area Agency on Aging or the state aging agency which uses administrative funds to pay for services when Medicaid is not available. Another form of presumptive eligibility operates in states with programs funded with state general revenues. In these programs, the care coordinator determines that the person is eligible for the state program and may be eligible for the Medicaid waiver program. Services are initiated under the state program while the Medicaid application is processed. Once found eligible, the individual is enrolled in the waiver program retroactively to the date of application and services are billed to Medicaid.

The following section presents examples of presumptive and fast track eligibility programs.

Presumptive eligibility

Washington

The Aging and Disability Services Administration (ADSA) developed a fast track system for long term care programs for adults with disabilities and elders that include presumptive eligibility. Social workers/nurses that conduct assessments and authorize long term care services and the financial eligibility workers are located within ADSA. Fast Track allows social workers or nurses to authorize delivery of essential services before the full eligibility process is completed. It is used when the case managers has sufficient financial information including a statement or declarations by the individual that lead staff to the reasonable conclusion that the applicant will be eligible. The case manager consults with the financial worker, completes an assessment and service plan and authorizes services for 90 days. Case managers and financial eligibility workers are employed by the same state agency. The individual must submit a formal

application within 10 days. Individuals sign a fast track agreement that specifies in which the individual says:

"I _____ understand that the services I will be receiving are temporary pending my Medicaid financial eligibility and may be authorized for a maximum of 90 days. I agree to apply for Medicaid by ___/___/___ (10 days from the starting date of services). Failure to apply for Medicaid will result in the termination of services. A determination of financial ineligibility will result in termination of services effective the date of the determination by financial services. I also understand that adjustments in my participation may be necessary when financial eligibility is determined. If I am determined to be financially eligible, services will be extended beyond 90 days."

The agreement is signed and dated by the individual and the worker.

Eligibility workers are able to “presume” eligibility and approve Medicaid coverage in a day if it means that a beneficiary can receive services in a residential or community setting instead of a nursing facility. Applicants are not required to make an appointment and come to a state office. Applications can be taken over the phone, by mail or during a home visit by the eligibility worker. Home visits facilitate the process and avoids delays when family members arrive at a state office without necessary documentation which requires a return visit once the papers are located.

In the person’s home, documentation can be located quickly. Case managers may help the person or family member complete the application and send it to the eligibility worker. The expedited process has reduced the average time required to make decisions from 37 days to 17 days.

The social worker obtains information from the individual and consults with the financial eligibility worker. Information that requires further review (trusts, real estate holding) or raises questions about the final decision preclude the use fast track. If the information obtained by the social worker seems clear, eligibility workers may “presume” a person is eligible before the application is completed and verified. A decision can be made by the eligibility worker based on “self-declaration” or information supplied by the applicant. Presumptive eligibility is only available to people who intend to receive home and community based services in their home or a residential setting. Full applications must be completed within 90 days or home care services stop.

Once the applicant is presumed eligible, the social worker enters the approval in the social services payment system using the program code appropriate to the applicant’s eligibility category.

Since FFP is not available for services delivered if the applicant is not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the risk is limited compared to the savings realized by serving a person in the community. Washington officials have determined that “fast track” clients save Medicaid an average of \$1964 a month by authorizing community services for people who would have entered an institution if services were delayed.

While states do not receive FFP when they presume financial eligibility, they may presume

disability and provide Medicaid coverage while the disability determination is being made. If, after the review, the applicant is found not to meet the disability definition, FFP is available for the costs of services provided during the period of presumptive disability.

Kansas

The Kansas Department of Aging conducted a pilot presumptive eligibility project in 1999 under direction from the state legislature. The pilot was evaluated by the University of Kansas, School of Social Welfare.⁶ The goal of the pilot was to initiate home and community based services within five days for customers who were likely to be eligible for Medicaid. A screening tool was developed to select applicants with the greatest need for home and community services and likelihood of being eligible. Individuals who were receiving SSI or already Medicaid beneficiaries were not included. Applicants whose income was reported to be less than the protected income level were selected.

Area Agency on Aging case managers were authorized to initiate services for individuals who were likely to be determined eligible for Medicaid. The screening tool was tested on 125 completed applications and found reliable. Case managers first completed the functional assessment. The financial screen was applied when the assessment indicated they met the level of care criteria. The pilot allowed services to be provided for a maximum of 60 days and individuals had to complete and submit a Medicaid application within ten days.

None of the customers who were presumed eligible entered a nursing home within 45 days while 11 who did not meet the screening criteria but were later found eligible for Medicaid did enter a nursing facility. The University of Kansas study concluded that the project would be cost effective if only five the 24 presumed eligible would have entered a nursing facility and stayed for seven months.

An agreement was signed by the applicant that included a page that the applicant signed attesting to the accuracy of the information provided. The form indicated that the services were temporary and a completed Medicaid financial application had to be submitted within ten days. Services would continue for 60 days from the date the completed application is submitted to the office responsible for determining financial eligibility. If the person were not eligible, services would terminate within ten days of the decision.

The pilot had unexpected implications. Staff from the agency responsible for determining financial eligibility became aware of the importance of processing applications from individuals seeking long term care services, and the time between application and a decision was reduced. State officials found that the expedited process was able to initiate services within 10-12 days, about the same time as the standard process after the pilot was implemented. While there are anecdotal reports of longer delays, the expedited service delivery process has been terminated.

Michigan

Area Agencies on Aging in Michigan have implemented a form of presumptive eligibility although there is not statewide policy on the practice. AAAs have several funding sources. Financial information is collected over the phone during the first screening call. During the call, the information and assistance staff explain that they may be eligible for Medicaid, that an

⁶ The following material was summarized from Rosemary Chapin, Ph.D., et. al. "Expedited Service Delivery Pilot Evaluation Final Report." School of Social Welfare, University of Kansas. Lawrence, KS. 1999.

application will be needed and what material should be located. A social worker makes a home visit to conduct the functional assessment. If eligible, the social worker asks the client/family member to sign a financial release form that allows the AAA to obtain verifications from banks, insurance companies and other organizations. The social worker helps the client complete the financial application and brings a portable copier to duplicate verifications received from the applicant. Services are started based on the client's needs and available funding sources. The financial information is reviewed by a Medicaid specialist employed by the AAA. The specialists were formerly employed by the Family Independence Agency (FIA) which is a county office of the state agency responsible for financial eligibility and have a thorough knowledge of Medicaid eligibility rules.

Normally, an individual would contact the county FIA office to apply for Medicaid. FIA changed from generalists who processed all Medicaid applications to long term care specialists who are responsible for all nursing home and waiver applications. The change has made it easier for the AAA to establish good relationships, and to improve eligibility worker's understanding of the pressing needs of people who need services to remain in the community. The relationships have reduced the average time needed to complete the application to two weeks. FIA eligibility workers know that applications submitted through the AAA will be complete and less likely to require additional work. In an emergency situation, applications have been approved in a day.

Because the AAA has several sources of funding, they have the flexibility to initiate services knowing one of the programs will cover the cost of authorized services in the unlikely event that Medicaid is denied. Very few applications are denied but the AAA has a small pool of funds to cover such contingencies. This system is not used by all Medicaid waiver agents though most, if not all, AAAs were reported to have such a process.

Nebraska

Nebraska allows presumptive eligibility for potential waiver clients when the client has signed and submitted a Medicaid application to the Medicaid eligibility staff. To avoid confusion with the federally approved presumptive eligibility option, Nebraska named its program "Waiver While Waiting." Financial eligibility is the responsibility of a state agency that is separate from the division responsible for waiver services. Service coordinators receive some training on the Medicaid financial eligibility criteria but do not advise applicants.

Service coordinators work closely with the financial eligibility worker to determine when a person may be presumed eligible. After the assessment has been completed and the level of care determined, clients are given a choice of entering a nursing home or receiving waiver services. The service coordinator contacts the Medicaid eligibility staff to determine if the applicant is likely to be Medicaid eligible. To receive services under presumed eligibility, the applicant must agree to complete the application, submit all necessary financial records and meet any cost sharing obligations. Applicants sign a consent form and a notation is made on the consent form indicating that the applicant is presumed eligible until a final Medicaid eligibility decision has been made. When approved by the financial eligibility worker, service coordinators may authorize ongoing waiver services and medical transportation services for clients while the application is being processed. Home modifications and assistive technology services may be not presumptively authorized.

The services coordinator maintains regular contact with the Medicaid eligibility staff until a final

decision is made. If the client is found ineligible, the services coordinator sends a written notification to the client in writing that services are terminated and offers assistance and referrals to other programs or resources. A ten day notice is not permitted. In the few instances in which applicants were later found ineligible, Social Services Block Funds were used to pay for the services delivered.

Ohio

The Ohio PASSPORT Program is a Medicaid waiver program administered by the Department of Aging through Area Agencies on Aging (AAA). Presumptive financial eligibility has been included since the program's inception as a pilot program in 1985. During the initial home visit, the AAA case manager completes a functional assessment and determines the level of care. The case manager uses a worksheet (see appendix) to judge whether the applicant is likely to be eligible for Medicaid. Services may be initiated immediately if the case manager determines the individual is likely to be eligible. The case manager or a case aide may help the applicant complete the official Medicaid application and submit it to the county eligibility agency. The case manager or case aide is designated as an "authorized representative" and may be contacted by the county eligibility staff if further information or clarification is needed. Once the functional assessment is completed and the level of care is determined, the case manager enters the findings into the centralized eligibility system. The case manager enters a date of application which becomes the date of eligibility. The case manager is able to track the progress of the application through the computerized eligibility system and case aides follow up with the applicant if there is a delay in completing the application.

Over half of the applications for PASSPORT are processed through presumptive eligibility. Since its inception, the error rate is about 1% of applications. Costs for services delivered in error are covered by state funds from the Department of Aging.

Providers are paid by the PASSPORT agency, submitted to the state Department on Aging which submits claims for Medicaid reimbursement to the state Medicaid agency.

Pennsylvania

The Governor's Office of Health Care Reform, Department of Aging and Department of Public Welfare identified delays in approving eligibility as a barrier to effective management of long term care resources and offering timely access to home and community based services to applicants who could be served in community settings. Delays were attributed in part to the length and complexity of the application itself and the process used to review and approve eligibility. The Community Choices pilot program was designed to simplify eligibility and expedite determinations. The goal of the pilot is to ensure that no consumer enters a nursing home because of delays in processing their application for assistance. The project operates in two areas of Pennsylvania reduced the financial application from 12 to four pages and permitted self-declaration of income and assets. The Medicaid agency raised the asset test from \$2,000 to \$8,000 under Section 1902(r)(2) which allows states to use less restrictive income and asset tests. The increase enabled otherwise eligible individuals to receive services in the community rather than entering a nursing home and spending down assets to the former level.

Area Agencies on Aging (AAA) are responsible for conducting assessments and determining the level of care decision using a revised "Community Choice Assessment Instrument." The program guidelines say that the assessment should be completed "with sufficient promptness to avoid any unnecessary nursing home placement (immediately, if necessary, but in all cases

triaged in a manner that avoids unnecessary institutionalization).” The AAA case manager completes an abbreviated assessment to determine level of care during the initial visit. The case manager also gives the revised Medicaid financial application to the consumer and helps the consumer complete the application if requested. The financial application is submitted to the county assistance office which reviews the information as presented. The financial eligibility worker notifies the AAA case manager within two days of the decision. Less than 2% of the approved applications in the pilot have been approved in error. All applications for long term care services are processed under the expedited arrangement.

AAAs may initiate services for applicants who are eligible for waiver services “with sufficient promptness to avoid nursing home placement.” If the applicant appears eligible for Medicaid but has not been determined eligible, AAAs are encouraged to serve the applicant immediately using funds from state general revenue programs. Once the financial determination is completed, services may be billed to Medicaid retroactive to the date of application.

Fast Track

Colorado

A study by the Colorado Division of Health Care Policy and Financing found that approximately 40% of the individuals who enter a nursing facility were admitted directly from a hospital.⁷ Hospital discharge planners often consider nursing facilities the quickest and easiest setting to arrange for people who need services. Colorado staff estimated that about a third of Medicaid hospital based placements could be appropriately diverted to community based settings and designed fast track to reduce barriers to community placement. The project included expediting the Medicaid financial application and the determination of disability. An eligibility technician and a single entry point case manager were assigned to work with staff from the Denver Health hospital. The eligibility technician completed the financial application and the case manager completed the medical (functional) assessment. Clerical support staff helped gather the information and verifications needed to complete the application. With signed release forms, the support staff obtained bank statements or Social Security Administration and other documentation that was needed. A decision was made within 72 hours.

This pilot program was implemented in 2000. About 60% of the Medicaid eligible people discharged from hospitals avoided nursing home placement. Reducing the time lag allowed 54% of individuals discharged to return home for a one year savings of \$407,012. However, the project was not continued due to budget shortfalls and concern from the Social Security Administration that the expedited disability decision did not meet federal requirements. The project allowed physicians to sign a statement that the individual was disabled and met the SSA test.

Georgia

The Georgia Division on Aging implemented a “fast track” pilot in ten counties in an attempt to reduce the time needed to make the financial determination for people being admitted to services on the waiting list for home and community based services. The state has about 5,000 individuals on a waiting list based on their functional impairments and unmet needs. Under normal

⁷ Joan C. Bell, MSW; Jacinda Schleisman; Jean Demmler, Ph.D.; and Julie Reiskin, LCSW. Appropriate use of community based care for persons discharged from hospitals. Colorado Department of Health Care Policy and Financing. HCFA Contract No. 11-P-90963/8-01. September, 2000.

procedures, AAA staff conduct a telephone screen to determine whether a person is likely to meet the nursing home functional eligibility criteria in order to place them on a waiting list. Scores are determined for ADL and IADLs and unmet need based on the availability of caregivers. When the individual reaches the top of the waiting list, a registered nurse hired or employed by the Area Agency on Aging or their care coordination contract agency conducts the face-to-face functional assessment using the MDS-HC. Under normal procedures, the Medicaid financial application process is separate. The individual is responsible for contacting the county Department of Family and Children's Services to complete the Medicaid financial application. Individuals may make an appointment with a county eligibility and or submit the application by mail. When available, family members often assist the individual with completing the forms, obtaining documentation, arranging the appointment or bringing the application and documentation to the county. The process normally takes 45 days or longer if the documentation is not complete or if, after signing a release, a bank or other source of verification does not return the verification.

Under the pilot program, telephone screening staff send a checklist along with the Medicaid application to the individual when their name reaches the top of the waiting list and a home visit can be scheduled. The check list advises that the individual obtain all the needed income and asset verifications before the home visit. The registered nurses/social workers have been trained on the Medicaid financial requirements to help the individual complete the application form, including signing release forms that are used by the county Medicaid eligibility worker. The nurse or social worker helps the individual obtain any missing documentation, asks a family member to obtain and send them to person conducting the assessment, or submits an incomplete application that identifies what is needed. Verifications for life insurance policies, proof of application for other income/resources, and resources that do not affect eligibility must be submitted within 90 days of the approval of the Medicaid application.

The completed Medicaid application is sent by the assessment nurse to the county Medicaid worker for processing. A green cover sheet is attached to applications that have all the required information and documentation. Eligibility workers give completed applications priority and approve eligibility within ten days.

A yellow cover sheet is attached to applications that have missing information and alert the eligibility worker to the items that are missing and need follow up.

Key components

Interviews with state and AAA staff found some common themes. State long term care agencies that are part of an umbrella agency serving as the Single State Medicaid Agency may be assigned responsibility for determining both functional and financial eligibility. Medicaid financial eligibility is determined more quickly when the case managers who complete the functional assessment and the financial eligibility workers are employed by the same agency and work in close proximity to each other – either locally or centrally. When eligibility staff and HCBS care coordinators are located in separate agencies, more cooperation and coordination is needed. Eligibility workers assigned exclusively to long term care applications can specialize in complex verifications and work more closely with case managers to process applications. Eligibility staff that also handle applications for women and children and the food stamp program are more likely to process applications as they arrive, may not understand the impact of delayed financial

determinations on service choices and face competing pressures that may interfere with processing of long term care applications.

Other key factors in the design of fast track and presumptive financial eligibility programs include:

- State general revenues or other funds must be available to cover services approved for individuals who are found to be ineligible for Medicaid. For states with both HCBS waiver programs and state funded home care programs, the process simply determines which program will cover the costs of services.
- The availability of complementary state general revenue programs eliminates the risk of loss of federal reimbursement for incorrect decisions.
- Other factors that contribute to eligibility delays, lengthy assessment tools or state prior approval/state review of locally developed care plans, can be examined to reduce the time needed to initiate services.
- Waiver funding must be available for new applicants. The program should not have a waiting list.
- Training on the Medicaid financial requirements must be provided to case managers if they “presume” eligibility or screen information to identify potentially eligible applicants.
- Community based organizations such as Area Agencies on Aging, can recruit former eligibility workers or train specialists in Medicaid eligibility rules and work closely with the state or county agency responsible for making eligibility decisions.
- Worksheets that guide the case manager and highlight the fields that indicate a need for more documentation or that pre-empt a presumptive decision are helpful to case managers.
- The presumptive eligibility process should have deadlines by which the applicant must submit a financial application for Medicaid.
- Case managers need to track the status of the formal application to make sure it has been filed and acted upon.
- A clear explanation should be given to applicants that services may be terminated if the application is not submitted or the person is found to be ineligible.

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Summary of Expedited Eligibility Program Characteristics								
Issue	CO¹	GA	KS¹	MI²	NE	OH	PA	WA
Allow self-declaration of income	N	Y	Y	N	N	N	Y	Y
Allow self-declaration of assets	N	Partial	Y	N	N	N	Y	Y
Application may be completed by								
Mail					Y		Y	Y ³
Home visit by case manager/eligibility worker	Y ⁴	Y	Y	N	Y	Y ⁵	Y	Y
Visit to eligibility office					Y			Y
Average time to make decision before initiative	Up to 45 days	Up to 45 days	11 days ⁶	Up to 45 days	Up to 45 days	NR	30-60 days	37
Average time to make decision after initiative	3 days	25 days	4 days	10-14 days	2 days	1-2 days	2-3 days	25
Presumptive (P) or fast track (F)	F	F	P	P	P	P	P	P
Presumptive								
Estimated error rate for presumptive clients	NA	NA	8%	0%	1%	1%	< 2%	1%
Application must be completed within:	NA	NA	10 days	NA	NS	NS	NA	10 days
Groups eligible for presumptive process								
All long term care applicants	NA	NA	Y					
Hospital discharges	NA	NA					Y	Y
Applicants for nursing home admission	NA	NA					Y	
Applicants for HCBS programs	NA	NA		Y	Y	Y	Y	Y
Percentage of applications using the process	NA	NA	36%	0%	5%	50%	100%	5%

1. Pilot programs in Colorado and Kansas are no longer operating.
 2. Information for Michigan applies to Area Agencies on Aging.
 3. Washington allows applications to be submitted by fax or email.
 4. The visits occurred in the hospital.
 5. The consumer is informed that a Medicaid application should be made. The case manager/aide may review the application with the consumer. A determination is made based on information collected for the HCBS assessment.
 6. During the pilot, the average time to process an application through the traditional process was reduced.
- NR = not reported.
NS = not specified.
NA = not applicable.

Appendix

- A. Ohio presumptive eligibility financial worksheet.
- B. Assessment instrument used by the Philadelphia Corporation for Aging pilot site.
- C. Directive, Bureau of Home and Community Services, Pennsylvania Department on Aging.

OHIO PRESUMPTIVE MEDICAID ELIGIBILITY WORKSHEET

CLIENT NAME: _____

Client ID# _____

MONTHLY INCOME:

LIST APPLICANT'S GROSS INCOME AMOUNTS:

SPOUSAL INCOME (MIA)

1	SOCIAL SECURITY	1	_____	_____
2	RAILROAD RETIREMENT	2	_____	_____
3	VA	3	_____	_____
4	PENSIONS	4	_____	_____
5	NET RENTAL INCOME	5	_____	_____
6	ALIMONY	6	_____	_____
7	CHILD SUPPORT	7	_____	_____
8	ESTATE OR TRUST FUND	8	_____	_____
9	INTEREST INCOME	9	_____	_____
10	DIVIDENDS	10	_____	_____
11	GROSS MONTHLY EMPLOYMENT	11	_____	_____
12	OTHER, SPECIFY _____	12 +	_____	_____
13	TOTAL GROSS INCOME	13	_____	_____

INSTITUTIONAL NEED STANDARD (\$1692/month: January 2004)

COMPARE TOTAL GROSS INCOME TO INSTITUTIONAL NEED STANDARD. IF TOTAL GROSS INCOME IS EQUAL TO OR LESS THAN THE STANDARD, APPLICANT MEETS INCOME TEST.

ASSETS: (PROTECTED ASSET LIMIT--\$1500)

COUNTABLE ASSETS	APPLICANT	SPOUSE	JOINT
14 CASH ON HAND	14 _____	_____	_____ 14
15 SAVINGS ACCOUNT	15 _____	_____	_____ 15
16 CHECKING ACCOUNT	16 _____	_____	_____ 16
17 CASH VALUE WHOLE LIFE	17 _____	_____	_____ 17
18 STOCKS AND SECURITIES	18 _____	_____	_____ 18
19 CDs/IRAs/MONEY MARKETS	19 _____	_____	_____ 19
20 TRADE-IN VALUE/SECOND CAR	20 _____	_____	_____ 20
21 EQUITY VALUE/REAL ESTATE	21 _____	_____	_____ 21
22 TOTAL COUNTABLE ASSETS	22A _____	B _____	C _____ 22

CONTINUE REVIEW OF ASSETS ON PAGE 2.

TRANSFER OF ASSETS? NO YES, WHEN?

IF APPLICANT HAS NO SPOUSE AND TOTAL ASSETS ARE EQUAL TO OR LESS THAN \$1500, APPLICANT MEETS ASSET STANDARD. CONTINUE WITH DETERMINING PATIENT LIABILITY BUDGET ON THIS PAGE.

IF THERE IS A COMMUNITY SPOUSE LIVING IN THE APPLICANT'S HOME, THEN IT IS NECESSARY TO FIRST REVIEW SPOUSAL IMPOVERISHMENT ELIGIBILITY FOR ASSETS AND INCOME ALLOCATIONS ON PAGES 3 & 4.

ESTIMATE OF MONTHLY LIABILITY PAYMENT:

AT ANY TIME THE RESULT IS < 0, THEN ENTER 0 ON THE APPROPRIATE LINE

23	ENTER TOTAL MONTHLY INCOME FROM LINE 13	23 _____
24	SUBTRACT:	
	a. SPECIAL INDIVIDUAL MAINTENANCE NEEDS ALLOW. (SIMNA):	24a - <u>\$1101.00</u>
	and	
	b. If EMPLOYED, SUBTRACT UP TO \$65.00 OF EARNED INCOME:	24b _____
25	SUBTOTAL	25 _____
26	SUBTRACT MIA, IF APPROPRIATE FROM LINE 55	26 - _____
27	SUBTOTAL	27 _____
28	SUBTRACT FA, IF APPROPRIATE FROM LINE 62	28 - _____
29	SUBTOTAL	29 _____
30	SUBTRACT HEALTH INSURANCE PREMIUMS	30 - _____
31	SUBTOTAL	31 _____
32	SUBTRACT RECURRING HEALTH EXPENSES	32 - _____
33	SUBTOTAL	33 _____
34	SUBTRACT PAST-DUE MEDICAL EXPENSES	34 _____
35	ESTIMATED MONTHLY CLIENT LIABILITY PAYMENT	35 _____

PASSPORT ASSESSOR

DATE

COMMUNITY SPOUSAL ALLOCATION OF ASSETS:

36	ENTER APPLICANT'S TOTAL ASSETS FROM LINE 22A	36	_____
37	ENTER SPOUSE'S TOTAL ASSETS FROM LINE 22B	37	_____
38	ENTER JOINT ASSETS FROM LINE 22C	38	_____
39	TOTAL COUNTABLE ASSETS	39	_____
40	SUBTRACT SPOUSAL FLOOR ALLOCATION	40	- 18,552.00
41	ENTER RESULT: ASSETS AVAILABLE TO APPLICANT	41	_____
42	COMPARE RESULT WITH MEDICAID ASSET STANDARD (IF LINE 41 IS EQUAL TO OR LESS THAN \$1500, THE APPLICANT MEETS THE ASSET STANDARD)	42	- 1,500.00
43	EXCESS RESOURCES (CURRENTLY INELIGIBLE FOR MEDICAID)	43	_____

A SPOUSAL ALLOCATION CAN OCCUR WHEN A CLIENT HAS LEGAL OWNERSHIP OF RESOURCES IN EXCESS OF THE MEDICAID STANDARD AND IS WILLING TO TRANSFER THAT OWNERSHIP TO THE COMMUNITY SPOUSE. MEDICAID ALLOWS THIS TRANSFER TO OCCUR DURING THE INITIAL YEAR OF MEDICAID ELIGIBILITY. THE CLIENT WHO IS REQUIRED TO TRANSFER RESOURCES MUST AGREE TO COMPLETE THE TRANSFER PROCESS WITH THE CDHS. THIS TYPE OF TRANSFER IS LEGITIMATE AND APPROPRIATE FOR MEDICAID ELIGIBILITY.

DETERMINING MONTHLY INCOME ALLOWANCE - (MIA) AND FAMILY ALLOWANCE (FA)

44	MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA) STANDARD FOR COMMUNITY SPOUSE	44	\$1515
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EXCESS SHELTER ALLOWANCE (ESA):

45	RENT OR MONTHLY MORTGAGE PAYMENT	45	_____
46	MONTHLY PROPERTY TAXES	46	_____
47	MO. RENTERS OR HOMEOWNERS INSURANCE	47	_____
48	MO. CONDO. OR HOMEOWNERS ASSOC. FEES	48	_____
49	UTILITY DEDUCTION	49	+ \$360
50	TOTAL SHELTER COSTS	50	_____
51	SUBTRACT ESA STANDARD	51	- \$455
52	EXCESS SHELTER ALLOWANCE (ESA) (ENTER 0, IF RESULT IS < 0)	52	+ _____
53	ADD LINES 44 & 52	53	= _____
54	SUBTRACT COMMUNITY SPOUSE'S INCOME	54	- _____
55	MONTHLY INCOME ALLOWANCE (MIA) ENTER RESULT ON PAGE 2, LINE 26	55	= _____

CALCULATE **FAMILY ALLOWANCE (FA)** IF APPLICANT HAS SPOUSE AND DEPENDENTS.

56	FAMILY ALLOWANCE STANDARD	56	<u>\$1515</u>
57	MULTIPLY BY # OF DEPENDENTS (EXCLUDING SPOUSE)	57	<u>x</u>
58	SUBTOTAL	58	<u></u>
59	SUBTRACT TOTAL GROSS INCOME OF DEPENDENTS (ENTER 0, IF RESULT IS < 0)	59	<u>-</u>
60	SUBTOTAL	60	<u></u>
61	DIVIDE BY 3	61	<u>/3</u>
62	FAMILY ALLOWANCE ALSO ENTER RESULT ON PAGE 2, LINE 28	62	= <u></u>

P C A

COMMUNITY CHOICE ASSESSMENT INSTRUMENT

1. Consumer Information

Date of Assessment: _____	Street Address: _____
Last name: _____	City or Town _____
First name: _____	Zip Code: _____
Middle initial: _____	Telephone Number: _____
Name suffix: _____	Language Spoken: _____
Gender	Emergency Contact _____
Male: <input type="checkbox"/>	
Female: <input type="checkbox"/>	
Date of Birth: _____	Special Instructions _____
Pension/ Social Security number _____	_____

2. Medical Condition

1) Enter current medical conditions/diagnoses

Cancer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
High Blood Pressure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Breathing Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Arthritis – Type _____	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Bone Fractures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Seizures	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Neurological Problems	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Alzheimer's/Dementia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Psychiatric Disorders	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Alcoholism/Drug Addiction	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other _____	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

1)

2) Medications (dosage and reason for taking) – Medication Allergies _____

2) Add Pharmacy Name _____ Phone #: _____

_____.

3) Managing medications? Type of help needed with medications:

- Regular monitoring of effects
- Verbal reminders
- Information
- Administration
- Setup
- None

4) List all other medical treatments/therapies the Consumer is receiving or ordered to receive.

5) Recent hospitalizations

6) Physician's name and telephone number

7) Describe needs for supervision, taking into account physical health, mental impairment, and behavior. How long can Consumer routinely be left alone at home?

- Indefinitely. Consumer is independent. No supervision needed.
- An entire day and overnight. Occasional checking needed.
- Eight hours or more, day or night. Checking needed daily.
- Eight hours or more, but day time only. Needs supervision at night.
- Short periods of few hours only. Regular daily supervision needed.
- Cannot be left alone at home. Constant supervision needed.

3. ADLs

1) Bathing? Rate Consumer's ability to bathe (include shower, full tub or sponge bath, exclude washing back or hair).

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does not do at all. Helper does more than half.

2) Dressing? Rate Consumer's ability to dress/undress and groom self.

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does not do at all. Helper does more than half.

3) Eating? Rate Consumer's ability to feed self. (Does not include meal preparation.)

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does not do at all. Helper does more than half.

4) Transfer? Rate Consumer's ability to transfer in and out of bed and chair.

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does with maximum help or does not do at all.

5) Toileting? Rate Consumer's ability to get to/from bathroom, on/off commode and cleanse self afterwards.

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does with maximum help or does not do at all.

6) Incontinence

- Does Consumer have a problem with incontinence (accidents?) Urinary Fecal
- Yes Daily Infrequent Accidents 2/3 times per week
 - No

7) Walking Indoors? Rate Consumer's ability to walk and move about indoors.

- Independent (does on own)
- Uses assistive device, takes long time, or does with great difficulty. Risk No Risk
- Does with supervision, set-up, cueing or coaxing.
- Does with hands-on-help.
- Does with maximum help or does not do at all.

8) Is Consumer at risk of falling?

- Yes
- No

4. IADLs

1) Meal Preparation? Rate Consumer's ability to prepare meals.

- Access to adequate food
- Independent (does on own)
- Independent, but with great difficulty. Risk No Risk
- Does with assistance of a helper.
- Unable/helper does.

2) Does housework? Rate Consumer's ability to do housework, to include light and heavy cleaning and laundry.

- Independent (does on own)
- Independent, but with great difficulty. Risk No Risk
- Does with assistance of a helper.
- Unable/helper does.

3) Shopping? Rate Consumer's ability to shop.

- Independent (does on own)
- Independent, but with great difficulty. Risk No Risk
- Does with assistance of a helper.
- Unable/helper does.

4) Using telephone? Rate Consumer's ability to use the telephone.

- Independent (does on own)
- Independent, but with great difficulty. Risk No Risk
- Does with assistance of a helper.
- Unable/helper does.

5) Cognitive functioning – SPMSQ Optional If Needed.

- | | | | |
|--|-------------------------------|--------------------------------|---------------------------------|
| Orientation to | <input type="checkbox"/> Time | <input type="checkbox"/> Place | <input type="checkbox"/> Person |
| Problem with Recent Memory | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problem with Distant Memory | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problem with Safety Judgment | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Problem with Understanding Consequences of Decisions | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

5. Home and Community Based Services Appropriateness

Informal Support

1) Who helps you? List names: _____	
Addresses: _____	
Phone Numbers: _____	
2) What do they do for you? _____	
3) How often do they help you? _____	

4) Rate Consumer's caregiver/informal support availability/capability?

- High degree of caregiver/informal support
- Usually sufficient caregiver/informal support
- Problematic
- Available, but inadequate
- Informal support only
- No caregiver/informal supports

5) Rate Consumer's physical environment?

- Good overall
- One or two negative features
- Substandard overall
- Substandard and potentially hazardous
- Strongly negative

6) Does Consumer want to stay in/return to the community?

- Yes
- No
- Lives Alone

6. Assessment Data

1) Name of the person completing this assessment: _____

2) Is a physician's medical evaluation recommending Nursing Facility Placement or Level of Care attached?

- Yes
- No
- No – but needed

7. Identified Protocols

- | | | |
|--|--|--|
| <input type="checkbox"/> Adverse Drug Reaction | <input type="checkbox"/> Depression | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Aging and Mental Retardation | <input type="checkbox"/> Elder Abuse | <input type="checkbox"/> Problems w/Money Management |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Falls | <input type="checkbox"/> Symptom Self-Care |
| <input type="checkbox"/> Alzheimer's & Related Dementias | <input type="checkbox"/> Families w/Dysfunctional Dynamics | |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Impaired Mobility | |

COMMUNITY CHOICE ASSESSMENT DECISION NARRATIVE

Consumer's Name: _____ Account # _____

<u>Level of Care</u>	<u>Locus of Care</u>	
<input type="checkbox"/> NFCE	<input type="checkbox"/> PDA Waiver	<input type="checkbox"/> FCSP
<input type="checkbox"/> Short Term	<input type="checkbox"/> BRIDGE	<input type="checkbox"/> DOMCARE
<input type="checkbox"/> Long Term	<input type="checkbox"/> OPTIONS	<input type="checkbox"/> LIFE
<input type="checkbox"/> NFI	<input type="checkbox"/> ACP WAIVER	<input type="checkbox"/> OSP
	<input type="checkbox"/> AIDS	<input type="checkbox"/> Michael Dallas

Document concisely the justification for NF clinically eligible recommendation. List diagnosis(es) condition and symptoms and medical need(s) created by diagnosis(es); complications, severity, effect on function, treatment and who provides. When a Consumer has applied for and requests waiver services and the decision/recommendation is for something other than what the Consumer applied for and requested, clearly explain and document why the Consumer does not meet the criteria for Nursing Facility Clinically Eligible (NFCE) and therefore does not qualify for the requested waiver.

SIGNATURES:

Assessor: _____ Date: _____

Registered Nurse: _____ Date: _____

Supervisor: _____ Date: _____

**BUREAU OF HOME AND COMMUNITY SERVICES DIRECTIVE
COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF AGING**

Date of Original Issue: October 30, 2003 <i>THIS DRAFT: 1/30/04</i>	Effective Date: October 31, 2003	Number: 2003-01
Subject: Implementation of Community Choice Demonstration Procedures	By:	

Scope:

To the Southwestern Pennsylvania Area Agency on Aging (SWPAAA), serving Washington, Fayette and Greene Counties, and the Philadelphia Corporation on Aging (PCA) serving Philadelphia County. Both agencies will be hereinafter referred to as AAAs.

Purpose:

To advise AAAs on new procedures to be followed to expedite applications for waiver services in Philadelphia, Washington, Fayette and Greene counties as a part of the new Community Choice Demonstration Program.

Background:

The Governor's Office of Health Care Reform, the Pennsylvania Department of Aging and the Department of Public Welfare are implementing the Community Choice pilot program in Philadelphia as well as Fayette, Greene and Washington counties to streamline waiver intake procedures effective. This expedited approach is being introduced to shorten the time frame from the date of initial request for services to the date services begin. The purpose of this Community Choice pilot is:

- To find efficient ways of getting services in the home to consumers in need, so they can avoid placement in a nursing facility, and
- To offer an alternative to nursing facility services that is often the only choice currently available in a short time frame.

Directive:

Below we provide you with new procedures that you are directed to implement immediately in the Philadelphia and Fayette, Greene, and Washington county areas. These procedures apply to all assessments and care plans related to Medicaid Waivers.

Streamlined Procedures:

- All Attendant Care, OBRA, Independence, Michael Dallas, AIDS and Pennsylvania Department of Aging (PDA) Waiver referrals and applications in the pilot area are to be expedited effective October 31, 2003. The COMMCARE waiver is not being included in this phase of the demonstration in Washington, Greene and Fayette Counties but will be included in Philadelphia, as will the LIFE program. The Bridge Program is also included.
- The AAAs will be responsible for maintaining a telephone hotline on a 24/7/365 basis, capable of receiving and triaging requests for the above-listed Medicaid Waivers.

- The AAAs will be responsible for assessing consumers and issuing a nursing facility level of care decision using the Community Choice Assessment Instrument and a PA 600 WP with sufficient promptness to avoid any unnecessary nursing home placement (immediately, if necessary, but in all cases triaged in a manner that avoids unnecessary institutionalization). If the consumer appears to be eligible for one of the waiver programs or the Bridge Program, The PA 600 WP and the decision narrative documenting clinical eligibility will be immediately transmitted electronically to the appropriate County Assistance Office. During the Demonstration period, AAAs are authorized to assess residents of their planning and service areas who are currently located in hospitals and other care facilities in neighboring counties, but wish to return home to receive home and community based services.
- In cases where the consumer is found to be eligible for the PDA Waiver, the AAA will initiate services with sufficient promptness to avoid nursing home placement. Within two weeks of initiation of services, a customized comprehensive service plan must be implemented. In cases where the person appears to be eligible for the PDA Waiver, but lacks necessary financial information, AAAs are encouraged to serve the consumer immediately using bridge or options dollars in that order of priority. If the consumer is subsequently found eligible for the PDA Waiver, Medicaid should be back-billed as appropriate for a period of 90 days.
- In cases where the consumer is below the age of 60 and determined eligible for one of the included Waiver Programs administered by the Department of Public Welfare, the AAA will immediately electronically forward the Community Choice Assessment form to the appropriate enrolling agency as designated by DPW. In cases where the consumer appears to be appropriate for the OBRA waiver, but presents first to the AAA, the AAA will make every effort to refer the consumer to the enrolling agency designated by DPW as soon as it is known that OBRA is the most appropriate waiver for the consumer. Ideally, this should occur at the initial telephone contact, thus avoiding unnecessary delays and/or duplicate assessments.
- If necessary, the AAA must assist PDA Waiver consumers in getting a doctor's order for nursing home level of care. The prescription may be in any format, but must say that the consumer is eligible for the nursing facility level of care and must be included in the consumer's case record. The prescription may initially be received, by the agency's nurse or any nurse working with the consumer or the consumer's family, orally from the physician. The order must be counter-signed by the physician, which may occur after the start of services. For DPW Waiver consumers, if the consumer presents with the prescription it should be forwarded to the appropriate enrolling agency with the Community Choice Assessment Form. If the consumer does not present with the prescription at the time of assessment, it is the enrolling agency's responsibility to secure one. A verbal order or signed order must be received before the case is opened by the CAO.
- Participation in this demonstration exempts the AAAs from using the COAF and its OMNIA automated version. An OMNIA version of the Community Choice Assessment Form will be provided.
- The COAF instructions in the Home and Community Based Services Procedures Manual are valid for the Community Choice Assessment Instrument.
- Except as specified in the item immediately above, the program guidelines contained in the Home and Community Based Services Manual should be utilized in the Community Choice demonstration. The AAAs must adhere to the SAMS 2000 requirements, including those related to the care plan. Part of what will be determined during the demonstration is whether the Community Choice Assessment and the SAMS Care Plan materials combine to provide sufficient documentation of data on the assessment and care planning processes.
- Both AAAs must develop a hospital outreach plan in conjunction with other participating entities. This will include specific timelines for regular contact with all hospital discharge planning staff to assure that discharge planners have current and accurate information, and are provided with an opportunity to give feedback.

- The AAA must develop a procedure to ensure availability of staff, whose role will include advocacy to support the consumer's community placement. This procedure will also include a process to involve the nursing home transition coordinator immediately following any nursing home placement.