ARKANSAS REGISTER

Transmittal Sheet

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SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

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Secretary of State
State Capitol Room 017
Little Rock, AR 72201-1094

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Name of Agency: Department of Human Services

Department: Division of County Operations

Contact Person: Carol McKnight

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CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

[signature]
Signature

Director, Division of County Operations
Title

11/29/95
Date

MANUAL TRANSMITTAL

Arkansas Department of Human Services
Division of County Operations

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BY

[X] Policy [ ] Form [ ] Policy Directive

Issuance Number MS 96-2

Medical Services Policy Manual

Issuance Date 03-01-96

From: Roy Hart, Director

Expiration Date Until Superseded

Subj: Revised Policy

Pages to be Deleted,	Dated	Pages to be Added,	Dated
MS 2076-2076.9	Varied*	MS 2076-2076.9.1	03/01/96*

* Entire Section

Summary of Changes

MS 2076 A paragraph has been added about the purpose of the program. Applicants will be advised of their responsibility to pay providers if found ineligible or to pay providers for services given in a nursing facility.

MS 2076.1 DAAS ensures that waiver services are available statewide and that, if waiver services are not being provided, DCO will be given notice.

MS 2076.2 Enter an EC indicator in the Waiver Field when registering an ElderChoices application on WIMA. Procedures regarding delayed applications have been added.

MS 2076.2.1 A new section regarding applications from facility residents has been added.

MS 2076.3 Applications will be referred within 2 days of the office interview to the DHS RN who will coordinate the medical assessment.

MS 2076.3.1 A new section regarding assessment for facility residents has been added.

MS 2076.5 Applicants who reside in RCFs will be advised that they do not meet the required level of care to receive waiver services.

MS 2076.7 Provisions for a beginning date of eligibility earlier than the date the DCO-57 is completed have been established. The DHS RN will be notified of certifications on the date the action is taken.

MS 2076.7.1 A new section has been added regarding approvals for Medicaid recipients who leave LTC.

MS 96-2
03-01-96

MS 2076.9.1 A new section has been added regarding temporary absences from the home.

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2076 Aging and Adult Services Alternative Community Services Waiver - "ElderChoices"

Section 2176 of the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35, allows states to provide noninstitutional long term care services, as an alternative to institutionalization, to elderly individuals who would require an Intermediate Level of Care if in an institution.

Arkansas implemented the Alternative Community Services (ACS) Program for the Aged (ElderChoices) effective August 1, 1991.

The Division of Aging and Adult Services (DAAS) is the sponsoring division for this waiver program.

Services available through this program include: Homemaker Services, Chore Services, Home Delivered Meals, Personal Emergency Response System, Adult Day Health Care, Adult Foster Care, Respite Care, and Adult Day Care.

In addition to the services listed above, AAS/ACS waiver recipients are eligible for the full range of Medicaid services.

* Those making inquiries about the program should be advised that the purpose of the program is to prevent the institutionalization of individuals who prefer to remain in their own homes with the assistance of ElderChoices services; that all of the eligibility requirements listed in 2076.1 below must be met, including medical needs that are indicative of nursing facility care; and that the need or desire for a Medicaid card only will not qualify an individual for the program.

* Applicants should be advised that, if they accept services from ElderChoices providers while their applications are pending and are subsequently found ineligible for the program, they will be responsible for payment to the providers. They will also be responsible for any payments to ElderChoices providers for services given to them while residents of nursing facilities.

2076.1 Eligibility Requirements

To be considered for the AAS/ACS waiver program, an individual must meet the following eligibility requirements:

1. Aged - (65 years of age or older). Applications made by individuals who have not reached their 65th birthday will be denied.

2. Intermediate Level of Care - Individuals must be classified as requiring an intermediate level of care if in an institution, as determined by the Utilization Control Committee (UCC) of the Office of Long Term Care (OLTC). Individuals classified as skilled care patients are not eligible for Medicaid in the ElderChoices program.

3. Income - Gross income cannot exceed the current LTC income limit. Income is determined and verified according to LTC guidelines (Re. MS 3340-3348). VA A&A and CME/UME will be disregarded as income for eligibility.

4. Resources - Total countable resources cannot exceed the current LTC limitations. Resources are determined and verified according to LTC guidelines (Re. MS 3330).

   The transfer of resource provisions will apply (i.e., if assets have been transferred since August 11, 1993, a period of ineligibility for waiver

services will be imposed for uncompensated value).

5. Citizenship - It must be verified that the individual is a citizen of the United States or a lawfully admitted alien (Re. MS 3324).

6. Residency - The individual must be a resident of Arkansas (Re. MS 2200).

7. Social Security Enumeration - (Re. MS 1390).

8. Cost Effectiveness - The average cost of services provided to individuals in the community must be less than the cost of services for those individuals if they were in an institution. This determination will be made by DAAS.

Each eligibility requirement, with the exception of cost effectiveness, will be verified and documented in the case record at initial certification.

It may be assumed by DCO that an individual applying for the AAS/ACS waiver program will meet the cost effectiveness criteria. If at any time DAAS determines that cost effectiveness is not met, DCO will be notified by DHS-3330 and the AAS/ACS waiver case will be closed.

NOTE: Medicaid only cannot be provided to an individual who is eligible for a waiver program but who is not receiving (or will not receive) waiver services. When certifying a waiver case, it may be assumed that there are waiver services available in the area where the individual lives and that the individual will receive a waivered service within a month of certification.

* It is the responsibility of DAAS to ensure that waiver services are available. If at any time a waiver recipient is not receiving a waiver service, DAAS will notify the DHS county office via the DHS-3330 so the waiver case can be closed.

2076.2 AAS/ACS Waiver Application Process

A potential AAS/ACS waiver client will make application at the DHS county office in his/her county of residence for a financial eligibility determination.

* Application will be made on Form DCO-777 and will be registered on WIMA in Category 11, with an EC indicator in the Waiver Field. Separate applications will be registered when both individuals of a couple apply. Other forms to be completed during the application process are the DCO-86, DCO-87, DCO-662, DCO-707, DCO-727, and DCO-769.

The county worker will have a maximum of 45 days from the date of application to dispose of the application.

* County workers will check with the DHS RN and/or the LTCU screen within 30 days of filing of the application to determine if the DCO-703 has been submitted. If the worker learns that the DCO-703 is being processed, the application will be held pending receipt of the DCO-704. If the DCO-703 is not being processed, a DCO-002 will be mailed to the applicant. If there is no indication within 45 days of filing of the application that the DCO-703 is being processed, the application will be denied by DCO-700 or system notice.

NOTE: If the applicant's income is under the SSI/SPA, he/she may be referred to SSA to make an SSI application. However, ACS waiver eligibility is not contingent upon SSI eligibility, and the ACS waiver eligibility determination will not be delayed pending an SSI determination.

2076.2.1 Applications from Nursing Facility Residents

* If the county is contacted regarding ElderChoices for a Medicaid certified nursing facility resident who is classified Intermediate Level of Care, the county will send a DHS-3330 to the DHS RN who will initiate an assessment. If the RN proceeds with an assessment and completes a Plan of Care, a DHS-3330 will be sent to the county office, along with page 2 of the Plan of Care showing the recipient's election of waiver services with signature. The signed election of waiver services will serve as the application for waiver services, and a DCO-777 need not be completed by the applicant (unless it is time for the annual RE of the LTC case). However, the top portion of the DCO-777 must be completed and given to the terminal operator in order to register the ElderChoices application.

* If an application is received from a non-Medicaid eligible nursing facility resident who indicates an interest in the ElderChoices program, the application must be registered and will not routinely be denied because the individual is institutionalized. The county will send a DHS-3330 to the DHS RN who will initiate an assessment as described in 2076.3 below.

2076.3 Assessment Process

* All applicants will be referred within 2 days of the office interview via DHS-3330 to the DHS RN for coordination of the medical assessment. The UCC of OLTC, via Form DCO-703, will determine if the applicant meets the intermediate level of care requirements.

The UCC assessment results will be routed by the DAAS Central Office staff to the DHS RN and to the county office via Form DCO-704.

If an individual meets the intermediate level of care requirements and if the individual is otherwise eligible, DAAS, after notice of eligibility has been received from DCO, will work with the client, family, or other caregiver to ensure that the client will receive those services necessary to meet his/her needs according to the written plan of care.

2076.3.1 Assessment Process for Nursing Facility Residents

* When a DHS RN receives a referral on a nursing facility resident who elects ElderChoices, the DHS RN will contact the individual to develop a plan of care. A DCO-703 will not be completed if the individual was classified as intermediate level of care within the preceding 6 months. If 6 months or more have elapsed since the last determination of level of care, a new DCO-703 will be submitted to the UCC.

2076.4 Eligibility Determination

Eligibility determinations for AAS/ACS waiver cases will be conducted in the same manner as for AA long term care cases.

The SSI related income and resource criteria located in the MSP 3000 section will be followed (SSI exclusions are not allowed from gross income in determining eligibility).

In determining an applicant's countable gross income when both spouses apply, each individual will be budgeted separately and his/her income will be compared in his/her budget to the current LTC limit.

For an applicant with an ineligible spouse, or for a single individual living in someone else's home, only the income of the applicant will be considered for eligibility.

In determining resource eligibility, the current LTC resource limits will apply. A single applicant's resources will be compared to the one person limit. When there is a married couple (whether both apply or not) their combined resources will be compared to the couple's resource limit.

2076.5 Residents of Residential Care Facilities

* If an individual living in a residential care facility (RCF) applies for waiver services, the county worker will explain to the applicant that, according to current LTC and RCF policy, he/she does not meet the required level of care to receive waiver services, and the application will be denied (Denial Reason 58).

2076.6 No Contribution to the Cost of Care

After the initial eligibility determination has been made, all income of the AAS/ACS waiver recipient will be disregarded, i.e., AAS/ACS waiver recipients are not required to make a contribution to the cost of their care.

2076.7 Approvals for New Applicants (Non-LTC)

* After all eligibility criteria have been established, the effective date of AAS/ACS waiver eligibility will be the day of the month in which the ACS Medicaid waiver eligibility is finalized by the county office (completion of the DCO-57). Unless specifically requested by the DHS RN as described below, the eligibility begin date cannot be prior to the date of completion of the DCO-57. If coverage prior to the date of certification is needed, eligibility must be established in a separate category, e.g., AA-MN-SD.

EXCEPTION: In some cases deemed critical by the DHS RN, the begin date of eligibility may be prior to the date of completion of the DCO-57 if all eligibility criteria have been met, if the waiver applicant and waiver provider made a request for services to the DHS RN prior to county certification, and if the provision of services was approved by the DHS RN. In cases where approved services were provided prior to county certification, it is the responsibility of the DHS RN to advise the county office of the eligibility begin date via the DHS-3330. Prior to submission of the DHS-3330 to the county authorizing a begin date prior to the date of completion of the DCO-57, the DHS RN must have:

Received a waiver referral,
Completed a medical assessment,
Developed and signed a plan of care signed by the applicant,
Submitted the DCO-703, with required signatures, and
Received a Start Services Form from a waiver provider(s) verifying that services have begun.

Example: A waiver application is received in the county office September 15th. The DHS RN completes the medical assessment, develops and signs the plan of care on September 25th, and submits the DCO-703 to OLTC on September 30th. The applicant requests and is determined to be in immediate need of services. A waiver provider is willing to begin services prior to applicant's notification of eligibility, and services begin on October 1st. The county office finalizes the eligibility determination and completes the DCO-57 October 30th, with an eligibility begin date of October 1st.

When services were provided prior to final determination of eligibility by the county and an applicant is subsequently found not eligible by the county, the denied applicant will be responsible for payment of services given, regardless of the reason for denial.

Under no circumstances will a county begin waiver eligibility prior to the date of application on the DCO-777, the date the plan of care is signed, or the date

waiver services began.

Application approvals will be entered on WASM prior to authorizing services on WAIV. If a case is currently an open SSI case, entry will be made on WAIV prior to update on WASM.

Action Reason 103 on WAIV and Action Reason 101 on WASM will be used for AAS/ACS waiver approvals. If there is a closed case number on file for the client, this number will be used to open the ACS waiver case.

On WAIV an entry of "2950" will be keyed in the WVNO field to identify clients entering the AAS/ACS waiver program from a community setting.

When certifying an eligible couple, each will be entered on a separate DCO-57, or DCO-765, with separate case numbers.

The gross income of an eligible individual will be entered in the appropriate fields on the DCO-57, or DCO-765. The total gross income will also be entered in the PROT MAINT field on WAIV since an AAS/ACS waiver recipient will not contribute to the cost of services.

* The county office will notify DAAS of certifications (and denials) via the DHS-3330 on the date the action is taken. The DHS-3330 may be mailed or faxed to the DHS RN or placed in a designated location at the DHS county office for the DHS RN to collect. A copy of the DHS-3330 will be kept in the case record.

2076.7.1 Approvals for Medicaid Recipients Who Leave LTC

* If the county has received a DHS-3330 and Page 2 of the Plan of Care signed by the recipient, if ACES shows an intermediate level of care and the level of care was entered into the system by the county in the previous 6 months or, if there is a future level of care review date, the case may be certified for ElderChoices once the county is notified by the nursing facility that the recipient has left the facility.

If the intermediate level of care was entered by the county more than 6 months previously or, if the level of care review date on ACES has expired, the ElderChoices case may not be certified until the county receives a new DCO-704 verifying intermediate level of care status.

To certify the ElderChoices case, close the LTC case on WNHU, but do NOT close Medicaid on WASM. The day after closure on WNHU, the ElderChoices case may be opened on WAIV. The numbers "2955" will be keyed in the WVNO field to identify clients entering the AAS/ACS waiver from a nursing facility.

To clear the pending application screen when approving NON-SSI recipients, counties will need to call the ACES Unit (682-8183) for assistance in clearing the register as an approval.

When approving SSI recipients, first key on WAIV an NA Action Type, Action Reason 103, and all other appropriate fields (Re. DCOUM 3721). Next key on WASM, the register number, application date, action date, B Action Type, Worker number, Notice indicator, and Action Reason 101.

When opening a case in which the intermediate level of care was entered on WNHU less than six months previously and there is no level of care review date in the system, show the level of care decision date and the eligibility begin date as the first day of ElderChoices eligibility, with a level of care review date 12 months from the original level of care decision date that was on WNHU.

showing the level of care decision date and the eligibility begin date as the first day of ElderChoices eligibility.

Counties should review the records of recipients who leave facilities for ElderChoices. If it is time for the annual reevaluation, a reevaluation should be done prior to ElderChoices certification. The county worker should also determine if the LTC recipient has a community spouse. If so, resources should be reviewed, as the couple's combined resources may exceed $3000 and the LTC recipient will not be eligible for ElderChoices.

NOTE: If a long term care case was closed, then reopened for ACS waiver services and a retroactive adjustment must be made to the long term care case, send a memorandum to the Office of Long Term Care, MMIS Unit, Slot 400, P.O. Box 1437, Little Rock, 72203. The memorandum should include the name, case number, month(s) of retroactive change(s), and the new net income amount(s).

2076.8 Reevaluations

AAS/ACS waiver reevaluations will be conducted annually by the county office. Form DCO-777 and all other forms required at initial application will be completed. After eligibility has been redetermined, the DCO-87 will be coded for the next reevaluation and/or anticipated change.

Reassessment of medical necessity will also be completed annually by the UCC of OLTC.

2076.9 Change/Closure

Recipients will be advised to report any changes in the amount of household income or resources.

If at any time DAAS or the UCC of the OLTC determines that cost effectiveness is not met, that the client no longer meets the requirements for intermediate level of care or, that the client is no longer receiving waiver services, the county office will be notified by Form DHS-3330 or DCO-704, and the AAS/ACS waiver case will be closed. If the AAS/ACS waiver case is closed for any reason, the county office will determine if the client is eligible for any other Medicaid category.

If the county office at any time finds the recipient ineligible for the AAS/ACS waiver program, the DHS RN will be notified immediately by DHS-3330 and the county office AAS/ACS case will be closed.

2076.9.1 Temporary Absences From the Home

* Once an ElderChoices application has been approved, waiver services must be provided in the home for eligibility to continue. Unless stated otherwise below, the county office will be notified immediately by the DHS RN when waiver services are discontinued, and action will be initiated by the county office to close the waiver case.

1. Institutionalization

   An individual cannot receive AAS/ACS waiver services while in an institution. However, the following policy will apply to active waiver cases when the individual is hospitalized or enters a nursing facility.

   a. Hospitalization

      When a waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does

a. Hospitalization

When a waiver recipient enters a hospital, the county office will not be notified and no action is necessary unless the recipient does not return home within 20 days from the date of entry. If after 20 days the recipient has not returned home, the DHS RN will notify the county office via Form DHS-3330, and action will be initiated by the county office to close the waiver case.

b. Nursing Facility Admission

If the county becomes aware that an ElderChoices recipient has entered a nursing facility and it is anticipated that the stay will be short, the case will be closed on WAIV effective the date of entry but the Medicaid case may be left open on WASM until the county is notified that the individual has returned home. When the individual returns home, the ElderChoices case may be reopened on WAIV effective the date of return home if the DHS RN has provided the county with a copy of Page 2 of the Plan of Care, showing election of ElderChoices. A new DCO-703 and DCO-704 will not be required unless the last review was completed more than 6 months prior to facility entry. A new DCO-777 will not be required unless it is time for the annual case reevaluation. It is not necessary to register a new application in this situation.

If the individual requests payment for the temporary stay in the nursing facility, a signed DCO-777 must be obtained and registered, along with a DCO-703 and DCO-704. If it is time for the annual case reevaluation, the reevaluation must be completed prior to certification on WNHU. If all eligibility requirements are met, eligibility for vendor will begin effective the date of entry into the nursing facility. If the stay in the facility was less than 30 days, vendor may still be authorized because ElderChoices recipients are considered to be "institutionalized" for Medicaid purposes and the ElderChoices eligibility prior to the facility stay may be applied toward the 30 day institutionalization requirement.

If the individual does not return home, i.e., stays in the facility and requests LTC services, the Medicaid case on WASM may be left open while processing the registered LTC application. If found eligible for vendor, the case will be opened on WNHU effective the date of NF entry.

To clear the pending application screen when approving NON-SSI recipients for vendor payment, counties will need to call the ACES Unit (682-8183) for assistance in clearing the register as an approval, when the Medicaid case has been left open on WASM. When approving SSI recipients, first key on WNHU an NA Action Type, Action Reason 102 and all appropriate fields (Re. DCOUM 3721). Next key on WASM, the register number, application date, action date, B-Action Type, Worker number, Notice indicator, and Action Reason 102.

If found NOT eligible for vendor (or if after 20 days in a facility the individual does NOT apply for vendor payment), appropriate notice will be given for case closure on WASM.

2. Absence From the Home - Non-Institutionalization

When a waiver recipient is absent from the home for reasons other than institutionalization, the county office will not be notified

unless the recipient does not return home within 20 days. If after 20 days the recipient has not returned home and the providers can no longer deliver services as prescribed by the plan of care (e.g., the recipient has left the state and the return date is unknown), the DHS RN will notify the county office via Form DHS-3330 and action will be taken by the county office to close the waiver case.

Arkansas Democrat-Gazette

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NOTICE OF RULE MAKING
Pursuant to AR Code Ann. 25-15-201 et seq. and AR Code Ann. 20-76-201 et

Legal Notices 1200

seq., the Director, Division of County Operations, issues proposed changes to the AAS/ACS Waiver section of the Medical Services Policy Manual.

Copies of the proposed changes may be obtained by writing the Division of County Operations, P.O. Box 1437 - Slot 1223, Little Rock, Arkansas 72203-1437. All comments must be submitted in writing to the address above no later than thirty days from the date of this publication.

If you need this material in a different format, such as large print, contact our Americans with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex, race, color or national origin.

Roy Hart, Director

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