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AGING PROGRAM DIRECTIVE

SUBJECT: **ISSUANCE OF AGING SERVICE POLICY AND PROCEDURE MANUAL CHAPTER VIII: OPTIONS**

TO:
AREA AGENCIES ON AGING
EXECUTIVE STAFF
PENNSYLVANIA COUNCIL ON AGING
ADMINISTRATION ON AGING
COMPTROLLER
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FROM:
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Secretary
Pennsylvania Department of Aging

LEGISLATIVE/ REGULATORY REFERENCE:

BACKGROUND: The Department of Aging has provided the Area Agencies on Aging with procedural requirements for OPTIONS in Chapters 2, 3 and 4 of the Department

of Aging's Home and Community Based Services Procedures Manual (April 2003).
The Department of Aging HCBS Manual required updates to provide local AAA and service providers the information regarding departmental policies, procedures and processes. The Quality & Compliance Division has worked with Pennsylvania Area Agency on Aging (P4A) and 13 volunteer Area Agencies on Aging (AAA) members that formed a work group to update and revise the manual renamed the "Aging Services Policy and Procedure Manual". This revised manual has 12 chapters which address aging programs and services. Due to the request of the AAA network, the chapters are being released individually as they are completed.

The process for this revision included a thorough review of previous aging APDs, policies, references, etc. followed with a draft chapter presented to an AAA work group for input and revisions. Following revisions the chapter was distributed to the entire aging network with a comment period and additional revisions made prior to finalization.

The updated Aging Service Policy and Procedure Manual is posted on the PDA website with links to chapter appendices, and additional reference documents for all users to have easy access to the information. The document can also be printed by local users if they prefer. The Department will not provide hard copies of the documents.

PURPOSE: The purpose of this Aging Program Directive is to set forth OPTIONS Program procedural requirements for aging program consumers. This APD rescinds Chapter 2.A, Chapter 3.C, and Chapter 4. Section 2 OPTIONS Services of the HCBS Manual including all appendices and forms.

CONTENT: Chapter VIII: OPTIONS overview/summary of revisions includes:

Consumers who receive OPTIONS service must be assessed using an LCD and NAT and must be care managed with the exception of individuals who receive Transportation non-care managed service and Non-Congregate/In-Home Meals only. Non-Congregate/In-Home Meals consumers will be assessed using the Needs Assessment Tool Express (NAT-E) and care management can be provided by a Case Aide that is supervised by a Care Manager or a Care Management Supervisor.

Section I: <u>Program Eligibility</u>

OPTIONS service recipients must be a lawful permanent resident of the U.S. as defined in Appendix E. Proof of receipt of SSA or SSI benefits or Medicare Part A or B will meet this requirement.

Section II: <u>Program Enrollment Requirements</u>

Mandatory Enrollment

All consumers who are seeking OPTIONS services and who have been assessed and determined NFCE must apply for MA Long Term Care services by completing a PA 600

for determination of financial eligibility. Failure to do so will preclude the consumer from participation in the OPTIONS Program, unless the consumer agrees to pay 100% of the care plan cost, including Care Management and Administrative Costs. The mandatory enrollment policy also applies to all consumers who are receiving OPTIONS services and have a change in level of care to NFCE, or who at reassessment or any other time it is determined that the consumer's income and/or assets are within MA guidelines for the Aging Waiver.

Interim Care Plan

An interim care plan not to exceed the care Plan cap may be provided for no more than 45 days beginning with the 600L submission. The timeframe can be extended with documented justification.

Services must be as close in scope, type and model to services in the Aging Waiver so that the plan can be replicated in the initial Aging Waiver Care Plan.

Consumer must be aware that they must pay calculated cost share rate until PA 162 is received. Agencies should not bill the individual for this cost share until the PA 162 is received.

If consumer is determined ineligible due to failure to complete the PA600L or provide required documentation, services must be terminated or consumer is billed 100% of care plan cost including Administration and Care Management costs.

If a consumer is denied MA Waiver for any reason other than excess income or resources, they must reapply within 15 days or by the date indicated on the PA 162.

Care Managers must closely monitor these cases.

Current OPTIONS care plans remain in place until PA 162 is received unless current care plan is below the cap if $765 and there is identified need for additional services but only up to the cap amount.

For new consumers the AAA must:

- Assure that the PA 600L has been completed and forwarded to the CAO
- Provide notice to the individual that their care plan (services/s and/or providers) may/will be revised upon enrollment in the Aging Waiver
- Assure that the OPTIONS Interim Care Plan remains in place until OLTL approves the recommended Aging Waiver care plan

Waiver Enrollment Broker tasks by AAAs that are so designated in order to be reimbursed appropriately for the MA Enrollment service are outlined.

Wait List

There is to be only one waiting list, which will include both consumers waiting to enroll in the OPTIONS program and existing consumers waiting for a new service or an increase in service. The AAA can determine that a current consumer receiving core services requires a supplemental service and provide that service if they have funds available.

Consumers whose only need is for Non-Congregate/In-Home Meals and are at nutritional risk and/or do not have the financial resources to purchase food are to be placed at the top of the waiting list. All other individuals whose only need is for Non-Congregate/In-Home Meals will be placed on the waiting list by FNS score.

Wait List consumers MUST be entered into SAMS as per SAMS instructions (Appendix D).

Care Plan Cost Caps

This section outlines the monthly cap on the cost of consumers' care plans, exceptions to the cost cap and the process for approval of an exception to the cost cap.

The monthly care plan cost cap has been raised to $765/month. This care plan amount includes ALL services in the consumer's care plan including Non-Congregate/In-Home meals and transportation cost paid by the AAA.

- New consumers should receive an initial care plan at or below the cap

- In rare exceptions consumers can receive OPTIONS service/s above the cap of $765/month up to, but not to exceed $1900/month for NFCE consumers or NFI consumers who receive Adult Day Services only (or Adult Day Services supplemented with other OPTIONS services) in which the cost of the Adult Day Services exceed 50% of the total care plan cost.

Approval for exceptions to the monthly care plan cost will be made by the AAA, who must establish written procedures for the approval process before any consumer can be served as an exception and there must be documentation of the justification for the exception in the consumer's record.

Consumers currently receiving care plans in excess of $1900/month will continue with their current plan with no increases in services until they are closed to the OPTIONS program.

Service rate increases which increase a consumer's care plan above $765 will not be subject to a cap exception ONLY when this increase is a result of a Departmental directive and not when due to a provider contractual agreement made by the AA.

Section III: <u>Required OPTIONS Core Services (OCS)</u>

These services include: Adult Day Services, Care Management, Consumer Reimbursement (for specified services), Emergent Services, Non-Congregate/In-Home Meal Service, Personal Emergency Response System and Personal Care Services. OPTIONS Service Standards can be found in Appendix E of this chapter.

Current consumers that are receiving these core services who have not had an LCD and/or NAT conducted must have these tools completed at the next home visit not to exceed one year from the issuance of this chapter.

Consumers currently receiving consumer directed PAS for personal care will, at time of reassessment, be offered the option of transitioning to an agency model with the same care

plan cost (increase in units of service if needed to equal current cost of care plan including FMS) or having their PAS worker be hired by the consumer or hired through a licensed home care agency/home care registry. Nurse supervisory review visits are addressed in the Service Standards.

New consumers may also hire their own personal care worker directly or through a licensed home care agency/home care registry.

The consumer's personal care worker may be employed through an agency that does not have a contract with the AAA.

Section V: Transportation- OPTIONS Non-Care Managed

Transportation for various essential and non-essential trips as provided and funded by the AAA and as available in the AAA Planning and Service Area.

Section IV: OPTIONS Supplemental Services

This section outlines Supplemental Services that may be offered by the AAA secondary to providing core services. These services include: Consumer Reimbursement (for specified services), Home Health Services, Home Modifications, Home Support, and Medical Equipment, Supplies, Assistive/Adaptive Devices.

An AAA cannot offer a supplemental service if there is a waiting list for an OPTIONS core service. Current consumers who are receiving services identified as Supplemental will continue to receive those services even if a waiting list is established. If a consumer is currently receiving Core Service/s and is in need of a Supplemental Service or an increase in a Supplemental Service already being received, that service/service increase can be provided without having to be placed on the waiting list.

Section VI: OPTIONS Cost Share

Consumers who refuse to disclose income or cooperate with the verification process and NFCE consumers who refuse to apply for the Waiver, as per Mandatory Enrollment, must pay 100% of the cost of the care plan, including the cost of Care Management and Administrative costs.

Cost Sharing Scale

A new cost share scale has been developed which reduces the number of income ranges and raises the starting point of the scale to 133% of the Federal Poverty Level (FPL). Consumers under 133% of the FPL will have a 0% cost share.

Cost Share Calculation

The only allowable deduction will be a flat 30% disallowance from the total monthly income of the consumer or consumer and spouse (if applicable).

All current consumers will have a new cost share calculation completed at the time of their next reassessment. If the new calculation reduces their cost share percentage, the consumer will cost share at the new, lower percentage beginning the month following

the date the reassessment was completed. If the new calculation increases the consumer's cost share percentage, the consumer will remain at their current percentage rate.

Assets will not be used to determine a consumer's cost share, but are to be collected and their use discussed as part of care planning process.

Billing

This section outlines the steps, timeframes and processes for the billing of consumers, use of revenues from collected fees, and appeals.

This chapter also includes the following Appendices:

A. Documentation Requirements
B. Forms
C. Regulations and Citations
D: SAMS Data Entry Requirements
E: Definitions and Service Standards
F: Other Resources