Overview

OPTIONS is a program that allows individuals to receive services and supports in their homes and communities. Funded primarily through the Aging Block Grant, the OPTIONS Program (OPTIONS) serves individuals who are either financially or clinically ineligible for Medical Assistance (MA) Long-Term Services and Supports. OPTIONS services are provided to eligible consumers aged 60+ to assist them in maintaining independence at the highest level of functioning in the community and help delay the need for more costly care/services. All other resources (individual, local, state and/or federal) shall be considered and utilized before OPTIONS services are provided. In discussing individuals' resources, the Area Agency on Aging (AAA) shall explore how use of individuals' personal resources can enhance and/or extend the receipt of long-term care services, and shall refer individuals to the most appropriate program that will best meet their needs. OPTIONS services are not an entitlement.

I. PROGRAM ELIGIBILITY REQUIREMENTS

An individual shall be:

- Age 60 and older
- Experiencing some degree of frailty in regard to physical and/or mental status that impacts daily functioning
- A Pennsylvania resident
- A U.S. citizen or lawful permanent resident (see Appendix F).

NOTE: The citizenship or lawful resident requirement will be met if the individual receives Supplemental Security Income (SSI), Social Security Administration (SSA) benefits, or is enrolled in Medicare Part A or B as evidenced by proof of enrollment.

An individual is ineligible for OPTIONS services if the individual is currently enrolled in MA Long-Term Services and Supports (Nursing Facility, LIFE, Home and Community Based Waivers) or Act 150 services. OPTIONS services may not be provided to individuals residing in personal care homes, assisted living residences, nursing homes, or correctional facilities.

NOTE: Individuals residing in a Domiciliary Care home may receive OPTIONS services with the stipulation that there is no duplication or replacement of services provided by the Domiciliary Care home provider.

II. PROGRAM ENROLLMENT REQUIREMENTS

An individual applying for OPTIONS services shall:

- Have needs initially assessed using the Needs Assessment Tool (NAT), with the exception of individuals who receive the following services alone or in combination:
  - In-Home Meal Service. Individuals shall be evaluated with a Needs Assessment Tool – Express (NAT-E)
  - Care Management. Individuals shall be evaluated, at a minimum, with the NAT-E, although completion of the NAT is recommended.
- Have unmet needs that can be addressed through OPTIONS services as determined by the NAT/NAT-E.
- Provide financial information

In order to maintain continuous enrollment in the OPTIONS Program an individual must comply with the assessment process, including verification of financial information. Consumers receiving OPTIONS services shall be assessed annually or at any time the AAA becomes aware the consumer has a change in condition, a change in income and/or assets or a change in living environment impacting the needs of the consumer utilizing the appropriate assessment tools. (Refer to Chapter III: Assessment) Failure to comply with this process may result in termination of OPTIONS services. (Refer to Chapter II: Hearings and Appeals)

A. Mandatory Medical Assistance (MA) Eligibility Determination Process

All applicants for OPTIONS services, or existing OPTIONS consumers whose income and assets are under the financial thresholds noted in Appendix (F.4), who have been assessed and determined to be Nursing Facility Clinically Eligible (NFCE) shall apply for MA Long-Term Services and Supports (MA LTSS), and comply with the MA Eligibility Determination Process.

Individuals who must apply for MA LTSS shall be referred by the AAA to the Independent Enrollment Broker. Failure to complete this mandatory process will preclude the individual from participation in the OPTIONS program; unless the individual agrees to pay 100% of the care plan cost.

The Mandatory MA Eligibility Determination Process policy applies to all existing consumers receiving OPTIONS services who (i) have a change in level of care to

NFCE or (ii) at any time the AAA becomes aware, their income and assets are within the financial thresholds defined in Appendix F.4.

NOTE: The Mandatory MA Eligibility Determination Process does not apply to individuals who need the following services alone or in combination:

- Care Management Service
- In-Home Meal Service

The consumer shall be required to follow through with the Mandatory MA Eligibility Determination Process and shall be eligible to receive OPTIONS services until enrollment in MA Long-Term Services and Supports occurs. The consumer shall be required to share in the cost of any services received at their calculated cost share rate according to the cost share guidelines in the OPTIONS Chapter.

It shall be the responsibility of the Care Manager to closely monitor these cases. The Care Manager shall make monthly phone calls to the consumer following the referral to the IEB to assure the consumer has submitted the completed PA 600L to the IEB. If the consumer needs assistance with the completion of the PA 600L, the Care Manager may assist the consumer or refer the consumer to the PA Link for Person Centered Counseling. The Care Manager shall contact the IEB, if needed, to check on the status of the MA Long-Term Services and Supports application.

The Care Manager shall do a home visit at ninety (90) days from the date of the consumer's referral to the IEB to assure the OPTIONS care plan of services effectively and adequately addresses the needs of the consumer, determine if the consumer has had any change in needs or supports, and whether the consumer has followed through with the submission of the completed PA 600L to the IEB. The Care Manager shall record the phone contacts and home visits in a journal entry in the consumer's record in SAMS. If the consumer has not followed through with submission of the PA 600L, the Care Manager shall notify the consumer that either services will be terminated or, in order for services to continue, pay 100% of the cost of their OPTIONS care plan.

If the consumer has submitted the completed PA 600L to the IEB and has not yet received notice of enrollment into MA Long-Term Services and Supports or notice of financial ineligibility, the consumer's care plan of service may continue for an additional ninety (90) days. The Care Manager must document in a journal entry in the consumer's record in SAMS the reasons that led to the

extension of the care plan of services for an additional ninety (90) days. The journal entry shall be titled "90 Day Extension." The Care Manager shall continue to monitor the case closely according the process described above.

Once a consumer is found eligible for MA Long-Term Services and Supports, the Care Manager shall follow the Department of Human Services, Office of Long Term Living's procedures for the OPTIONS to MA Long-Term Services and Supports Transfer Process (see Appendix F.2). Consumers found to be financially ineligible for MA Long-Term Services and Supports shall continue as an enrolled OPTIONS consumer according to this Chapter.

Consumers found eligible for MA Long-Term Services and Supports who refuse to enroll shall be notified by the Care Manager that services will be terminated or the consumer will be required to pay 100% of the cost of their OPTIONS care plan in order for services to continue.

B. Wait List

OPTIONS services are primarily funded through the Aging Block Grant. At times, limited funding may result in the establishment of a wait list by the AAA. The need for a wait list will be determined at the local level based on the AAAs' ability to provide OPTIONS Services. When an AAA determines a wait list shall be established, it shall provide notice to the Bureau of Finance at the Pennsylvania Department of Aging (hereafter referred to as "the Department") prior to implementation.

Only one OPTIONS wait list shall be maintained and used to prioritize services for individuals waiting for services. The wait list shall include the names of individuals waiting to enroll in the OPTIONS Program and existing consumers waiting for an increase in services or a new service to be added to their existing care plan.

Individuals who are in need of In-Home Meal Service have highest priority and are to be placed at the top of the wait list. Individuals shall be ranked by the date of completion of the NAT or NAT-E. If an individual needs In-Home Meal Service in addition to other OPTIONS services, the individual shall receive the meal first and be placed back on the wait list for the additional services.

Individuals in need of an OPTIONS Service (or an increase in an existing service) are placed on the wait list in order based upon a Needs Assessment Score (NAS) and needed services. Individuals with the same NAS shall be

ranked by the date of completion of the NAT. All individuals, regardless of score, shall be placed on the wait list.

The NAS is calculated based on information obtained through the NAT. The following areas are factored into the calculation of the NAS:

- Activities of Daily Living
- Physical Environment
- Informal Supports
- Cognition & Diagnosis
- Need for Supervision
- Instrumental Activities of Daily Living
- Mobility

When funding becomes available, individuals are served from the wait list in the order they were placed. AAAs shall establish a written wait list policy for their planning and service area (PSA), approved by the Department's Bureau of Aging Services, that outlines the AAAs' process for placing and serving individuals from their wait list.

Individuals placed on a wait list shall be identified in SAMS and their record shall include a completed NAT and a draft care plan within 30 calendar days of the completion of the NAT. Care Management shall be in "active" status in the care plan, while all other services shall have a status of "waiting". AAAs shall maintain accurate wait lists in SAMS. The wait list shall be updated anytime an individual is placed or removed from the wait list.

Regular contact shall occur with individuals on the wait list (refer to Chapter V: Care Management). Individuals shall be contacted, at a minimum, as follows:

- Telephone contact – 3 months
- Home visit – 6 months
- Telephone contact – 9 months
- Reassessment – 12 months

While on the wait list, if an individual's functional needs or supports change affecting his/her NAS, a new NAT shall be completed. Documentation of these changes and a recalculation of the individual's score are required to advance his/her placement on the wait list. If it is determined that the initial units of

services ordered do not meet the individual's needs, completion of a new NAT is not required.

NOTE: Individuals in need of Care Management services only are not to be placed on the wait list.

C. Care Plan Cost Caps

The OPTIONS monthly care plan cost cap is **$765 per month** (as averaged over the 12-month care plan period and is subject to change as determined by the Department.

- The costs of In-Home Meals, Assessment, Care Management, Emergent Service, Home Modifications, Specialized Medical Transport, and Protective Services costs are excluded from the cost cap.
- Fees paid to a Fiscal Agent are included in the cost cap.
- Individuals who do not comply with the Mandatory MA Eligibility Determination Process and choose to pay 100% of their service costs may exceed the $765/month cap amount.
- Individuals who comply with the Mandatory MA Eligibility Determination Process and have a calculated cost share of 100% may exceed the $765/month cap amount.
- When significant monthly variations in services occur, AAAs may use an average cost of services over the twelve month care plan period to determine the care plan cost. This shall be documented in a journal entry in SAMS titled "Average Care Plan Cost Determination".

All consumers shall receive an initial care plan at or below $765/month. In rare instances where services above this amount are needed, the care plan may be increased to a maximum of $1900 per month. This exception to the monthly care plan cost cap applies only to:

- Individuals with a Needs Assessment Score at or above **56** points
- Individuals who receive Older Adult Daily Living Services

Approval for an exception to the care plan cost cap will be made by the AAA. The AAA shall establish local policy and procedures for their planning and service area (PSA), approved by the Department's Bureau of Aging Services,

which outlines consistent protocols for cost cap exceptions including approval authority. All approved exceptions to the care plan cost caps shall be documented in a journal entry in SAMS which clearly outlines the reasons for the decision to exceed the cap of $765/month. The journal entry shall be titled, “Cost Cap Exception.” At a minimum, the SAMS documentation shall include:

- Current, detailed care plan information to include type of service/s and schedule
- A summary of the changes in the consumer’s condition and/or situation that supports the need for services above the care plan cost cap
- Efforts made to address increased needs prior to an increase in services (i.e. change in schedule or a consideration of another service such as Older Adult Daily Living Services instead of increased Personal Care)
- Evaluation and discussion with the consumer of all community resources as well as the consumer’s financial resources that could address the need for additional service/s
- Details on what will be added to the care plan to include type of service and schedule
- The length of time this service will be needed if not on-going

The Department’s Quality and Compliance Unit will conduct monitoring of the exception process.

NOTE: Active consumers whose care plan cost would exceed the $765/month cost cap, as a result of a Department issued service rate increase directive, will not be subject to the cost cap exception process.

III. OPTIONS SERVICES

A. The following services are **required** to be offered by the Area Agencies on Aging. All OPTIONS Services shall meet the Service Standards (see Appendix A). Allowable provider payment models (described in Section IV) are identified for each service.

1. Care Management

   Care Management activities through the AAA serve as a coordinative link between the identification of consumer needs and the timely provision of appropriate services to meet those needs by utilizing all available

resources. Care Management is a service to develop a person-centered plan of care to meet the consumer's needs in coordination with formal and informal supports. It supports the consumer's individual preferences and independence with a focus on health and safety, and is based on his/her lifestyle, cultural needs and frame of reference. Care Management also provides on-going monitoring and reassessment of the care plan to assure the consumer's needs continue to be met. Activities include, at a minimum, a comprehensive needs assessment of the consumer; development of a written care plan; arrangement, coordination and follow-up of service delivery; and ongoing case recording. Care Management can be offered as a stand-alone service to consumers who need the support and assistance of a Care Manager and are not receiving other services. (Refer to Chapter V: Care Management)

NOTE: All consumers who receive OPTIONS services shall be care managed and shall have Care Management as an active service in their care plan. For consumers who receive In-Home Meal Service only, the consumer may be care managed by a case aide or trained intern that is supervised by a Care Manager or a Care Management Supervisor.

Allowable Provider Payment Models: Agency Model

2. <u>In-Home Meal Service</u>

To be eligible for this service, an individual shall demonstrate a nutritional need and the need shall be documented in the NAT (or NAT-E for consumers who receive In-Home Meals only). The consumer may have nutritional needs such as, but not limited to, the inability to obtain food or prepare meals due to a physical or cognitive disability, lack of resources (money) for meals or absence of someone willing or able to prepare meals for them as evidenced by the completed NAT (or NAT-E). Prior to providing In-Home Meal Service, consumers should be referred to all available community nutritional resources including congregate meal sites.

Each meal shall adhere to the nutrition requirements outlined in the Department's most current Nutrition Services APD and can be provided hot, cold, frozen or in combination. These meals are provided to consumers in their individual residences and not in a congregate setting.

Allowable Provider Payment Models: Agency Model

3. Older Adult Daily Living Services

Older Adult Daily Living Centers operate for part of a 24-hour day and offer an interactive, safe, supervised environment for older adults with a functional impairment, and adults with a dementia-related disease, Parkinson's disease or other organic brain syndrome. Older Adult Daily Living Centers offer a community-based alternative to institutionalization and provide a reliable source of support and respite for caregivers. Refer to Older Adult Daily Living Center Regulations. Title 6, Chapter 11: 6 PA Code Chapter 11 - Older Adult Daily Living Centers.

All Older Adult Daily Living Centers in Pennsylvania provide personal care, nursing services, social services, therapeutic activities, nutrition and therapeutic diets and emergency care. Some centers offer additional services such as physical therapy, occupational therapy, speech therapy, medical services, podiatry, etc. to meet the range of client needs.

Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

4. Personal Care Services

Personal Care Services include assistance with Activities of Daily Living (ADL's), such as feeding, skin and mouth care, ambulation, bathing, hair care, grooming, shaving, dressing, transfer activities, toileting, and assistance with self-administration of medications (i.e. opening medication containers, providing verbal reminders).

Allowable Payment Models: Agency Model, Consumer Reimbursement Model, Fiscal Agent Model

The AAA may allow any combination of the three payment models for an individual who needs Personal Care Services. For example, a consumer may receive Personal Care Services via Agency Model during weekdays, but choose to hire their own Personal Care worker for weekend hours using the Consumer Reimbursement Model.

NOTE: Home Support activities can be included in Personal Care Service if they are necessary and secondary to the provision of personal care.

B. The following services **may** be offered at the discretion of the Area Agencies on Aging according to their local policies as funds are available. All OPTIONS Services shall meet the Service Standards (see Appendix A). Allowable provider payment models (described in Section IV) are identified for each service.

1. Emergent Services

Emergent Services address an immediate need for assistance and intervention due to a critical event that poses an imminent health and safety risk to consumers that cannot be addressed by existing community resources. These individuals do not meet the criteria for Older Adult Protective Services intervention. These services are short-term in nature (generally 24-72 hours) until a permanent arrangement/payment solution is made or an alternate caregiver or family member becomes available to provide care. Emergent services include:

- Personal Care Service
- Care Management
- In-Home Meal Service
- Overnight Shelter
- Emergency Life-Sustaining Supplies
- Emergency Home Heating Assistance
- Other Emergent Service

For consumers currently participating in any Aging program**,** this service can be provided within available agency resources. For individuals not known to the agency, Emergent Services are not an entitlement. Emergent Services shall be provided in the most cost effective manner, and the AAA shall explore all other potential resources first to resolve the crisis.

The AAA is responsible for developing consistent standards, policies and procedures to review, authorize, and reimburse for Emergent Services. The AAA shall clearly document in a journal entry in the consumer's record in SAMS the immediate need for the service(s), the other options explored, and the authorized service(s) chosen. The journal entry shall be titled "Authorization for Emergent Service". A Supervisor shall approve the authorization of services.

NOTE: Individuals not known to the agency who are found in need of Emergent Services will initially receive a Needs Assessment Tool-Express (NAT-E). However, if this service is required for more than 72 hours, the

AAA shall complete a NAT to fully evaluate their needs. Individuals receiving Emergent Services are not subject to OPTIONS cost share.

Allowable Provider Payment Models: Agency Model

2. Home Health Services

Home Health Services include the services of skilled nursing, medication management, physical therapy, occupational therapy, speech therapy, and home health aides on a part-time or intermittent basis, not otherwise covered under a third-party payer. Duties of a home health aide include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs and completing appropriate records. Consumers receiving home health aide services should have complex medical issues that require the oversight and supervision of a Registered Nurse. A physician's order is required for the provision of Home Health Services.

Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

NOTE: The AAA shall assure that OPTIONS is the payer of last resort and retain copies of Medicare or other insurance denials before providing Home Health Services. Medicare or other insurance denials are not required for RN/LPN medication set up. Medicare denials are available electronically. A consumer may request a copy of the denial from the provider to serve as verification. If the consumer is unable to obtain the insurance denial, the AAA may contact the provider to verify the home health service is not covered. This contact shall be documented in a journal entry in SAMS to include the date, time, name of provider, and name of the contact person and titled "Insurance Denial."

3. Home Modifications

Adaptations/modifications made to improve consumer safety, increase functionality, improve accessibility, and to assist in the provision of care to a consumer in his/her home. The "footprint" of the dwelling cannot be changed or altered in any way. Multiple bids should be solicited to ensure work is completed in the most cost effective and efficient manner.

Although a consumer is not required to choose the lowest bid, the AAA can only fund the lowest bid amount that meets all local and state building codes and American with Disabilities Act standards and the consumer will be responsible for the difference. If unable to solicit more than one bid, a journal entry in the consumer's record in SAMS shall document all bid solicitation efforts. The journal entry shall be titled, "Bid Solicitation"

There is a lifetime cap of up to $15,000 for each consumer, to include but not limited to all charges such as estimates, applicable licenses and inspection fees. The AAA shall explore all other resources and be the payer of last resort. The Department's Quality and Compliance Unit will monitor for compliance as evidenced by documentation in journal entries in the consumer record in SAMS.

Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

4. Home Support Services

Home Support Services include assistance with Instrumental Activities of Daily Living (IADL's), and should support continued, independent living in the consumer's residence when the consumer has no other informal supports that are available. The need for the service should be identified in the Instrumental Activities of Daily Living section of the NAT. Home Support activities may include, but not limited to:

- Basic housekeeping activities necessary to ensure safe and sanitary conditions.
- Laundry
- Shopping and errands such as grocery shopping, prescription pick-up
- Preparing meals
- Garbage removal
- Minor home repairs and maintenance that are absolutely necessary to allow a consumer to continue to live in his or her home.

Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model, Fiscal Agent Model

The AAA may allow a combination of Agency Model and Consumer Reimbursement for an individual who needs Home Support Services.

NOTE: Home Support activities may be included in Personal Care Service if they are necessary and secondary to the provision of personal care. In cases where Home Support is provided separately from Personal Care, the AAA shall ensure there is no duplication of services.

5. Medical Equipment, Supplies, Assistive/Adaptive Devices

Equipment, supplies and devices used to assist consumers with certain medical conditions, illnesses, and/or disabilities to remain independent and living in their homes and communities. The AAA shall assure that OPTIONS is the payer of last resort and retain copies of Medicare or other insurance denials before purchasing medical equipment, supplies or assistive/adaptive devices.

Durable Medical Equipment (DME) - items primarily used in the presence of illness, injury or functional disability that can withstand repeated use and are appropriate for use in the home. Items in this definition shall be Medicare, Medicaid or third-party non-reimbursable.

Medical Supplies - Expendable, disposable or consumable supplies used in the provision of home health or personal care to chronically ill or disabled consumers at home not otherwise covered by other insurance or third-party payer. These items shall complement the delivery of in-home services, or where cost effective and appropriate, replace the delivery of certain services.

Assistive/Adaptive Devices - Items and/or aids that will enable consumers with functional disabilities to perform ADLs and IADLs more independently. These items shall complement the delivery of in-home services, or where cost effective and appropriate, replace the delivery of certain services.

Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

NOTE: Hearing aids, dentures and eyeglasses are considered personal items and not Medical Equipment, Supplies, or Assistive Devices and cannot be reimbursed through OPTIONS.

NOTE: Medicare denials are available electronically to DME providers. A consumer may request a copy of the denial from the DME provider to

serve as verification. If the consumer is unable to obtain the insurance denial, the AAA may contact the DME provider to verify the equipment, supply, or device is a non-covered item. This contact shall be documented in a journal entry in SAMS to include the date, time, name of DME provider, and name of the contact person and titled, “Insurance Denial”.

6. Personal Emergency Response System (PERS)

   PERS is an electronic device which enables certain high-risk consumers to receive help in the event of an emergency. PERS services are limited to consumers who live alone or are alone for significant parts of the day, are significantly at risk for falls, have no regular caretaker for extended periods of time, or lives with an individual who may be unable to promptly call for help in the event of an emergency. The consumer shall be capable of using this device.

   Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

7. Pest Control/Fumigation

   Pest Control and Fumigation Services may be used for purposes of eliminating pests or rodents in order to maintain safe, sanitary living conditions in a consumer’s home environment. Services may be provided on a one-time or ongoing basis as deemed necessary to eradicate pests and rodents and maintain a pest-free or rodent-free living environment.

   Allowable Provider Payment Models: Agency Model, Consumer Reimbursement Model

8. Specialized Medical Transportation

   Specialized Medical Transportation is a non-emergent service for consumers who are unable to be transported for medical trips via regular transport due to the need for one of the following:
   - Lying down or requires a stretcher
   - Door through door service
   - Professional attendant supplied by the transport provider

The AAA shall pursue all other transportation resources, including the Medical Assistance Transportation Program (MATP) and Shared Ride, before authorizing this service. Specialized Medical Transportation Service may be provided to consumers under the following conditions:

- To obtain medical treatment or undergo diagnostic testing
- The consumer has a written order from his/her physician stating non-emergency ambulance transportation is necessary due to the consumer's medical condition
- The consumer has no other resources or payment sources that will cover this type of transport (including MATP and Shared Ride)

Allowable Provider Payment Models: Agency Model

IV. ALLOWABLE PROVIDER PAYMENT MODELS

The following describes the allowable provider payment models identified for OPTIONS services (see Section III: OPTIONS Services). When a service identifies multiple allowable provider payment models, the AAA has the discretion to offer one or more of the allowable models. A consumer's care plan may include multiple models.

A. Agency Model

An agency-directed model in which the AAA, or providers, vendors and/or sub-contractors under contract with the AAA, is responsible for the provision of services. The AAA arranges for and pays the provider, vendor or sub-contractor directly for the service authorized in the consumer's care plan.

B. Consumer Reimbursement Model

A consumer-directed model in which the AAA provides reimbursement to a consumer for services authorized in his/her care plan. The consumer has responsibility for the hiring of, or entering into an agreement with, the provider of the service. Personal care or home support service workers hired by the consumer who are not employed through a licensed home care agency/home care registry shall be considered self-employed, independent contractors who must attest to understanding the local and state employment requirements for tax implications. The AAA shall have a system in place to ensure that services provided through the Consumer Reimbursement Model are/were provided as

outlined in the consumer's care plan. These services shall be provided at a cost that is less than or equal to the AAA's designated agency model rate.

At a minimum, it is the responsibility of the AAA to:

- Approve a care plan that outlines the specific items and services to be reimbursed
- Obtain the completed Self-employed/Independent Contractor Declaration form from the consumer, when applicable (see Appendix C)
- Obtain receipts from the consumer for items or services purchased
- Obtain the completed Department required Consumer Reimbursement forms from the consumer (see Appendix C) that:
    - details the provision of services (days/hours, service provided and by whom);
    - contains sign-offs by the service provider and consumer; and
    - has a signed attestation statement made by the consumer that all submissions for reimbursement are true and correct and reflect the service was provided as documented in the care plan

The AAA shall identify and develop reasonable, appropriate standards for the authorization for reimbursement of specific services and apply these standards consistently in all cases.

The AAA shall develop a procedure for timely submission, review, approval, and payment of the submitted receipts for authorized services and apply the procedure consistently in all cases. The Care Manager shall review and approve all receipts to assure consistency with the care plan.

AAAs shall establish a written Consumer Reimbursement policy for their planning and service area (PSA) approved by the Department's Bureau of Aging Services.

NOTE: Individuals receiving services through the Consumer Reimbursement Model who are unable to self-direct their care may have this service directed by their identified primary caregiver and/or legal surrogate (i.e. power of attorney or guardian).

C. Fiscal Agent Model

A consumer-directed model in which a fiscal agent has responsibility for employer related tasks for a consumer who chooses to hire, or enter into an

agreement with, a personal care or home support service provider. These tasks shall include:

- Conduct applicable criminal history background checks and child abuse clearances.
- Payroll activities and the filing of tax forms with applicable governmental taxing agencies at all levels.
- Obtain an employer identification number (EIN).
- Authorize personal care and/or home support worker timesheets and/or vouchers.
- Withhold and deposit state and federal income taxes.
- Withhold and deposit Social Security and Medicare tax (FICA) and federal and state unemployment tax (FUTA/SUTA) payments.
- Purchase benefits (e.g. worker's compensation, disability, health, life) and manage any withholding of premium payments when applicable.
- Assure that all federal and state Department of Labor laws related to minimum wage, overtime and night personal care and/or home support workers are complied with.
- Issue IRS Form W-2's annually.
- Inform personal care and/or home support workers about the Earned Income Credit provision and manage advanced EIC payments when appropriate.

The Fiscal Agent must be approved as a fiscal agent with the IRS and operate as an approved vendor/contractor of the AAA. The AAA shall establish a written policy for their planning and service area (PSA), approved by the Department's Bureau of Finance, that outlines the AAA's process for approving a qualified Fiscal Agent vendor/contractor, the primary responsibilities of the Fiscal Agent, and fees and reimbursement to the Fiscal Agent.

All fees associated with utilizing a Fiscal Agent shall be included in the consumer's care plan and cost cap.

V. OPTIONS COST SHARE

Mandatory Cost Sharing applies only to OPTIONS services. Specifically excluded are:

- Assessment
- Care Management

- In-Home Meals
- Emergent Services
- Services provided through a Protective Services Care Plan

Consumers who refuse to disclose income or cooperate with the verification process and NFCE consumers who refuse to apply for MA Long-Term Services and Supports as per the Mandatory MA Eligibility Determination Process Policy (see Section II.A) shall pay 100% of the cost for services.

Non-payment of Mandatory Cost Sharing will result in termination of AAA participation in the cost of the consumer's care plan as outlined in Section V (C) Billing. The consumer may still receive, at no cost, services specified by the Department as excluded from Cost Sharing.

A. Cost Sharing Scale

- OPTIONS cost sharing is determined using a sliding scale that covers the range of income from 133% to 300% of the current Federal Poverty Level (FPL), which is updated annually (see Appendix F).

The application of the sliding scale to individual consumers shall occur during completion of the initial Needs Assessment Tool (NAT), annual reassessment, or when there has been a significant change in countable income that may affect the cost share amount.

- Those consumers under 133% of the FPL will not have to pay for services.
- The fee scale increases up to 300% of the FPL, at which point the consumer will pay for all of his/her services (except for excluded services).

B. Cost Share Calculation

Income

The cost sharing fee is based on the countable monthly income. Where significant monthly variations exist, the income amounts will be averaged over a 12 month period for purposes of determining eligibility and cost sharing rates.

- Income eligibility is based on the previous year's gross income received by the consumer and spouse (if married). Current year income is not used for this calculation unless there is a significant decrease in current income that would affect the cost share amount to the benefit of the consumer. However, there may be some rare instances where a consumer is unable

to produce or verify last year's income. In these instances it would be acceptable to use current year income; however, this would be an exception and shall be documented in a journal entry in SAMS titled, "Income Calculation Exception."

- If the consumer has filed a federal tax return, the adjusted gross income may be used to determine the amount of the cost share fee. However, non-taxable income such as Social Security shall be added to the adjusted gross income when determining the cost sharing fee.

- If sale of a home/property occurred, all capital gains shall be declared as income within two (2) years of the sale date even if the consumer did not file a State or Federal tax return. If the consumer used the proceeds to pay for nursing home costs or to purchase another residence deeded in his/her name, that portion of the capital gains used to pay for the aforementioned items is not considered income.

- If the consumer did not file a tax return, use the following list of types of income to be counted when determining the cost sharing fee:

    - Gross Social Security & SSI (deduct Medicare B premiums)
    - Railroad Retirement (RRB1099 & RRB1099R)
    - Gross Pensions
    - Salaries/Wages/Commissions
    - Self-Employment or partnership income
    - Alimony and Spousal Support Money
    - Taxable Amount of Annuities and IRAs
    - Unemployment
    - Veterans' Disability Payments
    - Cash Public Assistance
    - Interest/Dividends/Capital Gains
    - Net Rental Income
    - Royalties
    - Workers' Compensation
    - Life Insurance Benefits (death benefits over $10,000)
    - Spouse's income if married, living together
    - Gift and inheritance of cash or property over $300
    - Any amount of money or the fair market value of a prize, such as a car or trip won in a lottery, contest, or gambling winnings

- The following will **not** be considered as income for the cost sharing program:

    - Medicare Part B premiums

- Aid & Attendance payments from VA
- Certain AmeriCorps Vista payments may be excluded
- Property Tax/Rent Rebates
- Damages received in a civil suit/settlement agreement
- Benefits granted under 306c of Workers' Compensation Act
- Food Stamps
- LIHEAP payments
- Black or White Lung Benefits
- Reverse Mortgages

Deductions

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

Income Verification

Income shall be verified by the Care Manager and a copy of all documents shall be attached to the consumer's record in SAMS, both initially and at reassessment. Changes in the consumer(s) financial situation shall be reviewed annually during the reassessment process. Consumers should be encouraged to call the AAA when there has been a significant change in income at any point during the life of the case.

Assets

Assets will not be used to determine a consumer's cost share; however, the AAA shall collect asset information when completing the Needs Assessment Tool (NAT) and record what documentation was presented to verify assets. The Older Americans Act mandates provision of service to the most economically needy individuals and therefore, the Care Manager shall engage the consumer in a discussion about utilization of assets to meet his/her needs. The AAA has discretion on establishing local policy regarding the use of consumers' assets.

NOTE: The consumer's cost share amount, when subtracted from his/her monthly income, cannot reduce the consumer's income to less than the current 133% of Federal Poverty Level. For this purpose, the consumer's monthly income shall be his/her monthly income after the 30% disallowance is deducted. If this occurs, the consumer's cost share will be capped at that dollar amount which reduces the remaining consumer income to the 133% Federal Poverty Level.

C. Billing

Billing is handled locally by each AAA and shall be consistent with the following steps, timeframes and processes:

The AAA may opt not to bill consumers for monthly cost share amounts of $10 or less. For consumers with monthly cost share amounts of $10 or less, and with the consumer's consent, AAAs have the option to bill consumers on an annual, semi-annual, or quarterly basis, whichever is most cost-effective for the AAA and convenient for the consumer.

Steps and Timeframes:

- The AAA shall clearly advise consumers in writing, about cost share obligations, procedures, schedules and estimated monthly costs at the time the care plan is developed. Consumers shall also be informed in writing that paying for services is a shared responsibility between the consumer and the AAA.

- The AAA will issue a bill to the consumer for the consumer's cost share within **30** calendar days from the last day of service or by the last day of the month following the month the service was delivered.

- The bill shall note that payment is due upon receipt, and is considered "delinquent" if not paid within 30 calendar days from the date the bill is issued (mailed) by the AAA. The date at which a bill will be considered delinquent shall be clearly displayed on the bill, along with instructions for contacting the AAA if payment cannot be made by the specified date. The bill shall also include notice to the consumer that increases in needed services will not be considered until unpaid costs are paid in full.

- If a payment is not received by the due date, the AAA shall make direct contact with the consumer or responsible party (by telephone or in person) to determine why there is a payment problem.

- Where possible, the AAA shall make an effort to resolve any misunderstanding or payment problems the consumer may have and offer the consumer the opportunity to negotiate a payback schedule for past-due cost share amounts.

- The consumer shall be clearly informed during this contact that since the cost share is delinquent; the AAA will need to terminate its agreement to share in the cost of the consumer's services and will terminate services unless payment is received by a specified date (60 calendar days from the initial billing date).

- If payment is not made by the 60th calendar day from the initial billing date, the AAA shall mail a written notice to the consumer informing the consumer that services shall be terminated after a specified date. This notice shall also inform the consumer that the AAA will contact the consumer's service providers to give notice that the AAA will no longer be participating in the cost of the consumer's care plan after the specified date. The consumer shall also be advised that he/she may contact the provider(s) to continue services fully at his/her own personal expense.

- Only upon receipt of all cost sharing payments for all services received may the AAA enter into a new cost sharing agreement with the consumer for future services. The new cost sharing agreement may provide for shorter time frames for payments to assure the consumer does not become delinquent again in the future.

- The AAA shall document in journal entries in the consumer's record in SAMS all contacts with the consumer or his/her representative and actions to advise and assist the consumer with payment of his/her cost share.

- Non-payment of cost share precludes a consumer from receiving service/s at a later time unless and until his/her cost share payment is paid in full.

Process Standards:

Actions taken to ensure payment of the consumer's cost share of the service costs shall be designed to minimize any embarrassment or distress to the consumer.

- Reminder phone calls to the consumer can only be made during normal business hours; calls to a caregiver or authorized representative may be made after normal business hours if necessary to reach the person.

- These actions shall be carried out in as confidential a manner as possible so that information related to the payment status of the consumer is

shared only with the necessary AAA staff, the consumer and authorized representatives of the consumer.

- The AAA shall not assign past due cost share accounts to a commercial collection agency.

- The AAA may submit a claim for outstanding cost share balances upon the death of a consumer.

D. Using Revenues from Collected Fees

The AAAs shall retain revenues that are collected locally. The AAAs are permitted to retain a one-year balance of OPTIONS cost sharing revenues. The monies collected shall be accounted for separately from all other income sources such as consumer contributions. The AAAs shall track accounts receivable by consumer. Net revenues generated from OPTIONS services cost sharing may be expended only for Home and Community Based Services. The Department reserves the right to offset cost-sharing revenues when determining an AAA's need for funding from the Commonwealth. The AAAs shall have written policies and procedures that outline the collection, expenditure, and reporting of OPTIONS cost sharing revenues.

The Department's Fiscal Monitoring Unit will conduct monitoring of OPTIONS cost sharing revenues.

E. Appeals

Chapter II outlines the Department of Aging's procedures for the Hearing and Appeals processes. An adverse action notice is not required to be issued to a consumer when he/she is terminated due to non-payment under Cost Sharing for the OPTIONS program. (See above note for policy regarding termination due to non-payment)

Resources:

Appendix A - Definitions and Service Standards

- A.1 OPTIONS Service Standards

Appendix B - Documentation Requirements

- B.1 OPTIONS Service Order Documentation Requirements

Appendix C – Forms

- C.1 OPTIONS Consumer Reimbursement: Self-Employed/Independent Contractor Declaration
- C.2 OPTIONS Consumer Reimbursement Form: Personal Care and Home Support
- C.3 OPTIONS Consumer Reimbursement Form: Other

Appendix D - SAMS Data Entry Requirements

Appendix E - Regulations and Citations

- E.1 28 PA Code Chapter 601: Home Health Care Agencies
- E.2 28 PA Code Chapter 611: Home Care Agencies and Home Care Registries

Appendix F - Other Resources

- F.1 U.S. Citizen and Lawful Permanent Resident Requirements
- F.2 OPTIONS To MA Long-Term Services and Supports Transfer Process
- F.3 OPTIONS Cost Share Scale
- F.4 Financial Thresholds for Mandatory Medical Assistance Eligibility Determination Process