Operations Memorandum - Waiver
OPS020701

7/5/02

SUBJECT: Office of Social Programs Community Care (COMMCARE) Waiver

TO: Executive Directors

FROM: Mary Brugger, Acting Director, Bureau of Operations

Purpose

1. To announce the implementation of the Office of Social Programs (OSP) COMMCARE Waiver effective April 2, 2002.
2. To provide County Assistance Offices (CAOs) with procedures for determining eligibility for services under the COMMCARE Waiver.

Background

The Department of Public Welfare has received approval from the Centers for Medicare and Medicaid Services (CMS) to provide services under a home and community-based Medicaid waiver designed to provide services to recipients 21 years of age and older with traumatic brain injury. This waiver, called the COMMCARE Waiver, gives recipients the option of obtaining services in a community-based setting rather than receiving those services in a special rehabilitation long-term care facility. These services are available beginning April 2, 2002, on a Statewide basis.

Discussion

The COMMCARE Waiver requires a determination of eligibility for Medicaid by the CAO and a determination of clinical eligibility by OSP for waiver services. The CAO must send an eligibility notice advising an individual that he/she does or does not meet the eligibility requirements for the Medicaid program and eligibility/ineligibility for waiver-funded services.

A retroactive date of eligibility for waiver-funded services under the COMMCARE Waiver can be requested beginning the first day of the third month prior to the month of application for Medicaid. The effective date for waiver-funded services can be no earlier than 4/2/02. To qualify for retroactive coverage, an applicant must be both Medicaid eligible and clinically eligible for the services provided under the COMMCARE Waiver.

To be eligible for services funded under the COMMCARE Waiver, the applicant/recipient must:

- Be eligible for Medicaid.
- Be 21 years of age or older.
- Be disabled.

- Need Special Rehabilitation Nursing Facility Level of Care.
- Not be dependent on mechanical ventilator supports.
- Have traumatic brain injury as the primary diagnosis.
- Waiver services are limited to individuals with the following condition(s): must experience a medically determinable diagnosis of traumatic brain injury, defined as a sudden insult or damage to the brain or its coverings, not of a degenerative, congenital or post-operative nature, which is expected to last indefinitely and results in substantial functional limitation in three or more of the following major life activities:
    - Mobility
    - Behavior
    - Self care
    - Self direction
    - Independent living
    - Cognitive capacity (judgment, memory and reasoning)
    - Communication

Services provided under the waiver include:

- Service coordination
- Personal care services
- Respite care
- Habilitation and support
- Prevocational services
- Supported employment services
- Educational services
- Environmental adaptations
- Non-medical transportation

NOTE: This service is offered in addition to medical transportation services offered under the Medicaid Program.

- Assistive technology/specialized medical equipment/supplies
- Chore services
- Personal Emergency Response System (PERS)
- Extended state plan services

    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Part-time nursing

- Coaching/cueing
- Night supervision
- Structured day program
- Cognitive therapy
- Counseling (consumer and/or family)
- Behavioral specialist consultant
- Community integration

Additional Information

1. The OSP can deny waiver services to any person whose anticipated cost of services exceeds the aggregate cost-effectiveness cap. When the individual applies for waiver services, OSP staff review individual budgets against this cap.
2. Spousal Impoverishment provisions do not apply to this waiver.
3. Medicaid Estate Recovery provisions are applicable to this waiver.
4. CAOs must apply the look-back periods and transfer of assets (income and resource) requirements, for assets transferred for less than fair market value. This includes individuals who were current Medicaid recipients when determined eligible for the services provided under the COMMCARE waiver.
5. There is no patient pay amount associated with the COMMCARE Waiver.
6. Treatment of Resource Disregard:

For current recipients: resources are disregarded for the budget group when the individual(s) who qualify for the COMMCARE waiver live with children under 21 who meet the requirements in the Medical Assistance Eligibility Handbook (MAEH), Chapter 340. The individual(s) meets the eligibility requirements for Medicaid other than 300% of the Federal Benefit Rate limit.

For new applicants: the disregard of resources for persons living with a child under 21, as described in MAEH Chapter 340, does not apply when using 300% of the Federal Benefit Rate limit to evaluate eligibility for waiver-funded services for an individual. If the resource disregard is needed in order for the applicant to meet the resource requirements for Medicaid, then the appropriate Medicaid eligibility income limit must be used rather than the 300%.

7. As in other waivers, up to a three-year redetermination due date will apply.

8. There will be an initial group of individuals who will be transitioned from personal care boarding homes into a community setting who will be eligible for the COMMCARE Waiver. Authorize waiver-funded services, but the facility code for personal care boarding homes should be used for these individuals until notification is received from the OSP (Administrative Entity (AE)) that the transition is completed.
9. New applicants will be enrolled in HealthChoices, if that program is operating in their county. In non-HealthChoices counties, individuals may enroll in voluntary managed care (if available) or in the Fee-for-Service Program.
10. Medicaid recipients covered by HealthChoices, fee-for-service and voluntary managed care will remain in those health care plans under the COMMCARE Waiver.

Next Steps

1. Review this Operations Memorandum **and attached Procedures** with appropriate staff for implementation of the waiver procedures.
2. This Operations Memorandum becomes obsolete upon receipt of corresponding handbook pages.

Attachment

ATTACHMENT

The procedures for the waiver determination process are as follows:

For Current Recipients Requesting Waiver-funded Services:

REMINDER: A new application is not required for a recipient who is currently receiving Medicaid.

The CAO will:

1. Obtain notification (receipt of the OSP - Waiver Eligibility Form) from the OSP (Administrative Entity (AE)) indicating that the current Medicaid recipient is eligible for services provided under the COMMCARE Waiver. The effective date of eligibility for services provided by the COMMCARE Waiver is the date provided by the AE on the OSP - Waiver Eligibility Form.
2. Continue Medicaid in the appropriate category unless the individual is currently in a "PD" or "TD" category. These categories are not to be used for individuals receiving waiver-funded services. Authorize "PJ" category for these individuals. The effective date of eligibility for "PJ" is the same date the recipient is determined eligible for waiver-funded services by the AE. Code the individual as disabled on the Client Information System (CIS) by adding a "Y" in the disabled field on CAINDA and adding the identifier

for participation in the waiver, facility code 59, via CAIFAC or CCIFAC only for the line number of the recipient receiving waiver-funded services.

NOTE: CAOs must apply the look-back period and transfer of assets (income and resource) requirements for assets transferred for less than fair market value. This applies to all Medicaid recipients who are medically eligible for services under the COMMCARE waiver.

NOTE: If the recipient receiving waiver-funded services under the COMMCARE waiver is part of a budget group that becomes ineligible for Medicaid at any time, a new eligibility determination for Medicaid will be completed for the recipient receiving waiver-funded services, using only that the recipient's income and resources.

3. Send a Notice to Applicant (PA/FS 162) to notify the Medicaid recipient of eligibility to receive COMMCARE Waiver-funded services. Send a copy of this notice to the AE.
4. Send an Advance Notice (PA/FS 162-A) to notify the recipient/AE of the discontinuance of waiver-funded services when the AE provides the CAO with notification indicating that the recipient is no longer eligible for waiver-funded services. The CAO makes a determination of whether the recipient remains eligible for Medicaid. The identifier for participation in the COMMCARE Waiver, facility code 59, is removed from CIS, via CAIFAC or CCIFAC, after the expiration of the notice (PA/FS 162A).
5. Send a Confirming Notice (PA/FS 162-C) to notify the recipient/AE of a change in waiver-funded services when the AE provides the CAO with notification that the recipient is transferring between two waivers. The recipient remains eligible for Medicaid in the current category. The identifier for participation in the COMMCARE Waiver, facility code 59, is removed from CIS, via CAIFAC or CCIFAC and the facility code for the new waiver is entered.

NOTE: Every effort should be made by the CAO to insure a smooth transition from one waiver to another.

For New Applicants:

The CAO will:

1. Receive Medicaid applications from the AE.
2. Obtain notification (receipt of the OSP - Waiver Eligibility Form) from the AE indicating that the applicant is eligible for COMMCARE Waiver-funded services. The effective date of eligibility for the services provided by the COMMCARE waiver is the date provided by the AE on the OSP - Waiver Eligibility From if the applicant meets all eligibility requirements for Medicaid eligibility.
3. Determine Medicaid eligibility for the applicant.

    - Count only the income of the applicant. Exclude the income listed in the Medical Assistance Eligibility Handbook (MAEH), Chapter 389, Appendix A. Use

Chapter 389, Appendix B-1, for the income limit (300 percent of the current Federal Benefit Rate).

- Count the resources of the applicant. Exclude the resources listed in MAEH Chapter 389, Appendix A, and the Supplemental Security Income (SSI)-related exclusions of Chapter 340, Resources. Use Chapter 389, Appendix B-1, for the resource limit, currently $2,000.
- If the applicant meets the income and resource limitations, the CAO will authorize PJ (with Facility Code 59 on CIS, via CAIFAC or CCIFAC). The effective date of eligibility is the date the applicant was determined eligible for waiver-funded services by the AE and determined eligible for Medicaid by the CAO.
- If the applicant does not meet the income and/or resources limits for NMP (PJ), determine eligibility for MNO-MA (TJ). Exclude the income listed in the SSI-related exclusions of Chapter 350, Income. Use Appendix A-1, Chapter 369 for the income limit ($2,550 semi-annually). Do not allow private nursing facility care as an anticipated medical expense when determining eligibility for MNO-MA spend-down for the COMMCARE Waiver. Exclude the resources listed in the SSI-related exclusions of Chapter 340, Resources. Use Chapter 340, Resources, Appendix A-1, MNO Resource Limit for one person, $2,400. If the applicant meets the income and resource limits, the CAO will authorize TJ (with Facility Code 59 on CIS, via CAIFAC or CCIFAC). The effective date of eligibility is the date the applicant was determined eligible for waiver-funded services by the AE and determined eligible for Medicaid by the CAO.

4. Send a Notice to Applicant (PA/FS 162) to notify the applicant/AE of the eligibility/ineligibility decision for Medicaid.
5. Issue a separate Notice to Applicant (PA/FS 162) to notify the applicant/AE of eligibility for the COMMCARE Waiver for an applicant determined eligible for Medicaid.
6. Send an Advance Notice (PA/FS 162-A) to the recipient/AE to discontinue waiver services when the CAO receives notification from the AE that the recipient is no longer eligible for waiver-funded services. The CAO makes a determination of whether the recipient remains eligible for Medicaid. The identifier for participation in the COMMCARE Waiver, facility code 59, is removed from CIS via CAIFAC or CCIFAC after the expiration of the notice.
7. Send a Confirming Notice (PA/FS 162-C) to notify the recipient/AE of a change in waiver-funded services when the AE notifies the CAO that the recipient is transferring between two waivers. The recipient remains eligible for Medicaid in the current category. The identifier for participation in the COMMCARE Waiver, facility code 59, is removed from CIS, via CAIFAC or CCIFAC and the facility code for the new waiver is entered.

NOTE: Every effort should be made by the CAO to insure a smooth transition from one waiver to another.

For New Applicants and Current Recipients, the AE will:

1. Assist the applicant in applying for Medicaid and in preparing documentation, including the application form and other verification the CAO may require.
2. Determine whether the applicant is clinically eligible for the services provided under the COMMCARE waiver. Provide notice of this eligibility via and waiver service begin date to the CAO. CAOs cannot issue a PA/FS 162 notice of eligibility for waiver-funded services until they receive notice of the waiver service begin date.