



## DEVELOPMENTAL PROGRAMS BULLETIN


COMMONWEALTH OF PENNSYLVANIA • DEPARTMENT OF PUBLIC WELFARE

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**00-08-04**

SUBJECT:  
**Individual Eligibility for Medicaid  
Waiver Services**

BY:  
  
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**Deputy Secretary for Developmental Programs**

### SCOPE:

Administrative Entity Administrators or Directors  
County Mental Health and Mental Retardation Program Administrators or Directors  
Supports Coordination Entity Directors  
County Assistance Office Executive Directors

### PURPOSE:

The purpose of this bulletin is to issue procedures for the initial determination and annual re-determination of an individual's eligibility for services and supports provided under the Medicaid Waivers that provide home and community based services (HCBS) for individuals with mental retardation aged three and older.

### BACKGROUND:

The Department has two Medicaid Waivers for individuals with mental retardation covered by this Bulletin: the Consolidated Waiver and the Person/Family Directed Support (P/FDS) Waiver. As a condition of Federal Financial Participation (FFP), individuals receiving services under a Medicaid Waiver authorized under 1915(c) of the Social Security Act must satisfy level of care and financial eligibility requirements. These requirements are in accordance with state assurances established in federal regulations and the Department's approved Waivers. An individual may be enrolled in only one Medicaid Waiver at a time.

This bulletin clarifies procedures to evaluate whether individuals with mental retardation are eligible to receive state and federal funding for the provision of services under Medicaid Waivers. These procedures apply to responsibilities carried out by Administrative Entities (AEs), County Mental Health and Mental Retardation (MH/MR) Programs, Supports Coordination Entities, Supports Coordinators, and County Assistance Offices (CAOs). The conditions of eligibility are the same under these two

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**Appropriate Developmental Programs Regional Office**

Waivers with the exception of the frequency of the provision of services that is explained under the *Initial Determination Process* section below. The procedures contained in this bulletin reflect the requirements of both Waivers for individuals with mental retardation. This bulletin does not affect eligibility criteria procedures for services provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) which are contained in 55 Pa.Code Chapter 6210 and Bulletin 00-02-13, *Need for ICF/MR Level of Care*.

## **DISCUSSION:**

This bulletin applies to eligibility determinations for Waiver services when Waiver funds become available for an individual as well as re-determinations issued on and after the effective date of this bulletin.

### **ICF/MR Level of Care Requirements**

To be eligible for enrollment into a Medicaid Waiver, an individual must have a diagnosis of mental retardation, require active treatment and require an ICF/MR level of care. The AE or County Program shall request documentation of the diagnosis of mental retardation during the intake and registration process. The following three criteria found in 55 Pa.Code Chapter 6210 must be met to document a diagnosis of mental retardation:

1. A licensed psychologist, certified school psychologist, psychiatrist, or licensed physician who practices psychiatry certifies that the individual has significantly sub-average intellectual functioning which is documented by either:
  - Performance that is more than two standard deviations below the mean of a standardized general intelligence test.
  - Performance that is slightly above two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.
  
2. A Qualified Mental Retardation Professional (QMRP) who meets criteria established in 42 CFR 483.430(a) certifies that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning<sup>1</sup> which shows that the individual has either:
  - Significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his or her age and cultural group.
  - Substantial functional limitation in three or more of the following areas of major life activity:
    - self-care
    - receptive and expressive language
    - learning
    - mobility

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<sup>1</sup>An example of a standardized assessment of adaptive functioning would be the Vineland Adaptive Behavior Scales© (Copyright 1986, Pearson).

- self-direction
  - capacity for independent living
  - economic self-sufficiency
3. Documentation substantiates that the individual has had these conditions of intellectual and adaptive functioning manifested during the developmental period which is from birth up to the individual's 22<sup>nd</sup> birthday.

The results of both the standardized general intelligence test and the standardized assessment of adaptive functioning shall consist of all of the following:

- The clinical data and an overall score.
- A statement by the certifying practitioner that the results are considered valid and consistent with the person's degree of functional restriction.
- A statement by the certifying practitioner as to whether the results indicate that the individual has mental retardation.

To be considered as acceptable documentation, a standardized general intelligence test and assessment of adaptive functioning must reflect the intellectual and adaptive behavior challenges that the individual faces, along with existing social and psychological conditions.

In situations where the individual manifests serious impairments of adaptive behavior, the burden is on the examiner when certifying sub-average intellectual functioning to avoid misdiagnosis and to rule out such factors as emotional disorder, social conditions, sensory impairment, or other variables which might account for the deficits in adaptive behavior.

An individual's cultural background, ethnic origin, language, and means of communication should be considered when conducting all evaluations and assessments. The assessor will arrange for interpreters, people who do sign language, as well as others who are appropriate for the situation to assist in the evaluation process, as necessary. All efforts to adapt the IQ test to the individual's particular visual, motor, or language impairments must be described and documented in the individual's file.

Developmental scales, or standardized intelligence tests designed for infants or children, may be used for adults who cannot be tested using instruments standardized for adult populations. The scoring that results from using these scales may not be validated by normative data. Developmental scales should only be used when no other standard testing technique is available, and the evaluator will document the limitations of the test results, as well as the rationale for selection of the measure(s) used.

Many persons with autism also have mental retardation, and as such may be eligible for Consolidated and P/FDS Waiver services. Individuals with co-occurring autism and mental retardation need to meet the same level of care criteria as other persons applying for services under the Waiver. Persons with co-occurring autism and mental retardation who do not meet level of care criteria for services under the Waiver may be eligible for services provided through other funding sources such as the local Offices of

Mental Health or Behavioral Health or through the Office of Developmental Program's Bureau of Autism Services.

### **Individual Circumstances Where Testing may be Waived**

Testing may not be appropriate for all individuals even though the Office of Developmental Programs believes that all people can be evaluated or assessed. Documentation of the efforts to test individuals along with the results of the test should be kept by the AE or County Program in the individual's file until the case file is closed.

Testing may be waived in the following circumstances:

- The requirement for a standardized general intelligence test may be waived for a person who is profoundly intellectually impaired to the extent that the use of standardized measures is precluded. In such a situation, the requirement for the standardized intelligence test shall be substituted by a written statement from a licensed psychologist, certified school psychologist, psychiatrist or licensed physician who practices psychiatry that the person's inability to be tested is itself a manifestation of significantly sub-average intellectual functioning.
- The requirement for a standardized general intelligence test and assessment of adaptive functioning may also be waived for an individual who received Medicaid Waiver services after living in an ICF/MR where it was determined that the individual required specialized services. This requirement can be waived only upon the AE's or County Program's acceptance of a utilization review which affirms the individual's need for an ICF/MR level of care. The utilization review must be completed in accordance with 42 CFR Part 456 for individuals in ICFs/MR and be dated within 365 days prior to the AE's or County Program's determination of need for an ICF/MR level of care.
- The requirement for a standardized general intelligence test and assessment of adaptive functioning may also be waived for an individual who received Medicaid Waiver services after living in a nursing facility where it was determined that the individual required specialized services. This requirement can be waived only upon the AE's or County Program's acceptance of a utilization review which affirms the individual's need for specialized services for individuals in a nursing facility. The utilization review must be completed in accordance with pre-admission screening and annual resident review (PASARR) requirements for individuals in nursing facilities, and be dated within 365 days prior to the AE's or County Program's determination of need for an ICF/MR level of care.

### **Waiver Enrollment and Eligibility for Waiver Services and Available Funds**

If a decision is made that sufficient funds are available to provide a Waiver applicant the needed services under a Waiver, the AE or County Program notifies the individual

or surrogate<sup>2</sup> of the availability of enrollment in the Waiver in writing within 20 calendar days of the decision. Additional instructions regarding enrollment requirements are provided to the individual or surrogate in the notification letter. The date of this enrollment decision should be included in the written notification to the individual or surrogate and documented in a service note or on the appropriate eligibility screens in the individual's record in the Home and Community Services Information System (HCSIS). A standardized letter is attached to this bulletin that will be used to notify the individual or surrogate of the availability of enrollment in the Waiver (Attachment 1).

### **Verification of ICF/MR Level of Care**

The presumption that the individual meets the ICF/MR level of care requirements as per Bulletin 00-08-03, "*Procedures for Service Delivery Preference*", must be corroborated under the criteria outlined in this bulletin. This is documented by utilizing the "*Certification of Need for ICF/MR Level of Care*" form (DP 250, Attachment 2). The AE or County Program is required to ensure that a formal determination of the individual's eligibility for ICF/MR level of care is completed as described under the *Initial Determination Process* section of this bulletin within 45 calendar days of the date of the notification letter to the individual or surrogate that a decision was made to enroll the applicant into the Waiver.

Documentation to corroborate that the individual requires an ICF/MR level of care must be gathered by the AE or County Program prior to Waiver enrollment, if the information is not currently in the individual's file. The needed documentation consists of the following:

- The results of the standardized general intelligence test that certifies that the individual has significantly sub-average intellectual functioning.
- A statement by the certifying practitioner as to whether the results indicate that the individual has mental retardation.
- A statement by the certifying practitioner that the mental retardation manifested during the developmental period which is from birth up to the individual's 22<sup>nd</sup> birthday.<sup>3</sup>

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<sup>2</sup> Not everyone can make legally binding decisions for themselves. This would include minor children and some adults who have substantial mental impairment. In these instances, a substitute decision-maker may be identified under State law. Substitute decision-makers have various legal titles, but for the purposes of this bulletin, they will be referred to as "surrogates." "Surrogates" include the following:

- \* Parents of children under 18 years of age under the common law and 35 P.S. § 10101.
- \* Legal custodian of a minor as provided in 42 Pa.C.S. § 6357.
- \* Health care agents and representatives for adults as provided in 20 Pa.C.S. Ch. 54.
- \* Guardians of various kinds as provided in 20 Pa.C.S. Ch. 55 (as limited by 20 Pa.C.S. § 5521(f)).
- \* Holders of powers of attorney of various kinds as provided in 20 Pa.C.S. Ch. 56.
- \* Guardians of persons by operation of law in 50 P.S. §4417(c).

Any of these would be considered "legal representatives" as the Center for Medicaid and Medicare Services uses that phrase. Please see *Application for a §1915(c) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria* [[www.cms.hhs.gov/HCBS/02\\_QualityToolkit.asp](http://www.cms.hhs.gov/HCBS/02_QualityToolkit.asp)].

<sup>3</sup> For individuals who are age 22 or older, have never been served in the mental retardation service system, and have no prior records of testing, clinical judgment may be used to determine whether the age of onset of mental retardation occurred prior to the individual's 22<sup>nd</sup> birthday. Necessary testing (that is, intellectual and adaptive functioning) would still need to occur.

- The certification of a QMRP that the individual has impairments in adaptive behavior based on the results of a standardized assessment of adaptive functioning.
- The results of a medical evaluation completed within the previous 365 days that reflects the individual's current medical condition. The medical evaluation may be the medical evaluation approved by the Department (Form MA 51), or an examination that is completed by a licensed physician, physician's assistant, or nurse practitioner that states the individual is recommended for an ICF/MR level of care.

The individual or surrogate is responsible for ensuring that the Supports Coordinator receives the needed documentation in a timely manner. Efforts to obtain necessary information must be documented through written correspondence (Attachment 1) that gives clear instructions regarding acceptable documentation to the individual or surrogate and in a service note or on the appropriate eligibility screen in the individual's record in HCSIS. Once acceptable documentation is received by the AE or County Program, the DP 250 form is completed.

If acceptable documentation is not provided by the individual or surrogate within 30 calendar days, the AE or County Program will notify the individual or surrogate that the needed information must be received by a specified date (that is, usually a date 10 calendar days in the future) or the person will lose their opportunity for enrollment in the Waiver at this time. A standardized letter is attached to this bulletin that will be used to notify the individual or surrogate that all documentation must be received by the specified date or the opportunity for enrollment in the Waiver will be lost (Attachment 3). A service note or a notation on the appropriate eligibility screen should be entered in HCSIS which documents the date this letter was sent as well as the deadline date.

If the information is not received by the AE or County Program by the set deadline, a letter will be sent informing the individual or surrogate that the individual has lost the opportunity for Waiver enrollment at this time and will remain on the waiting list. A standardized letter is attached to this bulletin for this purpose (Attachment 4). A service note or a notation on the appropriate eligibility screen should be entered in HCSIS which documents the date this letter was sent as well as the deadline date.

Allowances to the deadlines may be made by the AE or County Program when an individual or surrogate contacts the AE or County Program before the deadline, asks for an extension to the deadline, and provides justification as to why acceptable documentation cannot be obtained by the deadline. If the AE or County Program has any questions regarding the extension of the deadline, they should contact the appropriate ODP Regional Office.

### **Initial Determination Process**

To be eligible for Medicaid Waiver funding, an individual must require services that normally would be provided in an ICF/MR. To meet these criteria, a QMRP, as defined in 42 CFR 483.430(a), must certify that the individual:

1. Requires active treatment.
2. Has a diagnosis of mental retardation.

3. Is recommended for an ICF/MR level of care based on a medical evaluation.

An individual shall meet the criteria for requiring active treatment only when a QMRP, based on a review of the individual's social and psychological history, determines that the individual will benefit from a professionally developed and supervised program of activities, experiences, or therapies that are necessary for assisting the individual to function at the individual's greatest physical, intellectual, social, or vocational potential. For individuals where no further positive growth is demonstrated, the criteria is met by the QMRP's certification that a program of active treatment is needed to prevent regression or loss of current functional status.

The QMRP's certification of need for services shall be based on a review of the individual's social, psychological, and medical history. This review shall consist of:

1. A review of notes, observations and reports from educational facilities, human service agencies, hospitals and other reliable sources. The review shall be done in conjunction with the individual's support team.
2. A review of a current medical evaluation which is completed by a licensed physician, physician's assistant, or nurse practitioner. The medical evaluation can be the medical evaluation approved by the Department (Form MA 51), or an examination that is completed by a licensed physician, physician's assistant, or nurse practitioner. To be considered current, the medical evaluation must occur within the 365-day period prior to the QMRP certification, detail the individual's current medical condition, and indicate that the individual is recommended for an ICF/MR level of care.

If questions remain regarding the ICF/MR level of care verification after the review of the available records and history, the QMRP may choose to request a face-to-face meeting with the individual, family, or surrogate.

#### A. Waiver Service Requirements

In order for an individual to be determined in need of Waiver services both at the time of initial enrollment into a Waiver and throughout the enrollment period, an individual must require the following:

1. Consolidated Waiver
  - a. The provision of at least one Waiver service, as documented in the Individual Support Plan (ISP).
  - b. The provision of Waiver services at least monthly, with the following exceptions:
    - i. For individuals living in their own home or a relative's home, the provision of at least one unit of a Waiver-eligible service is required monthly with the following exceptions:
      - (a) The individual is admitted to a medical facility (that is, hospital, rehabilitation facility, nursing home) for up to 45 calendar days;

- (b) The provider is unable to provide services for that period of time. Should this occur the provider must document why they were unable to provide services and provide a detailed corrective action plan to address such situations in the future; or
  - (c) The individual living at home requires an emergency relocation that prevents the delivery of planned services (for example, due to fire).
- ii. For individuals living in residential settings, the provision of at least one unit of a Waiver-eligible service is required monthly. If a monthly Waiver-eligible service is not provided, the individual's placement in the residential setting will be held under the following conditions:
- (a) The individual continues to pay the room portion of the Room and Board costs; and
  - (b) A Waiver service was provided within the previous 45 calendar days; and
  - (c) The individual is admitted to a medical facility (that is, hospital, rehabilitation facility, nursing home); or
  - (d) The individual requires an emergency relocation that prevents the delivery of planned services (for example, due to fire).

## 2. Person/Family Directed Support Waiver

In order for an individual to be determined in need of P/FDS Waiver services, an individual must require:

- a. The provision of at least one Waiver service, as documented in the Individual Support Plan.
- b. The provision of Waiver services as follows:
  - i. If a Waiver participant is receiving at least one of the following Waiver services, ODP requires the provision of a service at least once each calendar month in order for the participant to be determined in need of Waiver services:
    - Home and Community Habilitation (Unlicensed)
    - Licensed Day Habilitation
    - Prevocational Services
    - Supported Employment
    - Transitional Work Services
    - Transportation
  - (a) The following are exceptions to the requirement for at least one Waiver service each calendar month:

- (1) The individual is admitted to a medical facility (that is, hospital, rehabilitation facility, nursing home) for up to 45 calendar days;
  - (2) The provider is unable to provide services for that period of time. Should this occur the provider must document why they were unable to provide services and provide a detailed corrective action plan to address such situations in the future; or
  - (3) The individual living at home requires an emergency relocation that prevents the delivery of planned services (that is, due to fire or other environmental condition).
- ii. If a Waiver participant is only receiving one or more of the following Waiver services, ODP does not require the provision of a monthly service to indicate a need for Waiver services. If a monthly Waiver service is not provided, ODP requires an ISP monitoring contact by Supports Coordinators at least once every calendar month and a face-to-face monitoring contact at least once every three calendar months, regardless of the participant's living arrangement. At least two of the face-to-face visits per calendar year must take place in the participant's home.
- Homemaker/Chore
  - Respite
  - Therapies and Nursing
  - Personal Support Services
  - Adaptive Appliances and Equipment
  - Environmental Accessibility Adaptations
  - Supports Coordination

The AE or County Program, as the Department's agent, is authorized to determine level of care eligibility for all individuals who are applying for Waiver services. The AE or County Program is responsible to notify individuals or surrogates in writing regarding the determination of ICF/MR level of care within 20 calendar days of the finalized ICF/MR level of care decision. A copy of the completed DP 250 must be included with the written notification. The written notice will inform the individual or surrogate that the ICF/MR level of care determination must be communicated to the CAO as part of the Medicaid Waiver eligibility determination process. Please see Attachment 5 for a standardized letter to communicate to the individual or surrogate the decision that the individual meets ICF/MR level of care criteria.

Attachment 6 is a standardized letter to communicate to the individual or surrogate the decision that the individual does not meet the ICF/MR level of care criteria. The AE or County Program will give the reason for the decision and will include the individual's appeal rights. If the individual appeals the adverse ICF/MR level of care decision within 30 days of the written notification from the AE or County Program, the available Waiver capacity will be held for the individual until the appeal process is completed. In addition, the AE or County Program is required to offer assistance to the individual or surrogate if they choose to file an appeal of the ICF/MR Level of Care determination.

The following documentation must occur:

- **DP 250: Certification of Need for ICF/MR Level of Care (Attachment 2).** The determination of level of care eligibility must be documented by the AE or County Program on this form and must be based on an evaluation completed in accordance with the approved Waiver(s) and this bulletin. A completed copy of the form is maintained in the individual's file at the AE's or County Program's office. The AE's or County Program's determination on Form DP 250 will be in effect for 365 calendar days from the date of assessment by the QMRP. The determination of ICF/MR level of care eligibility is recorded in the "Eligibility/Program Assessment Information" section on Form PA 1768 (Attachment 7) by completing the "Assessment Date" block. The DP 250 form and associated letters will be kept in the AE's or County Program's files until the individual's case file is closed.
- **PA 1768: Home and Community Based Services (HCBS) Eligibility/Ineligibility/Change Form (Attachment 7).** The determination of ICF/MR level of care eligibility must be documented by the AE or County Program on this form by completing the "Assessment Date" block of the "Eligibility/Program Assessment Information" section on Form PA 1768 (Attachment 7). The "Service Begin Date" must be completed with the anticipated date the person will begin to receive services through the Waiver. The AE or County Program must indicate the name and complete address of the individual's residential provider agency, if known, in the "Other Information" section of the PA 1768 that is forwarded to the CAO. Form PA 1768 should be forwarded with the individual's Medical Assistance application, if needed (see the *Establishing Financial Eligibility for Waiver Services and Medical Assistance (MA)* Section), to the responsible CAO at least 30 calendar days prior to the individual's intended effective date for Waiver services. If an individual is in an emergency situation, the AE or County Program should contact the CAO directly to alert them to the situation and to discuss an expedited process. A copy of Form PA 1768 should be kept in the individual's file at the AE's or County Program's office.

### **ICF/MR Level of Care Determination Conflict of Interest**

Certification of need for an ICF/MR level of care by a QMRP, agency, or facility whose function or relationship constitutes a conflict of interest will not be accepted. The AE or County Program is responsible to ensure that no conflict of interest exists in the eligibility determination process.

Certification by AE or County Program staff is generally acceptable as long as these persons are not directly involved in the provision of service for the individual.

Certification of ICF/MR level of care will not be accepted from:

1. A QMRP employed or affiliated with an ICF/MR or nursing facility from which an individual is being referred or discharged.
2. A QMRP employed or affiliated with an agency that provides or may provide Waiver funded services for the individual. The only exception to this rule is a QMRP employed or affiliated with a Supports Coordination Entity; this QMRP may certify an individual's ICF/MR level of care as long as the individual:

- a. Is not on the QMRP's current caseload.
- b. Has not been on the QMRP's past caseload.
- c. Is not anticipated to be added to the QMRP's current caseload for a period of 365 calendar days.

AEs or County Programs may contract with another agency or independent professional who meets the criteria defined in 42 CFR 483.430(a) to obtain a QMRP certification of need for an ICF/MR level of care in order to ensure a conflict-free determination.

### **Establishing Financial Eligibility for Waiver Services and Medical Assistance (MA)**

There will be certain situations where an individual is offered enrollment in a Medicaid Waiver but the individual is not currently enrolled in MA or did not receive the option to choose service delivery preference. When sufficient funds become available to enroll the individual not currently receiving MA benefits in a Waiver, the AE or County Program will offer the service delivery preference process, verify the ICF/MR level of care, and submit the financial application to the CAO. For individuals not currently receiving MA benefits, a completed financial eligibility application consists of the following:

1. Home and Community Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768, Attachment 7).
2. Medical Assistance (Medicaid) Financial Eligibility Application for Long Term Care, Supports and Services (PA 600 L, Attachment 8).
3. Authorization for Release of Information (PA 4, Attachment 9).
4. Accompanying documentation which consists of gross monthly income, resources, and citizenship and identity information.

For individuals currently receiving MA benefits, only the Home and Community Based Services (HCBS) Eligibility/Ineligibility/Change Form (PA 1768, Attachment 7) must be submitted to the CAO. The CAO may request updated income and resource verification.

Medical Assistance eligibility is determined by the CAO based on the individual's reporting of income and resources for themselves and their spouse, if applicable. Income and resource limits are established in accordance with Federal requirements contained in each of the approved Waivers. Although the income and resources of a parent of a child under the age of 21 are not considered in the determination of eligibility for Waiver services, documentation of gross parental income is required by the CAO and every effort should be made by the AE or County Program to provide the information with the financial application.

The CAO has 30 calendar days to review the completed application for MA and issue a determination of financial eligibility or ineligibility. If a determination cannot be made in 30 calendar days, the deadline may be extended to 45 calendar days or longer based on individual circumstances. If the applicant is applying for MA and Supplemental Security Income (SSI) simultaneously on the basis of a disability, the determination of eligibility for MA is completed by the CAO but the determination of eligibility for SSI is referred to the Social Security Administration (SSA). SSA may take up to 90 calendar days for a decision of eligibility or ineligibility for SSI. The AE or County Program may

be asked to provide additional information to the CAO for persons referred for a disability evaluation by the CAO and the SSA. Individuals receiving SSI are automatically financially eligible for Waiver services.

### **Notice of Medical Assistance Waiver Service Eligibility by the CAO**

All individuals applying for Waiver services must receive a notice of Waiver eligibility from the CAO in order to be authorized for Waiver enrollment by the AE or County Program. A notice of eligibility for Waiver enrollment is issued by the CAO to the individual and surrogate, the AE or County Program, and the individual's residential provider agency if applicable. The CAO notice will contain an effective date for Waiver eligibility. The AE or County Program is responsible to ensure that no authorizations for Waiver services are made prior to the effective date on the notice of eligibility. AE or County Program staff may contact the CAO directly to inquire about the eligibility determination if a timely notice is not received for the individual. In addition, the status of the eligibility determination may be checked on-line if the AE or County Program has the required access to the on-line services. Detailed service notes or notations on the appropriate eligibility screens should be kept in HCSIS regarding information obtained by these methods.

Retroactive eligibility determinations for Medicaid may be issued by the CAO on request. AE or County Program staffs are advised to contact the CAO for current retroactive procedures.

The ISP must be approved and authorized by the AE or County Program prior to the initiation of Waiver services for the individual. Once the individual is enrolled in the Waiver, the AE or County Program and the individual or surrogate identify qualified, willing providers to render the approved and authorized services. Services should begin within 45 calendar days of the Waiver enrollment date, unless otherwise indicated in the ISP. Any delays in the initiation of a service after 45 calendar days must be discussed with the individual or surrogate. Discussion with the individual or surrogate at this time shall include a review of other appropriate service options and other qualified, willing providers to meet the needs of the individual. Due process information must also be provided. Discussions with the individual or surrogate must be documented in a service note or on the appropriate eligibility screens in HCSIS. In addition, the AE or County Program must submit a written request for extension of service initiation to the appropriate ODP Regional Office that includes documentation of the efforts to initiate services and barriers to service initiation.

### **Notice of Medical Assistance Ineligibility for Waiver Services by the CAO**

If an individual does not meet the requirements for an ICF/MR level of care as a result of the ICF/MR level of care review or the financial requirements for the Medical Assistance program, the CAO determines that an individual is ineligible for Waiver services and denies the application for Waiver enrollment. The CAO notifies the individual or surrogate and the County Program or AE of this determination in writing by issuing form PA 162. The CAO's notification will include a statement that the individual did not meet the ICF/MR level of care or financial requirements for the Waiver program. The CAO will continue to review the individual's application to determine eligibility for other Medical Assistance programs.

When an application for Medical Assistance is denied, the AE or County Program is required to research other funding options for which the individual may be eligible.

### **Annual Re-determination Process**

All individuals require annual re-determination of need for an ICF/MR level of care to continue to qualify for services funded under the Waivers. The AE or County Program is responsible to recertify need for an ICF/MR level of care based on the evaluation and certification of a QMRP. The first re-determination of need for an ICF/MR level of care is to be made within 365 days of the individual's initial determination, and subsequent re-determinations are made within 365 days of the individual's previous re-determination. To further explain this requirement, please see the example below:

- Johnny's need for an ICF/MR level of care was initially certified and all signatures obtained on form DP 250 on November 27, 2005. The 365 day timeframe starts on November 28, 2005 and the re-determination process must be completed by November 26, 2006.
- Johnny's re-determination of the need for an ICF/MR level of care was completed and all signatures obtained on form DP 251 on November 15, 2006. The 365 day timeframe starts over on November 16, 2006, and the re-determination process must be completed by November 14, 2007.
- Johnny's re-determination of the need for an ICF/MR level of care was completed and all signatures obtained on form DP 251 on October 31, 2007. The 365 day timeframe starts over on November 1, 2007, and the re-determination process must be completed by October 30, 2008.

A standardized letter has been developed to communicate this re-determination requirement to the individual or surrogate (Attachment 10). This letter should be sent to the individual or surrogate 60-90 calendar days before the expiration of the 365 day timeframe.

The QMRP must recertify that the individual continues to require an ICF/MR level of care, as outlined in the *Initial Determination Process* section of this bulletin. The re-determination is based on an assessment of the individual's current social, psychological, and physical condition, as well as the individual's continuing need for home and community based services. The assessment by the QMRP is completed in conjunction with the individual's team and a current medical evaluation (completed within the past 365 days) performed by a physician, physician's assistant, or nurse practitioner. An annual physical examination required under 55 Pa.Code Chapters 6400 and 6500 satisfies the requirement for a current medical evaluation. The assessment must include a review of the individual's ISP to validate that the individual meets the criteria listed in the *Discussion* section of this bulletin.

The re-determination process must be completed by the QMRP and AE or County Program signatures obtained before the end of each 365 day timeframe. Form DP 251, "*Annual Recertification of Need for ICF/MR Level of Care*" (Attachment 11) will be used to document the recertification and obtain the County Program or AE signature. A new 365 day timeframe starts the day after the AE or County Program's date of signature on the completed DP 251 form.

A standardized letter has been developed to communicate to the individual or surrogate that the individual continues to meet the ICF/MR level of care (Attachment 12). This letter will be sent to the individual or surrogate and the Supports Coordinator within

20 calendar days after the DP 251 form is completed and signed. A copy of the completed DP 251 form will be included with the letter. No contact with the local CAO is necessary when an individual continues to meet the ICF/MR level of care requirements.

If the AE or County Program determines that the individual no longer requires an ICF/MR level of care, the PA 1768 form should be completed with this determination and forwarded to the CAO. Upon receipt of the PA 1768 indicating that the individual no longer requires an ICF/MR level of care, the CAO will give advance notice to the individual that Waiver services will be discontinued, and will provide the individual with a PA 162 notice terminating eligibility for Waiver services. A copy of the PA 162 notice will be sent to the individual or surrogate, AE or County Program, and the residential provider agency if applicable. A standardized letter has been developed to communicate to the individual or surrogate that the individual no longer meets the ICF/MR level of care (Attachment 13) and explain the fair hearing rights. This letter will be sent to the individual or surrogate and the individual's Supports Coordinator within 20 calendar days after the DP 251 form is completed and signed.

The AE or County Program must discontinue Waiver services for the individual based on the CAO discontinuance effective date unless the individual exercises the right to fair hearing within the specified timeframes by completing the Fair Hearing Request Form (DP 458, Attachment 14). Waiver services should continue to be provided for the individual who is currently receiving Waiver services pending the results of the fair hearing or any subsequent timely legal appeal by an individual. However, if the individual receives Waiver services during the appeal process and subsequently loses the appeal, the individual will be responsible to repay the costs of all services that were provided from the discontinuance effective date until an adverse appeal decision is rendered. More information regarding appeals and fair hearing is contained in Bulletin 00-08-05, "*Due Process and Fair Hearing Procedures for Individuals with Mental Retardation*"<sup>4</sup>.

### **Transfers Between Waivers for Funding of Services**

If an individual transfers from one Waiver to another, the individual will require a new eligibility notice from the CAO. An individual who transfers from one Waiver to another or an individual who is already receiving MA will not be required to complete a new financial application unless one is requested by the CAO.

To obtain a new notice, the AE or County Program is responsible to provide the CAO with a completed form PA 1768 that reflects the eligibility and program assessment information and the change of Waiver. The CAO will provide a new PA 162 notice discontinuing the former Waiver services and authorizing eligibility for the new Waiver to the individual, the individual's surrogate, the AE or County Program, the former program office and the new program office.

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<sup>4</sup>Bulletin 00-08-05 entitled "*Due Process and Fair Hearing Procedures for Individuals with Mental Retardation*" will be published in final form shortly after this bulletin.

## **Transfers to Waiver Services From an ICF/MR or other Medicaid Funded Long-Term Care Facility**

The AE or County Program is responsible to follow the procedures listed above for the initial determination of ICF/MR level of care for individuals who transfer to a Waiver from an ICF/MR or other Medicaid-funded long-term care facility. The AE or County Program is responsible to notify the facility and the CAO regarding the actual effective date for Waiver services by completing PA 1768. This will avoid potential double billing of MA when individuals transfer to a Waiver from an ICF/MR or other Medicaid-funded long-term care facility.

## **Medical Assistance Estate Recovery**

Individuals age 55 and older who receive Waiver services are subject to the provisions of the MA Estate Recovery Program. Estate Recovery refers to the recovery of MA Program costs from the assets of the individual's probate estate. The AE or County Program is responsible to inform individual applicants and families regarding the MA Estate Recovery requirement and to refer them to the CAO for additional information and assistance. The discussion of this requirement will be documented in a service note or on the appropriate eligibility screens in HCSIS.

Additional information on estate recovery is provided in Publication 332, entitled Medical Assistance Estate Recovery Program or at [www.dpw.state.pa.us/ServicesPrograms/Other/](http://www.dpw.state.pa.us/ServicesPrograms/Other/). Please choose the "Estate Recovery Program" option from the list provided on this webpage.

## **Continuing Medical Assistance Eligibility**

All individuals, except SSI recipients, will require MA eligibility renewals by the CAO in accordance with the Department's financial renewal policy. However, periodic MA eligibility determinations may be required by the CAO for SSI recipients based on changes in the individual's income or resources. It is the responsibility of the individual, or the individual's family members or surrogate to report financial changes directly to the CAO. If these changes are reported to the Waiver services provider or the AE or County Program, these changes should be reported to the CAO using the PA 1768.

When a change is reported that has an effect on an individual's continuing eligibility for waiver services, the CAO will notify the individual, the individual's family or surrogate, the residential provider agency, and the AE or County Program by issuance of an advance notice (PA 162) regarding eligibility for Waiver services. An advance notice of continuing eligibility is not required for individuals receiving SSI.

## **Discontinuance of Eligibility**

When an individual terminates Waiver enrollment, the AE or County Program that currently authorizes these services is responsible to notify the CAO by completion of Form PA 1768. This form does not need to be completed when a specific Waiver service is reduced, suspended, or terminated.

On receipt of an advance notice of discontinuance of eligibility by the CAO based on an individual's income or resources exceeding the current limits or failure to meet other MA eligibility requirements (for example, citizenship, residency, ICF/MR level of care re-determination), the AE or County Program will help the individual file an appeal if assistance is requested by the individual or surrogate. In addition, various options may be exercised by the AE or County Program which include, but are not limited to:

1. Assisting the individual to spend down resources by the end of the advance notice period, so that the individual is within resource limits. The AE or County Program should contact the local CAO for information and questions regarding the approved methods to spend down resources.
2. Assisting the individual in applying income and resources to work-related expenses or a Plan for Achieving Support (PASS), in accordance with Bulletin 00-88-02, *Work Incentives for SSI and 2176 Waiver Recipients*.
3. Discontinuing Waiver funding for services and assist the individual in reapplying for Waiver eligibility when income and resources are within the allowable limits.
4. Discontinuing Waiver funding for services if no appeal is filed by the individual and select another individual to receive Waiver services.

If the individual is no longer eligible for Waiver services, the individual may continue to be eligible to receive funding for community Mental Retardation services in accordance with other applicable requirements. In addition, the individual may be eligible to receive other MA funded services. The CAO or AE or County Program will assist the individual in identifying these services. Waiver-funded services will continue until the service discontinuance date indicated on the CAO notice.

### **Recordkeeping:**

The AE or County Program and the Supports Coordinator are responsible to ensure that the following eligibility information is maintained for each individual receiving Waiver services:

1. The initial determination of ICF/MR level of care together with the initial form DP 250 and associated letters and supporting documentation including the results of the standardized intelligence test, adaptive behavior assessment, and examination by the clinician. The original documentation is kept in the individual's file at the AE or County Program and a copy of the documents is kept by the Supports Coordinator for as long as the individual is enrolled in the Waiver and for four years after the individual's case has been closed.
2. The initial PA 162 notice issued by the CAO which establishes the individual's effective date for Waiver services, the current PA 162 notice, and prior notices over the last four years. The notice is kept in the individual's file at the AE or County Program and a copy of the notices are kept by the Supports Coordinator.
3. The completed level of care re-determination (form DP 251 revised for the current year and prior years of service) and associated letters. The original information is kept in the individual's file at the AE or County Program and a copy is kept by the Supports Coordinator for as long as the individual is enrolled in the Waiver and for four years after the individual's case has been closed.

4. All applicable notices, documentation, and records relating to unresolved audit or litigation which shall be retained until the audit or litigation is resolved plus four years. The originals of these documents are kept by the AE or County Program and a copy of the documents is kept by the Supports Coordinator.

Residential provider agencies who receive a copy of PA 162 notices are advised to retain these notices for at least four years. If the individual is involved in unresolved audit or litigation, the records shall be retained until the audit or litigation is resolved plus four years.

#### **OBSOLETE BULLETIN:**

Bulletin 00-99-14 entitled, "*Individual Eligibility for Medicaid Waiver Services*", issued January 1, 2000.

Bulletin 00-00-09 entitled, "*Service Preference in Medicaid Waivers for Individuals with Mental Retardation*", issued November 1, 2000, as it applies to individual eligibility for Medicaid Waiver services.

#### **OBSOLETE FORMS**

MR 54, Consolidated and Person/Family Directed Support Waivers or ICF/MR Eligibility Application Cover Sheet

MR 55, MA Financial Application Release Form

MR 250, Certification of Need for ICF/MR Level of Care (**replaced by DP 250**)

MR 251, Annual Recertification of Need for ICF/MR Level of Care (**replaced by DP 251**)

MR 458, Fair Hearing Request Form (**replaced by DP 458**)