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Subject: ISSUANCE OF AGING SERVICE POLICY AND PROCEDURE MANUAL CHAPTER IV: OPTIONS Program

To: Pennsylvania Department of Aging
Area Agencies on Aging
Pennsylvania Association of Area Agencies on Aging
Pennsylvania Council on Aging

From:

Teresa Osborne
Secretary

Purpose: The purpose of this Aging Program Directive is to set forth OPTIONS Program procedural requirements for OPTIONS Program consumers and identify key revisions made to the program. This APD rescinds Chapter VIII, OPTIONS Program of the Department of Aging's Aging Service Policy and Procedure Manual, including all appendices and forms.

Background: The Pennsylvania Department of Aging (PDA) has previously provided the Area Agencies on Aging (AAA) with procedural requirements for the OPTIONS Program in Chapter VIII of the Department of Aging's Aging Service Policy and Procedures Manual. This Chapter included information and processes for the OPTIONS Program.

The Department of Aging determined Chapter VIII: OPTIONS Program required revision to services and processes for the administration of the OPTIONS Program. The Bureau of Aging Services, the Pennsylvania Association of Area Agencies on Aging (P4A) and several volunteer Area Agencies on Aging staff formed a workgroup to update and revise the OPTIONS Chapter. This chapter and other individual chapters, that are part of the overall

Aging Service Policy and Procedure Manual, are being renumbered and released individually as they are completed.

The process for this revision included a thorough review of previous Chapter VIII: OPTIONS Program and corresponding forms and appendices, followed with a draft Chapter presented to the above-mentioned AAA workgroup for input and revision. Following revisions, the chapter was distributed to the entire aging network with a comment period after which additional revisions were made prior to finalization.

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

Directives:

Chapter IV: OPTIONS Program overview/summary of revisions includes:

OPTIONS is a program that allows consumers to receive services and supports in their homes and communities. OPTIONS services are provided to eligible consumers aged 60 and older to assist them in maintaining independence with the highest level of functioning in the community and delay the need for more costly care/services. OPTIONS services are not an entitlement.

The following highlights selected key revisions from each section of the OPTIONS Chapter:

Section I: Program Eligibility

This section identifies all eligibility requirements for individuals to receive OPTIONS Services.

OPTIONS services may not be provided to individuals residing in personal care homes, assisted living residences, nursing homes, or correctional facilities.

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.

Section II: Program Enrollment Requirements

This section identifies the requirements and process for enrolling individuals in OPTIONS services, as well as information on the Mandatory Medical Assistance (MA)

Eligibility Determination Process, wait lists, and monthly care plan cost caps.

A level of care determination of Nursing Facility Clinically Eligible (NFCE) or Nursing Facility Ineligible (NFI) is not required for enrollment in the OPTIONS Program. There shall only be one OPTIONS care enrollment: OPTIONS.

NOTE: There continues to be a care enrollment for Emergent Service that is separate from the OPTIONS care enrollment. This is for those individuals, who are not enrolled in OPTIONS, who receive up to 72 hours of Emergent Services.

References to the Level of Care Determination Tool (LCD) are removed from the OPTIONS Chapter, as the LCD is no longer used for the OPTIONS Program. Consumers seeking OPTIONS services are assessed with the Needs Assessment Tool (NAT) or Needs Assessment Tool-Express (NAT-E).

In order to maintain continuous enrollment in the OPTIONS Program, individuals must comply with the assessment process, including the verification of financial information.

Mandatory Medical Assistance Eligibility Determination Process

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

The Mandatory MA Eligibility Determination Process does not apply to individuals who need Care Management service alone or in combination with In-Home Meal Service.

New consumers are eligible to be enrolled in the OPTIONS Program while going through the MA Eligibility Determination Process and receive services, if no wait list exists, like all other OPTIONS consumers. The previous Interim Care Plan process has been removed. All OPTIONS consumers are to be treated the same. It shall be the responsibility of the Care Manager to closely monitor these cases via phone contacts and home visits according to guidelines in the Chapter. However, failure to complete this mandatory process will preclude the consumer from

participation in the OPTIONS Program, unless the consumer agrees to pay 100% of the care plan cost.

Wait List

There is only one wait list, which includes both new consumers waiting to receive OPTIONS services and existing consumers waiting for a new service or an increase in service. Consumers in need of In-Home Meals have the highest priority and are placed at the top of the wait list based on the date of completion of the NAT or NAT-E. If a consumer needs In-Home Meal Service in addition to other OPTIONS services, the consumer shall receive the meal first and be placed back on the wait list for additional services based on their Needs Assessment Score (NAS).

The term Functional Needs Score (FNS) has been replaced with Needs Assessment Score (NAS) and is calculated based on information obtained through the Needs Assessment Tool (NAT).

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

While consumers shall be removed from the wait list based on the order they were placed, and the date of their NAT, there is no longer a requirement that funding/provision of some services be secondary to others. AAAs shall provide person-centered services based on identified un-met needs and have greater flexibility in managing their wait list.

Care Management shall be in "active" status in the care plan while all other services shall have a status of "waiting". A contact plan for consumers on a wait list has been added to the OPTIONS Chapter.

Care Plan Cost Caps

The monthly OPTIONS care plan cost cap is $765/month. This monthly care plan cap amount includes all OPTIONS services in the consumer's care plan, with the exception of In-Home Meals, Assessment, Care Management, Emergent Services, Home Modifications, Specialized Medical Transportation, and Protective Services costs. Home Modifications and Specialized Medical Transportation were added to the list of services that are excluded from the OPTIONS care plan cost cap.

New to this version of the OPTIONS Chapter is the Fiscal Agent provider payment model. Fees paid to a Fiscal Agent are included in the monthly care plan cost cap.

Exceptions to care plan cost caps are no longer based on a level of care. Individuals with a NAS at or above 56 points or who are in need of Older Adult Daily Living Services may have their care plan increased up to a maximum of $1900/month.

As of the effective date of this APD, OPTIONS consumers who have been previously approved for an exception to the care plan cost cap above $765 up to $1900/month, may continue to receive their current care plan of services even if their calculated NAS is below 56 on subsequent assessments so long as there continues to be an identified need for those services.

In instances where an OPTIONS consumer is a care receiver in the Caregiver Support Program (CSP), the CSP care plan cost does not count towards the monthly OPTIONS care plan cost cap. CSP is a separate program that serves the caregiver.

Section III: <u>OPTIONS Services</u>

This section outlines all OPTIONS services that are required to be offered by the AAA and those that may be offered at the discretion of the AAA according to their local policies, as funds are available. References to "Core" and "Supplemental" services, and their corresponding stipulations in the previous chapter to provide certain services before others, have been removed.

OPTIONS Services that are "required" to be provided by the AAA include Care Management, In-Home Meal Service, Older Adult Daily Living Services, and Personal Care. OPTIONS services that "may be offered" at the discretion of the AAA include Emergent Services, Home Health Services, Home Modifications, Home Support Services, Medical Equipment and Supplies, Assistive/Adaptive Devices, Personal Emergency Response System (PERS), Pest Control/Fumigation, and Specialized Medical Transportation.

All consumers who receive OPTIONS services shall be care managed and shall have Care Management as an active service in their care plan.

Consumer Reimbursement is no longer considered an OPTIONS service. It is appropriately identified as an

allowable provider payment model for the following OPTIONS Services: Older Adult Daily Living Services, Personal Care Services, Home Health Services, Home Modifications, Home Support Services, Medical Equipment, Supplies, Assistive/Adaptive Devices, Personal Emergency Response System, and Pest Control/Fumigation.

Additional services have been added to what may be covered under Emergent Services, including Emergency Home Heating Assistance and Other Emergent Service.

Additional examples of services have been added to what may be covered under Home Support Service. These include, but not limited to, preparing meals, garbage removal and minor home repairs and maintenance.

Other changes to OPTIONS services include:

- Pest Control/Fumigation has been added as a stand-alone service.
- Specialized Medical Transportation has been added as a new service.
- Counseling has been removed as a service.
- Requirements around daily provider/consumer testing and an inactivity timer on Personal Emergency Response System (PERS) Service have been removed.
- The lifetime cap for Home Modifications for a consumer was increased from $5,000 to $15,000

OPTIONS Service Standards can be found in Appendix A of this chapter.

Allowable provider payment models are defined for each OPTIONS service, which are Agency Model, Consumer Reimbursement, and Fiscal Agent. Use of a fiscal agent is new to this chapter and is an allowable provider payment model for Personal Care Service and Home Support Service.

Consumers currently receiving Consumer Reimbursement as a service for Personal Care Service or Home Support Service as of the effective date of this APD will, at the time of reassessment, be offered the option of transitioning to an Agency Model, to the Fiscal Agent Model, or remaining in

the Consumer Reimbursement Model for their Personal Care Service or Home Support Service.

Section IV: Allowable Provider Payment Models

This new section outlines the allowable provider payment models identified for each OPTIONS service and the requirements for each model. These provider payment models include: Agency Model, Consumer Reimbursement Model, and Fiscal Agent Model. When a service identifies multiple allowable payment models, the AAA has discretion to offer one or more of the allowable models. A consumer's care plan may include multiple payment models.

Section V: OPTIONS Cost Share

This section outlines mandatory cost sharing for consumers receiving OPTIONS services. Consumers who refuse to disclose financial information, or who refuse to apply for MA LTSS, as per the MA Eligibility Determination Process, must pay 100% of the cost of their services. OPTIONS services specifically excluded from cost sharing are Assessment, Care Management, In-Home Meals, Emergent Services, and services provided through a Protective Services care plan.

Cost Sharing Scale

The consumer cost share amount shall be determined by use of the OPTIONS Program Cost Sharing Scale, which runs from 133% to 300% of the Federal Poverty Level (FPL). Consumers utilizing the previous Cost Sharing Scale that ranged from 125% to 300% of the FPL shall be transitioned to the current scale at their next scheduled reassessment. Consumers whose countable income is 133% or lower of the FPL will have no cost share.

Cost Share Calculation

Income eligibility and cost share amounts are based on the consumer's previous years' income. An exception was added to allow the use of a consumer's current years' income when the consumer is unable to verify the previous years' income.

Assets will not be used to determine a consumer's cost share, but are to be identified and their use discussed as part of the care planning process. The AAA has discretion to establish a local policy regarding the use of consumers' assets.

Billing

This section outlines the steps, timeframes and processes for the billing of consumers, use of revenues from collected fees, and appeals. The billing timeframes and consumer contacts related to billing are outlined in the Chapter.

Bills to consumers shall include a notice to the consumer that increases in needed services will not be considered until unpaid costs are paid in full. The requirement to send a second bill with new dates to consumers who have not made payment or arranged for a payment plan has been removed.

Additional Changes:

All references to Transportation service relating to Shared Ride and trips provided by AAA-owned vehicles have been removed from the OPTIONS Chapter, as it is not an OPTIONS service. A new policy Chapter on Transportation Service will be developed in the future.

In an effort to create consistency across the AAA network, and aid in the monitoring process, the Department has added a number of specific Social Assistance Management Software (SAMS) journal entry types/titles for specific activities. These are identified throughout the OPTIONS Chapter. In addition, Appendix D of the OPTIONS Chapter contains additional SAMS-specific data entry requirements.

This Chapter includes the following Appendices:

- A.1 OPTIONS Service Standards
- B.1 OPTIONS Service Order Documentation Requirements
- 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
- D SAMS Data Entry Requirements
- 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
- 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