



Arkansas Department of Human Services

Division of Medical Services

Donaghey Plaza South

PO Box 1437

Little Rock, Arkansas 72203-1437

Internet Website: www.medicaid.state.ar.us

Telephone: (501) 682-8292 TDD: (501) 682-6789 or 1-877-708-8191

FAX: (501) 682-1197

OFFICIAL NOTICE

DMS-2004-NN-2

TO: Health Care Provider – ElderChoices

DATE: October 1, 2004

SUBJECT: Retroactive Eligibility

I. General Information

Effective for dates of service on and after October 1, 2004, the following policy revisions will be implemented regarding retroactive eligibility for the ElderChoices Program (EC).

In an effort to begin ElderChoices in-home waiver services as quickly as possible for potentially eligible waiver applicants, the Division of Aging and Adult Services, the Division of Medical Services, and the Division of County Operations have jointly revised policy affecting an ElderChoices applicant's Medicaid and waiver eligibility dates.

II. Provisional Plan of Care

A. Development of the Provisional Plan of Care

The ElderChoices registered nurse (DHS RN) will develop a **provisional** Plan of Care, based on information obtained during the in-home medical assessment, when recommending medical approval based on the following nursing home criteria.

To be determined a functionally disabled elderly individual, the individual must meet at least one of the following criteria as determined by a licensed medical professional.

The individual is unable to perform either of the following:

1. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person
2. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person

Applicable definition of limited and extensive assistance remain unchanged.

The provisional Plan of Care will include all current Plan of Care information except for the waiver eligibility date, the Medicaid recipient ID number, the diagnosis(es), and the physician's signature. The provisional Plan of Care will expire after 60 days. The provisional Plan of Care expiration date will be entered on page 1 of the Plan of Care and will be calculated as 60 days from the date the provisional Plan of Care is signed by the DHS RN and the applicant.

A signed copy of the provisional Plan of Care will be mailed to each provider included on the Plan of Care. If the provider chooses to implement the provisional Plan of Care, the provider must begin services within an established timeframe as determined by the Division of Aging and Adult Services and notify the DHS RN via form AAS-9510 that services have started. The DHS RN will continue the current practice of tracking the start of care dates and giving the applicant options when services are not started.

B. Services Begin Based on the Provisional Plan of Care

This change in policy will be applied only when the DHS RN recommends the applicant for medical approval and only when the recommendation is based on the medical criteria shown above.

The waiver eligibility date will be established retroactively, effective on the day the provisional Plan of Care was signed by the applicant and the DHS RN, if:

1. At least one waiver service begins within 30 days of the development of the provisional Plan of Care

AND

2. The waiver application is approved by the Division of County Operations.

C. Services Do Not Begin Based on the Provisional Plan of Care

If at least one waiver service does not begin within 30 days from the date the provisional Plan of Care is signed by the DHS RN, the DHS county office will establish the waiver eligibility date as follows:

1. According to current policy, i.e., the date the application is keyed into the system as an approved application

OR

2. Retroactively, effective the day a waiver service started, as verified by the DHS RN

III. Denied Applications

- A. If the DHS county office denies the Medicaid eligibility application for any reason, Medicaid and waiver services provided during a period of ineligibility will be the financial responsibility of the applicant. The DHS county office will notify the DHS RN. The DHS RN will notify the providers via form AAS-9511 immediately upon learning of the denial. Reasons for denial include, but are not limited to:

1. Failure to obtain the physician's signature on the required ElderChoices forms
2. Failure to meet the nursing home admission criteria
3. Withdrawal of the application by the applicant
4. Death of the applicant when no waiver services were provided

Note: If waiver services were provided and the applicant dies prior to approval of the application, waiver eligibility will begin (if all other eligibility requirements are met) on the date of the beginning of the waiver service(s) and end the date of death.

- B. The client has the right to appeal by filing for a fair hearing. When an appeal ruling is made in favor of the applicant, the actions to be taken by the DHS county office are as follows:

1. If the individual has no unpaid ElderChoices Waiver charges, Medicaid coverage will begin the date of the appeal decision. However, the waiver portion of the case will not be approved until the date the DHS county office completes the case.
2. If the individual has unpaid waiver charges and services were authorized by the DHS RN, eligibility for both Medicaid and waiver services will begin the date service began unless the hearing decision sets a begin date.

NOTE: Under no circumstances will waiver eligibility begin prior to the date of application or the date the provisional Plan of Care is signed by the DHS RN and the applicant, whichever is later.

IV. Comprehensive Plan of Care

Prior to the expiration date of the provisional Plan of Care, the DHS RN will mail the comprehensive Plan of Care, signed by the applicant's physician, to all providers included on the Plan of Care. The comprehensive Plan of Care will replace the provisional Plan of Care. If the DHS county office has approved the application, the comprehensive Plan of Care will include the Medicaid recipient ID number, the diagnosis(es), the waiver eligibility date established according to this revised policy, and the comprehensive Plan of Care expiration date.

The comprehensive Plan of Care expiration date will be 365 days from the date of the DHS RN's signature on the form AAS-9503, the Elderchoices Plan of Care. If the application is still pending at the county office when the comprehensive Plan of Care is mailed to the providers, the waiver eligibility date and the Medicaid recipient ID number will not be included. Once the application is either approved or denied by the DHS county office, the providers will be notified by the DHS RN. The notification for the approval will be in writing via a Plan of Care that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS-9511 reflecting the date of denial.

V. Elderchoices Applicants Leaving an Institution

The revised policy regarding retroactive eligibility applies to applicants entering the waiver program from the community and applicants entering the program from an institution. The same process and the same policy determining the waiver eligibility date will apply to applications of each type.

Exception: No waiver eligibility date may be established prior to an applicant's discharge date from an institution. Therefore, if a provisional Plan of Care is developed while an applicant is a resident of a nursing home or an inpatient in an institution, the earliest waiver eligibility date will be the day the applicant is discharged from the facility.

NOTE: For inpatients, if a waiver application is filed at the local DHS county office prior to discharge AND if a provisional Plan of Care is developed by the DHS RN prior to discharge, it may be possible to establish retroactive eligibility back to the date the applicant returned to his home, if ultimately found eligible for the program.

If no waiver application is filed and no medical assessment and provisional Plan of Care are completed by the DHS RN prior to discharge from an institution, retroactive eligibility will not be possible back to the date the applicant returned to his home.

Medical assessments and Plans of Care may be completed during a period of institutionalization, however, there must be a discharge date scheduled. Since the purpose of the assessment and the Plan of Care is to depict the applicant's condition and needs in the home, premature assessments and Plan of Care development do not meet the intent of the program.

This policy applies to applicants leaving hospitals or nursing facilities.

VI. Optional Participation

Neither waiver providers nor waiver applicants are required to begin or receive services prior to an eligibility determination by the Division of County Operations. When services are started based on the receipt of a provisional Plan of Care, it is the responsibility of each provider to explain the process and financial liability to the applicant and/or family member **prior to beginning services**. The decision to begin services prior to an eligibility determination must be a joint decision between the provider and the applicant, both of whom must understand the financial liability of the applicant, if eligibility is not established.

An Optional Participation Statement developed by the Division of Aging and Adult Services must be signed by the applicant and the provider prior to the beginning of services. This statement of understanding must be returned to the DHS RN with the Start of Care form and will be filed in the recipient's chart. The provider must keep a copy of the form in the recipient's waiver chart. These forms will be provided to each waiver provider prior to October 1, 2004.

NOTE: Regardless of the reason for the denial and regardless of when a new waiver application may be filed, a provisional Plan of Care will only be utilized on a current waiver application. Once an application is denied, a new provisional Plan of Care must be developed, if a subsequent waiver application is filed.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this notice, please contact the EDS Provider Assistance Center at In-State WATS 1-800-457-4454 or locally and out-of-state at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.