STATE OF ALASKA DEPARTMENT OF HEALTH & SOCIAL SERVICES SENIOR AND DISABILITIES SERVICES POLICY & PROCEDURE MANUAL	**Section:** 7 Adults with Physical Disabilities Waivers	**Number:** 7-1	**Page:** 1
	Subject: Adults with Physical Disabilities Program Eligibility and Enrollment		
	Approved: /s/ *Kimberli M. Poppe-Smart* Kimberli Poppe-Smart Acting Director	**Date**: 6/30/10	

Purpose

To provide a standardized process for program eligibility determinations.

To delineate responsibilities for the process.

Policy

Senior and Disabilities Services (SDS) administers the Adults with Physical Disabilities (APD) program, a component of Home and Community-Based Waiver Services. The APD program is a Medicaid program that funds services for individuals, ages 21 through 64 years, who require a level of care ordinarily provided in a nursing facility. The Division of Public Assistance determines whether individuals meet financial eligibility requirements, and SDS determines whether individuals meet program eligibility requirements.

Individuals interested in services submit a complete application with information about medical needs and functional abilities. SDS reviews these materials to evaluate whether there is a reasonable indication that the individual would need the level of care provided in a nursing facility unless he/she receives home and community-based waiver services; if so indicated, SDS schedules an in-depth assessment of the individual's physical, emotional, and cognitive functioning, and need for care and services, for the purpose of determining program eligibility.

Individuals who meet the age, financial eligibility, and level of care requirements are eligible for APD program services. When notified of program eligibility, the care coordinator prepares a *Plan of Care* that must be approved by SDS before reimbursement for services can be authorized

Once enrolled, participants remain eligible for waiver services as long as both financial and program requirements are met. SDS reviews the need for services and determines whether the participant continues to meet program eligibility requirements annually. The care coordinator then prepares a new *Plan of Care*, and submits it to SDS for approval, resulting in renewal of the waiver.

Authority

7 AAC 130.205 Recipient enrollment and eligibility; 7 AAC 130.230 Screening, assessment, plan of care, and level of care determination; 7 AAC 140.505 (a) [Determination of level of care]; 7 AAC 140.510 Intermediate care facility services; 7 AAC 140.515 Skilled nursing facility services. AS 47.07.045 (b) [Termination of payment for APD services]. SDS Policy and Procedure 2-2: Program Rights Information for Recipients.

Definitions

"Complete application" means all documents required by SDS to determine eligibility and enroll an applicant, or to renew the waiver of a participant.

"Nursing facility" means a facility certified to provide or intermediate care facility services or skilled nursing facility services.

"Participant" means an individual who is enrolled in the Adults with Physical Disabilities program.

"Representative" means a parent, guardian, or other individual with authority to act on behalf of an applicant/participant.

Responsibilities

1. The **applicant/participant** or **representative** is responsible for
   a. providing documentation required for an application, and
   b. scheduling and participating in an assessment.
2. The **care coordinator** is responsible for
   a. submitting a complete application,
   b. facilitating the scheduling of an assessment when requested,
   c. providing information for the assessment, and
   d. developing a plan of care for the applicant/participant.
3. The **SDS scheduler** (or assessor) is responsible for
   a. contacting the applicant/participant or representative to schedule an appointment for an assessment, and
   b. notifying the care coordinator of the appointment.
4. The **SDS Assessment Unit** is responsible for
   a. assigning an assessor to evaluate the applicant/participant,
   b. completing the assessment form,
   c. determining whether the applicant/participant meets the level of care requirement,
   d. requesting a third-party review when the requirement is not met, and
   e. notifying the applicant/participant or representative and the care coordinator of the determination.

5. The **SDS Waiver Unit** is responsible for
   a. evaluating the plan of care,
   b. approving or denying services,
   c. confirming Medicaid financial eligibility, and
   d. notifying the applicant/participant or representative and the care coordinator of the services approved.

Procedures

A. Timeframes.

1. Initial application.
   a. Within 30 business days of receipt of a complete application, SDS conducts an assessment, determines whether the applicant meets the nursing facility level of care (NF LOC) requirement, and notifies the applicant and/or representative and the care coordinator of the determination.
   b. Within 10 business days of receipt of a complete application indicating circumstances that require expedited processing, SDS conducts an assessment, determines whether the applicant meets the NF LOC requirement, and notifies the applicant and/or representative and the care coordinator of the determination.
   c. Within 60 days of receipt of the NF LOC determination notice, the care coordinator submits a complete *Plan of Care* to SDS.
   d. Within 30 days of receipt of a complete *Plan of Care*, SDS approves services and notifies the applicant and/or representative and the care coordinator of the approval.

2. Waiver renewals.
   a. No later than 60 days before the expiration of the period covered by the preceding NF LOC approval, the care coordinator submits a complete renewal application with current information regarding the participant.
   b. No later than 45 days before the expiration of the period covered by the preceding NF LOC approval, SDS schedules and conducts an assessment (within 365 days of the last assessment), determines whether the participant continues to meet the NF LOC requirement, and notifies the participant/representative and the care coordinator of the determination.
   c. Within 30 days of receipt of the NF LOC determination notice, the care coordinator submits a complete *Plan of Care* to SDS.
   d. Within 30 days of receipt of a complete *Plan of Care*, SDS approves services and notifies the applicant and/or representative and the care coordinator of the approval.

e. For reassessments indicating a participant not longer meets NF LOC requirements.
   i. Within 5 business days of the NF LOC determination, the reviewer requests an independent third-party review.
   ii. Within 15 days of receipt of the SDS document packet (or additional materials, if requested), the third-party reviewer notifies SDS of its determination.

B. Application for services.

1. Initial application.
   a. The care coordinator prepares or obtains, and submits to SDS, all documents required for a complete initial application:
      i. *Appointment for Care Coordination Services* form;
      ii. Application form (sections of the *Plan of Care*)
         (A) *Section I ~ Information and Identification*,
         (B) *Section II ~ Diagnosis & Medical* (except for *Current Medications*),
         (C) *Section III ~ Personal Profile*;
      ii. *Authorization for Release of Information* form;
      iii. *Verification of Diagnosis* form;
      iv. copy of the applicant's Medicaid coupon; and
      v. copy of documents (e.g., guardianship or Power of Attorney) indicating another has authority to act on behalf of the applicant.
   b. SDS reviews the application for completeness.
      i. If complete, SDS
         (A) determines whether there is a reasonable indication that the applicant would need the level of care provided in a nursing facility unless he/she received home and community-based waiver services, and
         (B) assigns a Care Coordination Assignment Number (CCAN) and, for individuals not listed in the SDS database, a DSDS ID number.
      ii. If incomplete, SDS notifies the care coordinator by email regarding the documentation needed to complete the application.
         (A) If the requested documentation is insufficient or not received within 5 days of the email message, SDS notifies the care coordinator and the applicant, allowing an additional 10 days for a response.

(B) If the requested documentation is not provided or is insufficient for program purposes, SDS sends a letter indicating program eligibility cannot be determined.

iii. For complete applications, SDS
(A) assigns an assessor to evaluate the applicant, and
(B) notifies the care coordinator of the CCAN and DSDS ID number.

2. Expedited application.
   a. The care coordinator submits a complete initial application requesting expedited processing, and indicating the qualifying circumstances regarding the applicant in the *Plan of Care*, *Section II ~ Diagnosis & Medical, Health Synopsis*.
   b. SDS reviews the application for completeness and determines whether the application indicates any of the following qualifying circumstances:
      i. diagnosis of a terminal illness,
      ii. anticipated discharge from an acute care facility within 7 days,
      iii. death of the primary caregiver within the previous 90 days,
      iv. absence of the primary caregiver due to hospitalization or travel because of a medical or family emergency,
      v. referral from Adult Protective Service, or
      vi. referral from the Office of Children's Services.
   b. For applications indicating qualifying circumstances, SDS conducts an assessment, determines whether the applicant meets the NF LOC requirement, and notifies the applicant and/or representative and the care coordinator of the determination within 10 days.

3. Waiver renewal.
   a. The care coordinator submits, no later than 60 days before the expiration of the period covered by the preceding NF LOC approval, a complete renewal application with current information regarding the participant:
      i. Application form (sections of the *Plan of Care*)
         (A) *Section I ~ Information and Identification,*
         (B) *Section II ~ Diagnosis & Medical* (except for *Current Medications*),
         (C) *Section III ~ Personal Profile*;
      ii. *Authorization for Release of Information* form; and
      iii. signed *Senior and Disabilities Services Program Recipient Rights* form..

b. Although the *Verification of Diagnosis* form is not required for the renewal application, SDS may request that the care coordinator submit the form with current information if it is deemed necessary for the NF LOC determination.

C. Assessment.

1. Scheduling.
   a. The scheduler or assessor
      i. schedules an in-person appointment for the assessment, and
      ii. notifies the care coordinator by telephone and/or email of the date, time, and place of the assessment.
   b. If the scheduler or assessor is unable to reach the applicant/participant or representative after two attempts (at least 3 days apart), SDS contacts the care coordinator by email and requests assistance with scheduling an appointment.
      i. If no appointment is scheduled within 10 days of contacting the care coordinator, SDS sends a certified letter to the applicant/participant or representative requesting that he/she contact SDS to schedule an appointment.
      ii. If the applicant/participant or representative fails to respond to the letter, SDS sends
         (A) a certified letter giving notice of closure of the application or of termination of eligibility for services, and
         (B) a copy of the letter to the care coordinator.

2. Preparation. The assessor reviews
   a. the medical, developmental, and functional information records,
   b. previous assessment forms, and
   c. previous plans of care and amendments.

3. In-person appointment. The assessor
   a. interviews the applicant/participant and representative;
   b. as necessary, collects additional information by contacting
      i. medical providers to request records related to condition of the applicant/participant,
      ii. others knowledgeable about his/her condition, and/or
      iii. others in attendance at the time of the assessment; and
   c. uses the information collected to complete the *Consumer Assessment Tool (CAT).*

D. LOC determination.

1. SDS review. The reviewer
   a. evaluates
      i. the *CAT*,
      ii. *Verification of Diagnosis* form,
      iii. other information submitted on behalf of the applicant/participant, and
      iv. forms/documents on file with SDS from previous assessments;
   b. determines whether the applicant/participant requires a NF LOC on the basis of the following guidelines for determining level of care:
      i. intermediate LOC characteristics, 7 AAC 140.510,
      ii. skilled LOC characteristics, 7 AAC 140.515, and
      iii. Criteria for Placement section of the *Manual for Prior Authorization of Long Term Care Services*;
   c. signs the *Eligibility Determination* section of the *CAT* indicating that the NF LOC requirement is or is not met; and
   d. in the case of a reassessment, requests a third-party review when he/she finds that the participant does not meet the NF LOC requirement.

2. Third-party review. The third-party reviewer
   a. evaluates the document packet provided by SDS,
   b. determines whether the participant's condition has materially improved since the previous assessment, as defined in AS 47.07.045 (b)(3), and
   c. notifies SDS of the determination.

3. Notice of decision. For both initial assessments and reassessments, SDS sends to the applicant/participant or representative and to the care coordinator
   a. a letter indicating whether the NF LOC requirement is met, and
   b. a copy of the *CAT*.

E. Plan of care.

1. Development. The care coordinator
   a. develops a *Plan of Care* (*POC*), and
   b. submits to SDS
      i. the POC, and
      ii. the signed *Senior and Disabilities Services Program Recipient Rights* form.

2. Evaluation. SDS evaluates the *POC* to determine whether it
   a. is consistent with the assessment, and
   b. meets the identified needs of the applicant/participant.
3. Approval. SDS approves services which meet regulatory requirements of 7 AAC 130.230 or denies services which do not.

F. Enrollment.

1. The applicant/participant is eligible to receive Adults with Physical Disabilities program services funded by Medicaid when he/she is enrolled.
2. The applicant/participant is considered to be enrolled when SDS
   a. confirms program eligibility,
   b. verifies Medicaid financial eligibility with the Department of Public Assistance, and
   c. sends a letter approving the *POC*.