P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

Medicaid individuals who are in Level III and Level IV Residential Care Homes and who do not receive SSI benefits (because these individuals are automatically eligible) may be eligible for a spend-down deduction for the cost of personal care services received.

Residential care homes are state licensed group living arrangements designed to meet the needs of people who can not live independently and usually do not require the type of care provided in a nursing home. Level III homes provide nursing overview, but not full-time nursing care. Level IV homes do not provide nursing overview or nursing care.To determine if he/she is in a Level III or Level IV Residential Care Home (RCH), refer to the list of Level III Residential Care Homes at http://dail.vermont.gov/dail-programs/dail-programs-providers/dail-providers-list-rchiii/dail-rchiii-providers-default-page.

Assisted Living Facilities (ALF) are state licensed residences that combine housing, health and supportive services to support resident independence and aging in place.The ALF list is found at http://dail.vermont.gov/dail-programs/dail-programs-providers/dail-providers-list-alf/dail-alf-providers-default-page.

If an individual lives in a home that is not on either list, contact the home administrator to determine if they are a Level III home or ALF.

ACCS is a more comprehensive bundle of services than Personal Care Services (PCS), but many overlap. The main difference is that ACCS can become a covered Medicaid service, whereas PCS is not a covered service for individuals over age 21.

1. Determining eligibility

a. If the individual is in a level III home, send the Verification of Eligibility for Medicaid payment of Assistive community Care Services (ESD 225A) to the client to complete and return. The purpose of the form is twofold: 1. Since most ACCS providers charge more than the standard ACCS rate at P-2420 D5, you will have the actual private pay rate to use when determining the ACCS start date. 2. once eligibility is processed, returning the 225A will let the client and provider know the ACCS start date. However, if the form is not returned, do not deny or close for non-cooperation. Process the spenddown using the ACCS standard deduction at P-2420 D5.

b. Enter an INST panel in ACCESS with code 23 (Community Care Home/ACCS) in the INST TYPE field.

c. Compute the spenddown per procedures at P-2424 A.

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d. If the spenddown is met using allowable deductions, other than ACCS, proceed with grant procedures at P-2423 A.

Because the spenddown was met without using ACCS expenses, the individual is eligible for both Medicaid and coverage of Assistive Community Care Services (ACCS). Medicaid eligibility begins on the first day of the application month or retroactive period, if applicable. ACCS eligibility starts the date the individual started receiving services in the Level III or IV RCH or ALF.

- Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (ESD 225A). If the client did not return this form, you will need to complete this section out and send with the Notice of Decision.
- Send a computer generated Notice of Decision to the individual. Select the "ACCS Initial Approval" Optional Notice Paragraphs text indicating ACCS effective coverage date. If you use the standard ACCS rate because the form was not returned, let the client know you used the standard ACCS rate and thye may submit a completed 225A providing the actual private pay ACCS rate which may result in an earlier spenddown and ACCS start date.
- If the case is a review, select the "Assistive Community Services Review" Optional Notice Paragraphs text to indicating the ACCS coverage and payment dates.
- Include the individual's copy of the 225A with the Notice of Decision to the individual.
- Send the facility's copy of the ESD 225A to the administrator of the home.

Example:
Application date: Aug. 2
ACCS services began: Aug. 16
Notice of Decision gives the Medicaid eligible date of Aug.1
Enter the ACCS eligible dates on the Optional Notice Paragraphs and would read; "You are eligible for ACCS effective Aug. 16."

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e. If spenddown is not met using allowable deductions:

Compare the spenddown (after all other allowable deductions) to the ACCS deduction over six months (example: $1,110 x 6 = $6,660). Use the actual daily rate for ACCS (care services only) provided by the home on the 225A. If the amount is not listed, or is the same amount as the room and board cost, call the home and request the ACCS services daily rate only. If they refuse to provide the amount, or to separate the ACCS services rate from the room and board rate, use the Medicaid rate, per P-2420 D5.

1. If the individual's spenddown is less than the ACCS deduction over six months, the spenddown has been met. Follow procedure below.

a. Medicaid is granted effective the first day of the month of application or the first day of the retroactive period, if applicable.

b. The ACCS start date is determined as follows:

Divide the spenddown by the daily cost of ACCS per the ESD 225A or the Medicaid rate, per P-2420 D5, whichever is higher. Drop any numbers after the decimal point. The result is the number of days the client must privately pay his or her ACCS costs. Medicaid will pay for ACCS starting the following day through the end of the spenddown period.

CATN the ACCS daily rate of pay, per ESD 225A form, as well as the private pay and department pay dates (i.e. "Individual responsible to pay ACCS from 01/01/09 – 02/16/09. Dept will pay ACCS 02/17/09-06/30/09").

- Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (ESD 225A). Send a computer generated Notice of Decision to the individual. Be sure to add the "ACCS Initial Approval" Optional Notice Paragraphs text indicating ACCS effective coverage date. Send the individual's copy of the ESD 225A with the notice. Send the facility's copy of the ESD 225A to the administrator of the home.

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If the case is a review, be sure to select the "Assistive Community Services Review" Optional Notice Paragraphs text indicating ACCS coverage and payment dates.

Example:

Review application date: Sept 5. individual's current period ends Sept 30.
Individual's spenddown after deductions of Medicare premiums, over-the-counter (OTC) items, and old bills: $1500.00
ESD 225A states ACCS rate is $40/day
$1500 ÷ $40 = 37.50 Individual must private pay 37 days.
Medicaid start date: October 1
ACCS private pay dates: October 1 through November 6
Medicaid covers ACCS cost: November 7 through March 31

i. Individuals with both resource and income spenddowns are eligible for Medicaid as of the month they meet both financial and resource requirements. In the month both tests are met, Medicaid is granted as of the first of that month. ACCS eligibility begins the day after they meet their income spenddown.

NOTE: The same medical expense cannot be used to meet both spenddowns. The cost can only be used to meet one or the other.

Example:

An individual completes the July review application. They have a resource spenddown of $400 and an income spenddown of $800.

The individual meets their resource spenddown August 10th by spending down their resources on ACCS services (ACCS daily rate $40 x 10 days = $400). The individual privately paid ACCS services from Aug 1st – Aug 10th.

If they don't have other expenses to meet their income spenddown and need to use ACCS costs, we would begin counting ACCS private pay days from August 11th forward. Using ACCS costs the client would meet their income spenddown on August 30th (ACCS $40 x 20 days = $800).

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As both income and resource requirements were met in the month of August they are eligible for the following coverage:

Medicaid begins: August 1st
ACCS eligibility begins: August 31st
The individual is responsible for ACCS private pay: August 1st – 30th.
If the individual met their income spenddown on September 5 instead of August 30, their Medicaid start date would be September 1 and their ACCS start date would be September 6.

2. If the spenddown is greater than the ACCS deduction for six months, the individual is ineligible for ACCS services for the spenddown period, but may become Medicaid eligible.

a. From the spenddown, deduct the cost of the ACCS over six months. If the remaining spenddown is met during the period, they may become *Medicaid* eligible during that time, but ACCS will not be covered.

- If the individual incurs unexpected medical expenses, re-calculate the spenddown to find the earliest Medicaid and ACCS start date.

Example:

Application date: Jan 5.
Client's spenddown after deductions of insurance premiums and over-the-counter items: $9,000
ESD 225A states ACCS rate is $45/day.
$45 x 30 days = 1,350 x 6 months = $8,100 (the total ACCS deduction for the six-month period).
Individual's spenddown ($9000) exceeds the total ACCS rate for the six months ($8,100). Therefore, ACCS services will not be covered during this spenddown period and the ACCS rate is used as a non-covered service deduction.
$9000 - $8100 = $900
Individual's spenddown is $900 from Jan – June.
If spenddown is met during the spenddown period, he/she will be granted Medicaid on the day the spenddown was met. (ACCS services will not be covered).

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b. Send a denial Notice of Decision denying Medicaid for being over income and add the following in Additional Text of the notice:

"Since you are in a Level III or IV Residential Care Home, you may be able to use personal care expenses to meet your spenddown.

Please have your doctor complete the enclosed forms (ESD 288B, Statement of Need for Personal Care Services and ESD 288C, Statement of Cost for Personal Care Services) and return them to our office".

- The completed forms may provide additional deductions to help meet their Medicaid spenddown. The only additional allowable PCS deductions would be for those services not already covered by ACCS (see chart on following page). Calculate the expense by multiplying the number of hours required each month by the state minimum wage (found at http://www.labor.vermont.gov/Portals/0/UI/WH-11%2008%20Minimum%20Wage%20Rate.pdf), multiply the result by six to calculate the expense over the six-month period.

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Service description	**Service Category**	
	PCS	**ACCS**
Assistance with self-administered medications	X	X
Assistance w/dressing	X	X
Assistance /bathing	X	X
Assistance w/grooming	X	X
Assistance w/eating, drinking, diet	X	X
Assistance w/toileting	X	X
Assistance w/positioning	X	X
Assistance w/transferring	X	X
Assistance w/ambulation	X	X
Assistance w/use of adaptive equipment	X	X
General supervision of physical & mental well-being	X	X
Assistance w/ food prep	**X**	
Assistance w/limited housekeeping services	**X**	
Accompany individual to clinics, physician's office	X	X
Continuation of training programs	**X**	
Management of money	**X**	
Assistance in monitoring vital signs	X	X
Routine skin care	X	X
Assistance w/exercise	X	X
Medication monitoring		X
Medication administration		X
Restorative nursing		X
Nursing assessment		X
Health monitoring		X
Routine nursing tasks		X
24-hr on-site assistive therapy		X
Case management		X

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c. Note: If the ESD 288B and ESD 288C are not returned, no follow-up is required.

- If the ESD 288B is received at a later date, treat it as if it had been returned in a timely manner.

- When the ESD 288B is returned and it indicates that the individual receives medically necessary personal care services, beyond what is covered by ACCS, recalculate the spenddown by deducting the appropriate standard for the level of care (P-2420 D5).

- If the spenddown is met using the standard deduction, grant Medicaid.

- If a physician requests authorization to charge more than $50 to complete the ESD 288B and ESD 288C, you may authorize up to $75. Amounts from $76 to $150 require supervisory approval. Any amount over $150 requires approval by Operations. Give the authorization over the phone to the physician and document it in the case file.

- For specifications on when a new plan of care is needed, see 4452.3.