OVERVIEW

OPTIONS is a program of home and community based services funded primarily through the Aging Block Grant (ABG). The services in this program are provided to eligible consumers aged 60+ 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. All other resources (individual, local, state and/or federal) must be considered and utilized before OPTIONS services are provided. In discussing the individual's resources, the Area Agency on Aging must explore how use of their resources can enhance and/or extend their receipt of long-term care services. AAAs are encouraged to explore and refer individuals to the program that will best meet the individual's needs.

NOTE: Consumers who receive OPTIONS services must be assessed using an LCD and NAT and must be care managed with the exception of individuals who receive only Non-Congregate/In-Home Meal Service who will be evaluated with the Needs Assessment Tool – Express (NAT-E) and can be care managed by a case aide that is supervised by a Care Manager or a Care Management Supervisor. The NAT-E is a shorter version of the LCD and NAT with a focus on nutritional indicators (see Chapter IX - Assessment).

I. PROGRAM ELIGIBILITY REQUIREMENTS

An individual must be:

- Age 60 and older
- A Pennsylvania resident
- A U.S. citizen or lawful permanent resident (see Appendix D).

NOTE: The citizenship or lawful resident requirement will be met if the individual receives Supplemental Security Income (SSI), Social Security Administration (SSA) benefits, or is enrolled in Medicare Part A or B as evidenced by an enrollment card.

- Experience some degree of frailty in regard to physical and/or mental status that impacts daily functioning

In addition, the individual cannot be receiving Medical Assistance (MA) Long-term Care Services (Nursing Facility, LIFE, Home and Community Based Waivers) or Act 150.

II. PROGRAM ENROLLMENT REQUIREMENTS

An individual applying for OPTIONS services must:

- Be assessed as evidenced by a completed Level of Care Determination (LCD) with a level of care determination of Nursing Facility Ineligible (NFI) or Nursing Facility Clinically Eligible (NFCE)
- Copy of PA162 from the County Assistance Office (CAO) indicating financial ineligibility for MA funded programs received by the AAA on Consumers determined NFCE as part of the Mandatory Enrollment Process (see below)
- Be determined to have unmet needs that may be addressed as evidenced by a completed Needs Assessment Tool (NAT)
- Have a completed OPTIONS Enhanced Cost Share Calculation Tool (See Appendix B)

*Consumers determined to be NFCE and who appear to be MA eligible may receive limited OPTIONS services while awaiting the PA 162 (See Interim Care Plan below).

A. Mandatory Enrollment

All consumers who are seeking OPTIONS home and community based services and who have been assessed and determined to be NFCE must apply for MA Long Term-Care services by completing and submitting to the appropriate CAO a PA 600 for determination of financial eligibility. The failure to do so preclude the consumer from participation in the OPTIONS program, unless the consumer agrees to pay 100% of the care plan cost, including Care Management and Administration costs as calculated by the average monthly cost Care Management and Administration in the previous Fiscal Year (see Appendix F). NFCE consumers who apply for the Aging Waiver and are found to be financially ineligible due to excess income and/or assets as evidenced by receipt of a PA 162 that denies them enrollment, can receive OPTIONS services if they meet all other program eligibility requirements.

NOTE: Mandatory Enrollment policy applies to all consumers who are receiving OPTIONS services and have a change in level of care to NFCE, or who at reassessment (or at any time the AAA becomes aware) it is determined that the consumer's income and/or assets are within MA guidelines for the Aging Waiver. If an active consumer fails to initiate a PA 600L within 30 days or fails to fully complete this application, the consumer must be notified that services will be terminated (see Chapter II Hearings and Appeals).

B. Interim Care Plan

An interim care plan for OPTIONS services can be provided to NFCE consumers who are waiting for determination of their MA financial eligibility. The Interim Care Plan cannot exceed the cost cap of **$765/month**.

The Interim Care Plan will be provided for no more than 45 days. The 45 day time limit begins on the day the PA600L is submitted to the CAO. This time limit may be extended with details documented in the consumer's record in SAMS that outline the specific reason/justification of the extension. Should an individual be denied the MA Waiver for any reason other than excess income or resources, they must reapply within 15 days or by date indicated on the PA 162. The Care Manager must closely monitor the case so that the individual reapplies. If the individual does not re-apply, services are to be terminated (see Chapter II Hearings and Appeals).

The consumer must pay a cost share at their calculated rate until the PA162 is received or they are to be billed 100% of the cost, including Administration and Care Management costs.

1. For existing consumers the current care plan of OPTIONS service/s must remain in place until the PA 162 is received. In instances where the current care plan is below the cost cap, additional services can be provided if there is an identified need, but the care plan cannot exceed the cost cap of $765/month. Any services added to the care plan must be as close as possible in scope, type and model of service/s to services in the Aging Waiver so that the plan can be replicated in the initial Aging Waiver Care Plan.

2. For new consumers, the OPTIONS Interim Care Plan cannot be initiated until the completed PA600L is submitted to the CAO. To initiate the Interim Care Plan the AAA must:

   - Assure that the PA 600L has been completed and forwarded to the CAO.
   - Assure that the Interim Care Plan is as close as possible in scope, type and model of service/s to services in the Aging Waiver so that the plan can be replicated in the initial Aging Waiver Care Plan.

- Assure that the OPTIONS Interim Care Plan remains in place until which time the Office of Long Term Living (OLTL) approves the recommended Aging Waiver Care Plan
- Provide written notice to the individual that their care plan (service/s and/or provider/s) may/will be revised upon enrollment in the Aging Waiver.

C. AAA Enrollment Broker Responsibilities

When the AAA is the Enrollment Broker for the Aging Waiver the AAA must complete the following tasks (for existing and new consumers) under the auspice of "Waiver Enrollment" in order to be reimbursed appropriately for the Enrollment Service W0009:

- Assist the individual in securing Physician's Certification
- Assist the individual in completion of the PA600L
- Internally coordinate completion of the LCD
- Ensure the individual's CMI has been completed according to OLTL guidance (see Appendix B)
- Provide the individual with choice of service coordination agencies
- Send the PA 1768 to the CAO
- Upon receipt of the PA 162 from the CAO, submit corresponding enrollment paperwork to the individual's chosen SC agency to begin service plan development.
- Follow OLTL OPTIONS to Aging Waiver transfer instruction (see Appendix F).

D. Wait List

OPTIONS services are mostly funded through the Aging Block Grant (ABG) and limited funding may result in the establishment of a wait list. This will be determined at the local level based on the AAAs ability to provide core services. When an AAA determines that a waiting list needs to be established, they must provide notice to the fiscal department at PDA.

There is to be only one waiting list for consumers. This waiting list will include both consumers who are waiting to enroll in the OPTIONS program and also

existing OPTIONS consumers who are waiting for an increase in services or a new service to be added to their existing care plan. All individuals being placed on a waiting list must be identified as such in SAMS which includes the completion of a NAT and a draft service plan within 30 days of the completion of the LCD (See LTLTI website for webinar/instructions on SAMS data entry requirements for wait list).

All consumers waiting for a Core or Supplemental Service are placed on this list in order based upon a Functional Needs Score (FNS) which will be calculated based on responses in the Needs Assessment Tool (NAT).

NOTE: Consumers whose only need is for Non-Congregate/In-Home Meals, and who are at nutritional risk and/or do not have the financial resources to purchase food are to be placed at the top of the waiting list. All other individuals whose only need is for Non-Congregate Meals/In-home Meals will be placed on the waiting list by FNS score.

The following areas will factor into this calculation:

- LCD Tier Score
- Hospitalizations
- Formal and Informal supports
- Financial resources
- Physical Environment

Consumers with the same Functional Needs Score will be ranked by the date of completion of the LCD.

NOTE: Individuals waiting for a Supplemental Service only cannot be served until all individuals waiting for a Core Service (or an increase in Core Service) are served. Core and Supplemental services will be identified as such in SAMS, so as to assure that consumers waiting for Core Service (or an increase in Core Service) are removed from the waiting list before a consumer waiting for a Supplemental Service is served.

There must be regular contact with individuals on the wait list (See Care Management Chapter). In situations where a change in a consumer's functional need or a change in their supports would affect their FNS, a new NAT must be completed to document these changes and recalculate their score to advance their placement on the waiting list. However, if the need for additional units of service is not based on a change in need that would change their FNS, such as the determination that the number of units of service ordered initially does not

meet the consumer's needs, these individuals will not require the completion of a new NAT.

E. Care Plan Cost Caps

The OPTIONS monthly care plan cost cap is **$765.00 per month** (as averaged over the care plan period and documented in SAMS) and is subject to change as determined by the Department.

- The costs of Non-Congregate/In-Home Meals, Assessment, Care Management, Emergent Service and Protective Services costs are excluded from the cost cap.
- Individuals who choose to pay for 100% of their service cost can exceed this cap amount. For individuals that choose to pay for 100% of their service cost and exceed the cost cap, the cost of Administration and Care Management (see Appendix F) will be included in cost of the care plan.
- In developing a care plan, all resources must be evaluated and utilized unless harm to the consumer can be determined. This evaluation and utilization of resources must be clearly documented in the case record.
- If a consumer needs a high level of services or a home modification at initial assessment, but less service in the subsequent months, AAAs may use an average cost of services over the next twelve months to determine the care plan cost.

All consumers should receive an initial care plan at or below $765/month. In the rare instance where services above this amount are needed by consumers who are not MA eligible, the only consumers whose care plan can be increased to the maximum of $1900 per month are:

- NFCE consumers
- NFI consumers who receive Adult Day Services only or who receive Adult Day Services supplemented with other OPTIONS services in which the cost of Adult Day Services exceeds 50% of the total care plan cost.

Approval for an exception to the care plan cost cap will be made by the AAA. The AAA must establish local policy and procedures for their PSA which outlines consistent protocols for cost cap exceptions including approval authority. These policies and procedures must be in place before any consumer can receive

services above $765/month. All approved exceptions to the care plan cost caps must be documented in a SAMS journal entry which clearly outlines the reasons for the decision to exceed the cap of $765/month. At a minimum the SAMS documentation should include:

- Current detailed care plan information to include type of service/s and schedule
- A summary of the changes in the consumer's condition and/or situation that supports the need for services above the cap
- Efforts to address increased needs prior to increase in services (i.e. change in schedule or a consideration of another service such as Adult Day instead of increased personal care)
- Evaluation and discussion with the consumer of all community resources and the consumer's financial resources that could address the need for additional service/s
- Details on what will be added to the care plan to include type of service and schedule
- The length of time this service will be needed if not on-going

The Aging Quality and Compliance Unit will conduct monitoring of the exception process.

NOTE: Should the Department issue a service rate increase directive, all active consumers whose care plan cost would then exceed the $765/month cost cap will not be subject to the cost cap exception process, and the AAA must document this in the service plan in SAMS. <u>This is strictly for increases in care plan costs that are affected by a Department directive and NOT for those consumers whose care plan cost exceeds $765/month due to an increase in unit cost as per a provider contractual agreement made by the AAA separate from a PDA directive.</u>

III. OPTIONS CORE SERVICES (OCS)

The following services are **required** to be offered by the Area Agencies on Aging. All OPTIONS Core Service must meet the Service Standards (see Appendix E).

A. OCS - Adult Day Services

Adult day services centers operate for part of a 24-hour day and offer an interactive, safe, supervised environment for older adults and adults with a dementia-related disease, Parkinson's disease or other organic brain syndrome. Adult day services centers offer a community-based alternative to institutionalization and provide a reliable source of support and respite for caregivers. Refer to Older Adult Daily Living Center Regulations. Title 6, Chapter 11): 6 PA Code Chapter 11 - Older Adult Daily Living Centers.

All adult day centers in Pennsylvania provide personal care, nursing services, social services, therapeutic activities, nutrition and therapeutic diets and emergency care. Some centers offer additional services such as physical therapy, occupational therapy, speech therapy, medical services, podiatry, etc. to meet the range of client needs.

B. OCS - Care Management

Care Management activities through the Area Agencies on Aging serve as a coordinative link between the identification of consumer needs and the timely provision of appropriate services to meet those needs by utilizing all available resources. Care Management is a service to enrolled consumers that develops a plan of care that is coordinated with formal and informal supports. It supports the consumer's individual preferences and independence with a focus on health and safety and based on their lifestyles, cultural needs and frame of reference. It also provides on-going monitoring and reassessment of the care plan to assure that it continues to meet the needs of the consumer. Activities include, as a minimum, a comprehensive needs assessment of the consumer; development of a written service plan; arrangement, coordination and follow-up of service delivery; and ongoing case recording. Care Management can be offered as a stand-alone service to consumers who need the support and assistance of a Care Manager, but are not receiving other services.

C. OCS - Consumer Reimbursement

A consumer-directed service which provides reimbursement to a consumer for services authorized in a consumer's care plan. Under this service the AAA must have a system in place to assure that the service is/was provided as outlined in the consumer's care plan. As a Core Service Consumer Reimbursement can only be used for:

- Consumer-Directed Personal Care
- Pest Control/Fumigation

Consumer reimbursement should mirror the requirements in the Caregiver Support Program including at a minimum:

- An approved care plan that outlines what specifically will be reimbursed
- Submission of receipts for items purchased
- Completion and submission of a form that details the provision of services (days/hours, service provided and by whom) and sign-offs by the service provider and consumer
- An attestation statement made by the consumer that all submissions for reimbursement are true and correct and reflect that the service was provided as documented in the care plan

NOTE: Individuals receiving consumer reimbursement that are unable to self-direct their care may have this service directed by their identified primary caregiver and/or legal surrogate (i.e. power of attorney or guardian). In addition, in instances where the consumer cannot afford to purchase a service "up front", it will be allowable for the AAA to pay for the service directly; however this would be considered an exception to this policy and must be clearly supported in documentation in the consumer's record in SAMS.

D. OCS - Emergent Services

Services that address an immediate need for assistance and intervention due to a critical event that poses an imminent health and safety risk and that cannot be addressed by existing community resources. These individuals do not meet the criteria for Older Adult Protective Services intervention or the provision of emergent services would prevent a referral to Protective Service if provided. These services are short-term in nature (generally 24-72 hours) until a permanent arrangement/payment solution is made or an alternate caregiver or family member becomes available to provide care. Emergent services include:

- OPTIONS Core Services
- Overnight shelter
- Emergency life sustaining supplies

NOTE: Individuals who are found in need of emergent services can initially receive a Needs Assessment Tool-Express (NAT-E); however if this service is

required for more 72 hours, the AAA must complete a LCD and NAT to fully evaluate their needs. Individuals receiving Emergent services are not subject to OPTIONS cost share.

E. OCS - Non-Congregate/In-Home Meal Service

To be eligible for this service the individual must be at nutritional risk, physically or mentally unable to obtain food or prepare meals and have no one willing or able to prepare meals for them as evinced by a completed NAT- E. Each meal shall adhere to the nutrition requirements as outlined in the most current PDA Nutrition Services APD and can be provided hot, frozen or in combination. These meals are provided to consumers in their individual residences and not in a congregate setting.

NOTE: Mandatory enrollment does not apply to Non-Congregate/In-Home meal service when the meals are the only service the individual requires. In addition, when a consumer has no resources (money) for food and is determined not to be nutritionally at risk, according to the nutritional risk score; the AAA may choose to provide meals if the consumer is still without food after being referred to all available community food resources, including congregate meal sites. Document these extenuating circumstances in the SAMS journal notes.

F. OCS- Personal Emergency Response System (PERS)

This is an electronic device which enables certain high-risk consumers to receive help in the event of an emergency. PERS services are limited to those consumers who live alone or who are alone for significant parts of the day, have a significant risk for falls, an unstable medical condition and have no regular caretaker for extended periods of time. The consumer must be cognitively and functionally capable of using this device.

G. OCS - Personal Care Services

Personal Care Services include assistance with ADL's and IADL's, such as feeding, skin and mouth care, ambulation, bathing, hair care, grooming, shaving, dressing, transfer activities, toileting, meal preparation and assistance with self-administration of medications (i.e. opening medication containers, providing verbal reminders). This service must be provided through contract with an

agency who meets all requirements under the purview of the Department of Health.

NOTE: Home Support activities as defined below can be included in personal care service if they are necessary and supplemental to the provision of personal care.

IV. OPTIONS SUPPLEMENTAL SERVICES (OSS)

Funding for supplemental services must be secondary to providing core services; therefore an AAA cannot provide a supplemental service if there is a waiting list for an OPTIONS core service. Supplemental service cannot be provided prior to assessment or enrollment. All OPTIONS Supplemental Service must meet the Service Standards (see Appendix E).

A. OSS- Consumer Reimbursement

A consumer-directed service which provides reimbursement to a consumer for services authorized in a consumer's care plan. Supplemental Consumer reimbursement services include:

- Minor Home Repairs and Maintenance
- Counseling (PDA funds must be payer of last resort)
- Other services/items not provided by OPTIONS that are needed as evidenced by a Needs Assessment Tool (NAT) and that can be obtained by the consumer at a more cost effective rate.

See Consumer Reimbursement (OCS) for minimum requirements (Section III.C.)

NOTE: Hearing aids, dentures and eyeglasses are NOT considered an allowable purchase under this or any other OPTIONS service.

B. OSS - Home Health Services

Home Health Services include the services of skilled nursing, physical therapy, occupational therapy, speech pathology, and home health aides on a part-time or intermittent basis, not otherwise covered under a third party payer. Duties of a home health aide include the performance of procedures as an extension of therapy services, personal care, ambulation and exercise, household services

essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's conditions and needs and completing appropriate records. Consumers receiving home health aide services should have complex medical issues that require the oversight and supervision of a Registered Nurse.

C. OSS - Home Modifications

Adaptations/modifications made to improve consumer safety, increase functioning, and to assist in the provision of care to a consumer in their home. The "footprint" of the dwelling cannot be changed or altered in any way. Multiple bids should be solicited to assure that work is completed in the most cost effective and efficient manner. Although a consumer is not required to choose the lowest bid, the AAA can only fund the lowest bid amount and the consumer will be responsible for the difference. If unable to solicit more than one bid, the case record must document all bid solicitation efforts.

There is a lifetime cap of $5000 for each consumer, to include but not limited to all charges such as estimates, applicable licenses and inspection fees. The AAA must explore all other resources and be the payer of last resort. The Quality and Compliance Division will monitor for compliance as evidenced in by documentation in journal entries in the consumer record in SAMS.

NOTE: If an existing consumer has previously received $2000 in home modifications, they would be eligible for an additional $3000 in home modifications if there is a clear need established, not to exceed the $5000 life time limit. This must be documented in the consumer record in SAMS.

D. OSS - Home Support

Home Support services include basic housekeeping activities necessary to ensure safe and sanitary conditions. This service may also include the activities of:

- Shopping assistance
- Laundry

NOTE: Home Support cannot be provided as a separate service to consumers who are receiving Personal Care or Consumer Reimbursement (Consumer-Directed Personal Care) as evidenced by the completion of a Needs Assessment

Tool (NAT) that supports the necessity of this service. It is expected that these activities would be completed by the personal care aide.

E. OSS - Medical Equipment, Supplies, Assistive/Adaptive Devices

NOTE: Hearing aids, dentures and eyeglasses are considered personal items and not Medical Equipment, Supplies, or Assistive Devices and cannot be reimbursed through OPTIONS.

Durable Medical Equipment - items primarily used in the presence of illness, injury or functional disability that can withstand repeated use and are appropriate for use in the home. Items in this definition must be Medicare, Medicaid or Third Party non-reimbursable.

NOTE: The AAA must assure that OPTIONS is the payer of last resort and retain copies of Medicare or other insurance denial before purchasing a DME.

Medical Supplies - Expendable, disposable or consumable supplies used in the provision of home health or personal care to chronically ill or disabled consumers at home not otherwise covered by other insurance or third party payer. These items must complement the delivery of in-home services, or where cost effective and appropriate, replace the delivery of certain services.

Assistive Devices - Items and/or aids to functionally disabled consumers that will enable them to perform ADLs and IADLs more independently. These items must complement the delivery of in-home services, or where cost effective and appropriate, replace the delivery of certain services.

V. TRANSPORTATION – OPTIONS Non-Care Managed

The following transportation services provided and funded by the AAA, depending on the availability of these services in each AAA Planning and Service Area (PSA) include:

- Essential rides provided to senior centers, medical appointments, social service agencies, Adult Daily Living Centers, grocery stores and pharmacies for individuals age 65 and older. The AAA must contract with the local Shared-Ride Provider to fund all or some portion of the shared-

ride copay for rides provided to individuals age 65 and older who are going to the aforementioned six destinations.

- Rides to individuals age 60-64 for any reason. If this ride is with a shared ride provider it will require that the AAA determine how much, if any, of the full fare they will pay and the consumer would be responsible to pay the balance.

- Rides for individuals 65+ for any non-essential reason with a shared ride provider for which the AAA will be responsible to pay the provider a co-pay of up to 15%. The AAA can determine how much they will pay of the 15% co-pay and how much will be the responsibility of the consumer.

- Riders 60+ for trips where an AAA owned vehicle is the means of transportation.

VI. OPTIONS COST SHARE

Mandatory Cost Sharing applies only to OPTIONS services. Specifically excluded are:

- Assessment
- Care Management**
- Non Congregate/In-Home Meals
- Emergent services
- Services provided through a Protective Services Care Plan

**Consumers who refuse to disclose income or cooperate with the verification process and NFCE consumers who refuse to apply for the Waiver as per Mandatory Enrollment Policy (Section II.A) must pay 100% co-pay for services, to include the cost of Care Management and Administrative costs.

Non-payment of Mandatory Cost Sharing will result in termination of AAA participation in the cost of the consumer's care plan. The consumer may still receive, at no cost, services specified by the Department as excluded from Cost Sharing.

A. Cost Sharing Scale

- OPTIONS cost sharing will be determined using a sliding scale that covers the range of income from 133% to 300% of the current Federal Poverty Level (FPL), which is updated annually (see Appendix B).

The application of the sliding scale to individual consumers should occur during completion of the initial Needs Assessment Tool (NAT), annual reassessment, or when there has been a significant change in includable income that may affect the cost share amount.

- Those consumers under 133% of the FPL will not have to pay for services.
- The fee scale increases up to 300% of the FPL, at which point the consumer will pay for all of their services (except for excluded services and including Care Management as outlined in Section V.A).

B. Cost Share Calculation

Income

The cost sharing fee is based on the countable monthly income. Where significant monthly variations exist, the income amounts will be averaged over a 12 month period for purposes of determining eligibility and cost sharing rates.

- Income eligibility is based on the previous year's gross income received by the consumer and spouse (if married). Current year income is not used for this calculation unless there is a significant decrease in current income that would affect the cost share amount to the benefit of the consumer.
- If the consumer has filed a federal tax return, the adjusted gross income may be used to determine the amount of the cost share fee. However, non-taxable income such as Social Security must be added to the adjusted gross income when determining the cost sharing fee.
- If sale of a home/property occurred, all capital gains must be declared as income within two (2) years of the sale date even if consumer did not file a State or Federal tax return. If consumer used the proceeds to pay for nursing home costs or to purchase another residence deeded in his/her name, that portion of the capital gains used to pay for the aforementioned items is not considered income.

- If the consumer did not file a tax return, use the following list of types of income to be counted when determining the cost sharing fee:

    - Gross Social Security & SSI
    - Railroad Retirement (RRB1099 & RRB1099R)
    - Gross Pensions
    - Salaries/Wages/Commissions
    - Self-Employment or partnership income
    - Alimony and Spousal Support Money
    - Taxable Amount of Annuities and IRAs
    - Unemployment
    - Veterans' Disability Payments
    - Cash Public Assistance
    - Interest/Dividends/Capital Gains
    - Net Rental Income
    - Royalties
    - Workers' Compensation
    - Life Insurance Benefits (death benefits over $10,000)
    - Spouse's income if married, living together
    - Gift and inheritance of cash or property over $300
    - Any amount of money or the fair market value of a prize, such as a car or trip won in a lottery, contest, or gambling winnings

- The following will **not** be considered as income for the cost sharing program:

    - Medicare Part B premiums
    - Aid & Attendance payments from VA
    - Certain AmeriCorps Vista payments may be excluded
    - Property Tax/Rent Rebates
    - Damages received in a civil suit/settlement agreement
    - Benefits granted under 306c of Workers' Compensation Act
    - Food Stamps
    - LIHEAP payments
    - Black or White Lung Benefits
    - Reverse Mortgages

Deductions

The only allowable deduction will be a flat 30% disallowance from the total monthly income of the consumer or consumer and spouse (if applicable).

Income Verification

The income must be verified by the Care Manager and a copy of all documents placed in consumer's case file, both initially and at reassessment. Changes in the consumer(s) financial situation must be reviewed annually during the reassessment process. Consumers should be encouraged to call the AAA when there has been a significant change in income at any point during the life of the case.

Assets

Assets will not be used to determine a consumer's cost share; however the AAA must collect asset information when completing the Needs Assessment Tool (NAT) and record what documentation was presented to verify assets. The Older American Act mandates us to provide service to the most economically needy consumer which is why the care manager must engage the consumer in a discussion about utilization of assets to meet their needs.

NOTE: The consumer's co-payment amount, when subtracted from their monthly income, cannot reduce the consumer's income to less than the current 133% of Federal Poverty Level. If this occurs, then the consumer co-payment will be capped at that dollar amount that reduces the remaining consumer income to the 133% Federal Poverty Level.

C. Billing

Billing is handled locally by each AAA but must be consistent with the following steps, timeframes and processes:

The AAA may opt not to bill consumers for monthly co-payments of $10 or less. With the consumer's consent, AAAs have the option to bill consumers whose monthly co-payments do not exceed $10 on an annual, semi-annual, or quarterly basis, whichever is most cost-effective and convenient for the consumer.

Steps and Timeframes:

- The AAA must clearly advise consumers in writing, about co-payment obligations, procedures, schedules and estimated monthly costs at the time the care plan is developed. Consumers must also be informed in

writing that paying for services is a shared responsibility between the consumer and the AAA.

- The AAA will issue a bill to the consumer for the consumer's co-pay within **30** days from the last day of service or by the last day of the month following the month the service was delivered.

- The bill must note that payment is due upon receipt, and is considered "delinquent" if not paid within 30 calendar days from the date the bill is issued (mailed) by the AAA. The date at which a bill will be considered delinquent must be clearly displayed on the bill, along with instructions for contacting the AAA if payment cannot be made by the specified date.

- If a payment is not received by the due date, the AAA will make direct contact with the consumer or responsible party (by telephone or in person) to determine why there is a payment problem.

- Where possible, the AAA will make an effort to resolve any misunderstanding or payment problems the consumer may have and offer the consumer the opportunity to negotiate a payback schedule for past-due co-payments. The consumer must be clearly informed during this contact that since the co-payment is delinquent; the AAA will need to terminate its agreement to share in the cost of the consumer's services and will terminate services unless payment is received by a specified date (60 calendar days from the initial billing date).

- The AAA must send a second bill with the new date or the date and the amount due if a payment plan has been agreed upon. The bill must also clearly state that payment must be received by the indicated date to avoid service termination.

- If no payment is made by the date scheduled for the AAA to take action, the AAA will again make personal contact with the consumer and mail a written notice. This notice will advise the consumer that the AAA is informing the consumer's service providers that the AAA will no longer be liable for any costs associated with providing services to the consumer after a specified date (90 calendar days from the initial billing date) and advise the consumer that he/she must contact the provider(s) to continue services fully at his/her own personal expense.

- On that same day, the AAA will send a written termination notice containing all of the aforementioned information and clearly provide the date services will no longer be paid for by the AAA. The AAA will also contact the service provider/s to give notice that the AAA will not be participating in the cost of the consumer's care plan after a specified date.

NOTE: Services cannot be terminated if the unpaid cost share is less than 25% of the total care plan cost; however, individuals who have unpaid cost regardless of percentage cannot receive an increase in service.

- Only upon receipt of all cost-sharing payments for all services received may the AAA enter into a new cost-sharing agreement with the consumer for future services. The new cost sharing agreement may provide for shorter time frames for payments to assure the consumer does not become delinquent again in the future.

- The AAA must document in the consumer's SAMS journal all contacts with the consumer or their representative and actions to advise and assist the consumer with payment of their cost share.

- Non-payment of cost share precludes a consumer from receiving service/s at a later time unless and until their cost share payment is paid in full.

Process Standards:

Actions taken to ensure payment of the consumer's cost share of the service costs shall be designed to minimize any embarrassment or distress to the consumer.

- Reminder phone calls to the consumer can only be made during normal business hours; calls to a caregiver or authorized representative may be made after normal business hours if necessary to reach the person.

- These actions must be carried out in as confidential a manner as possible so that information related to the payment status of the consumer is shared only with the necessary AAA staff, the consumer and authorized representatives of the consumer.

- The AAA shall not assign past due cost share accounts to a commercial collection agency.

- The AAA may submit a claim for outstanding cost share balances upon the death of a consumer.

D. Using Revenues from Collected Fees

The AAAs will retain revenues that are collected locally. The AAAs will be allowed to retain a one-year balance of OPTIONS cost sharing revenues. However, the monies collected must be accounted for separately from all other income sources such as consumer contributions. The AAAs will have to track accounts receivable by consumer. Net revenues generated from OPTIONS services cost sharing may be expended only for Home and Community Based Services. The Department reserves the right to offset cost-sharing revenues when determining an AAA's need for funding from the Commonwealth. The AAAs must have written policies and procedures that outline the collection, expenditure, and reporting of OPTIONS cost sharing revenues.

The Aging Quality and Compliance Unit will conduct monitoring of OPTIONS cost sharing revenues.

E. Appeals

Chapter II outlines the Department of Aging procedures for the Hearing and Appeals processes. An adverse action notice is not required to be issued to a consumer when he/she is terminated due to non-payment under Cost Sharing for the OPTIONS program. (See above note for policy regarding termination due to non-payment)