HOME AND COMMUNITY BASED SERVICES PROCEDURES MANUAL

CHAPTER 3 (Program and Requirements)

A. PDA 60+ MEDICAID WAIVER PROGRAM (PDA Waiver)

The PDA Waiver program is a Medicaid home and community-based services waiver granted under the authority of section 1915© of the Social Security Act. It was granted by the Center for Medicaid and Medicare (CMS) to the Department of Public Welfare, Pennsylvania's designated Medicaid agency. The Pennsylvania Department of Aging (PDA) has been designated as the agency to operate and oversee the waiver.

1. Waiver Consumers

Must:

- be age 60 or over.
- Be a PA Resident
- be assessed as Nursing Facility Clinically Eligible (NFCE) as determined by the current assessment process.
- be able to be appropriately served in the community at a cost not to exceed 80% of the statewide average Medical Assistance (MA) payment for nursing facility services in Pennsylvania. The 80% calculation is based on an individual's twelve-month average and includes only the cost of Waiver services.
- meet financial eligibility requirements for participation in the MA Program. The County Assistance Office will make all financial eligibility determinations. **(See Appendix- Financial Status Screening Form)**

2. Medical Eligibility

- The procedures for assessment and care management are contained in **Chapters 1 and 2**. These procedures apply to the PDA Waiver, BRIDGE and OPTIONS programs.
- The MA 51 must be completed annually in order to re-certify the level of care decision. The MA 51 should be retained in the consumer's case file. It is not necessary to submit an MA 51 to the County Assistance Office (CAO) in the reassessment process unless the consumer is found to no longer be Nursing Facility Clinically Eligible.
- If a consumer requests admission to a nursing facility while receiving PDA Waiver services, the AAA will work with the CAO to obtain additional information as requested. In many cases it will not be necessary for the consumer to file a new application (600L). **(See Appendix- PA 600L)**

3. Financial Eligibility

The income limit is equal to 300% of the S.S.I. Federal Benefit rate. The asset limit is $2,000.

a. Managed Care Organizations

- A person enrolled in the PDA Waiver may not participate in a Medical Assistance managed care program. If the applicant is currently enrolled in a managed care organization (MCO), then their coverage will be maintained by the MCO for 30

days after the beginning date of PDA Waiver services. AAA's are to notify the CAO with the start date of PDA Waiver services.

b. General Information Pertaining to Financial Eligibility

- Medical Assistance eligibility entitles the consumer to all of the state plan fee-for-services that are in addition to the PDA Waiver services such as hospital stays, doctor visits, dental coverage, etc. **(See Appendix- Medical Assistance Handbook Release and Medical Assistance Eligibility Handbook)**

- The consumer will not incur charges in conjunction with PDA Waiver services; however, co-pay amounts that are collected as part of non-waiver Medical Assistance services do apply. These co-pay amounts are given directly to the providers. A provider may not refuse to furnish a service even if a consumer does not have the money for the required co-payment when a service is rendered.

- The AAA may choose to arrange for services for individuals who are likely to be eligible while waiting for a confirmed financial determination from the County Assistance Office. This determination may take a maximum of 90 days. If the individual is determined to be financially eligible, then the provider(s) of service(s) will be instructed to back-bill MA for the period that the consumer was presumed eligible. If the consumer is found to be financially ineligible, cost sharing rules described in Chapter 1 of this manual will be applied to costs incurred.

c. Fair Consideration Provisions

- A penalty for the transfer of assets for less than fair market value (also called fair consideration provisions) is imposed on PDA Waiver applicants.

- The CAO does <u>not</u> apply the fair consideration provisions when property is transferred to the applicant's:
    1. Spouse;
    2. Child age 21 or younger;
    3. Child of any age who is blind or permanently and totally disabled based on Social Security Administration requirements;
    4. Sibling who has an equity interest in the property and who lived in it at least one year immediately before the individual applied for the PDA Waiver;
    5. A son or daughter of any age who, for at least two years immediately before the individual applied for PDA Waiver resided in the home and provided care to the individual, which permitted the individual to reside at home.

For more information regarding the fair consideration provisions please refer to the Medical Assistance Nursing Care Handbook section 440.9. Individuals who are denied Waiver services may be served through the OPTIONS program.

d. Estate Recovery

Estate recovery specifies that the <u>estate</u> of a Medical Assistance (MA) consumer who was fifty-five years or older at the time MA was received is liable to repay the Department of Public Welfare for the amount of MA paid for all nursing facility services, HCBS, and related hospital and prescription drug services.

Most estate property is subject to DPW's claim, however, property held by a decedent and another at the time of death as joint tenants with rights of survivorship, or as tenants by the entireties, is not subject to the Department's claim. Information may be obtained at **www.dpw.state.pa.us.** Questions regarding Estate Recovery may be directed to:

The Department of Public Welfare
Estate Recovery Program
P.O. Box 8486
Harrisburg, Pennsylvania 17105-8486
1-800-528-3708

e. Information Regarding Services

The service standards for the PDA Waiver have been included in **Chapter 4** of this manual. The service standards are requirements for the agencies providing the care.

4. Administrative Requirements

a. Consumer Choice

CMS requires that a consumer determined to be Nursing Facility Clinically Eligible (NFCE) and his/ her legal representative be:

- Informed of any feasible alternatives under the waiver; and
- Given the choice of either institutional or home and community-based services.

CMS also requires that PDA provide an opportunity for a fair hearing to consumers who are not given the choice of home or community based services as an alternative to the institutional care, or who are denied the service(s) of their choice or the provider(s) of their choice.

The process for hearings and appeals for PDA Waiver consumers is contained in Chapter 5. There are four forms that must be used (as appropriate) to document freedom of choice and the offering of a fair hearing. These forms must be maintained in the consumer's case file. The Department of Public Welfare handles all hearings and appeals for the PDA Waiver.

- Medical Assistance is the payer of last resort. Care managers are responsible for investigating all other insurance options.

- Regulations for Medical Assistance Hospice Services **(See www.pacode.com/secure/data/o55/chapter1130/chap1130toc.html)** state that recipients may not access other Medical Assistance Program coverage (including the PDA Waiver) for services that are covered under hospice. These services include: nursing care, medical social services, physician services, counseling services, short-term inpatient care, medical supplies and appliances, drugs that are used primarily for the relief of pain and symptom, control related to the terminal illness, home health aide services and physical therapy, occupational therapy, and special language pathology services. Recipients of MA Hospice may access PDA Waiver services that are not listed above as contained in an agreed upon plan of care.

b. PDA Waiver Provider Enrollment

- Staff from the Area Agencies on Aging are acting on behalf of the Department of Public Welfare when they distribute, collect and forward the paperwork for providers to become enrolled and/or certified in the PDA Waiver program. DPW is the final authority regarding enrollment or certification of providers. When a

provider signs the enrollment form and affirmation sheets he/she is "affirming" that his/her agency meets all applicable standards. If the AAA has information to the contrary it should not recommend the provider for enrollment. All pertinent information indicating the decision not to recommend the provider should be documented. The application materials, including the reason for denial should be forwarded to:

Chief, Division of Long Term Care Consumer Services
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

- A letter specifying the reason for denial should also be sent to the agency requesting enrollment/certification. The letter must indicate the right to appeal the decision and all appeals should be sent to DPW at the above noted address.

- All appropriate provider enrollment forms are available at http://www.dpw.state.pa.us/omap/provinf/enrollapps/pdaapp.pdf. **(See Appendix- PDA Waiver Provider Enrollment Forms)**. The forms are as follows:

- Long Term Care Waiver Program Enrollment Information Form (MA49) **(**– Must be sent to the Office of Medical Assistance (OMA).

- Supplemental Provider Agreement for Electronic Media Claim Invoicing – Must be sent to OMA for providers who choose electronic invoicing. **(See Appendix- Provider Agreement)**

- Provider Agreement – Two with original signatures must be sent to OMA.

- PDA Waiver Program Certification Form/Agency Profile – Should be maintained at the AAA. **(See Appendix- MA Provider Certification Forms)**

- PDA Waiver Program Provider Affirmation – Should be maintained at the AAA. **(See Appendix- PDA Waiver Program Provider Affirmation Form)**

- PDA Waiver Program Price Certification Forms – Should be maintained at the AAA. **(See Appendix- PDA Waiver Program Price Certification Forms)**

- The AAA may request additional information from any or all agencies, at their discretion.

c. Rate Structure

See the PDA Contract Procurement Requirement for AAAs for rate setting information**. (See Appendix- APD #00-01-06, PDA Contract Procurement Requirements for the AAA)**

d. Provider Billing

Once enrolled in the Medical Assistance system the provider agency will receive a PDA Waiver Services Handbook from the Office of Medical Assistance, which will include a billing section to guide them through the billing process. PDA Waiver procedure codes are in the Appendix. **(See Appendix- PDA Waiver-Procedure Codes for PDA Waiver Services)**

e. Provider Quality Assurance

AAAs are responsible for ensuring the quality of the PDA Waiver providers. PDA Waiver providers must comply with all reporting requirements as specified by the AAA. Each AAA should request and expect to have submitted upon request information necessary to adequately monitor and evaluate the providers.

Reports are not required by the HCBS Procedures Manual however the following is a list of reports that are currently being required by some AAAs:

- Monthly reports for all "hands-on" services.
- Quarterly reports regarding staffing patterns turnover and training information.
- Daily consumer work sheets for Home Health services.
- It is also expected that AAA's will make an annual on-site visit to each provider. In the event that a provider is serving consumers in more than one service delivery area AAAs may make arrangements to alternate their visits. Arrangements are suitable as long as there are annual visits to each provider.

f. Components of the On-Site Audits and On-Going Monitoring

In addition to the annual on-site review, provider monitoring will be an on-going activity and will include the following:

- Time slips must be reviewed and compared to the times authorized on the care plan.
- Times specified on the care plan (not the inflated amounts as allowed for MAMIS data entry) must be compared to times indicated on the signed time slips. These totals must also be compared to amounts billed and paid. This information is available on the paid claims history file in MAMIS. Providers have up to 180 days to bill MAMIS.
- Monitoring must be conducted to ensure that the providers are meeting all of the service standards.
- Direct observation by AAA Care manager of service provision in the consumers' homes must be a part of the monitoring plan.
- AAA staff must meet with the providers on a regular basis. Care managers and procurement staff should be evaluating providers in terms of service delivery, responsiveness, cooperation, reporting, etc.
- AAA staff must assure that the agencies understand the clinical and administrative requirements of the program.
- The providers' clinical records must be reviewed.
- The providers' usual and customary charges and Medicare rates must be verified during an on-site review.
- Consumer complaints must be documented and maintained. Complaints may be obtained from a consumer satisfaction survey, direct conversations with the care managers, or from the ombudsman.

g. Consumer Satisfaction Surveys

Provider monitoring must include a consumer satisfaction component. It is preferred that satisfaction surveys are conducted every six months, however, it is required that they be conducted annually. The following are guidelines for designing and administering consumer satisfaction surveys:

- Surveys should be conducted in varying ways and not always by the same method. Telephone contact, in-home visits, and direct mailings can all be useful means for collecting information.

- AAAs may obtain a contractor to conduct the surveys. Additionally, AAA's may use in-house staff or utilize local colleges and universities.
- All surveys should strive for a 90 percent confidence interval.

- Individuals collecting the information should be trained in appropriate interviewing techniques.

- Providers should be informed regarding survey results.

- Consumer focus groups may be used as a complement to a well designed survey but should not be construed or presented as objective. Information from focus groups is anecdotal and usually cannot be generalized to the entire population.

h. Provider Decertification Procedures

The following steps should be taken when provider agencies do not meet the standards specified under the PDA Waiver:

- Deficiencies must be documented.

- Requests for corrective actions must be submitted to the provider agency.

- If a provider agency fails to take appropriate corrective actions, the AAA may begin de-certification procedures by informing the provider in writing of its intent to recommend decertification to the Office of Medical Assistance and the reasons for its intent. It must notify the provider of its right to appeal and provide the address for submitting appeals.

Chief, Division of Long Term Care Consumer Services
Dept. of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675

- A copy of the letter to decertify must be sent to the address noted above.

i. AAA as Provider of PDA Services

- AAAs may not directly provide home and/or community based services other than assessment and care management. If compliance with these policies will have a negative effect on the AAA local service delivery system, the AAA will have an opportunity to request a waiver from the Secretary of Aging. Such waivers will only be approved when the Secretary agrees there is clear and convincing evidence the waiver is necessary to accommodate unique local circumstances. When a AAA wishes to become a MA certified provider for Waiver services, in addition to submitting the waiver request described in the previous paragraph, the following documentation must also be submitted:

- Completed MA-49 and all other required enrollment forms such as signed provider agreement form(s), agency profile, appropriate provider affirmation form(s), price certification form(s) and agreement for electronic claim invoicing (if requested).

- Rates that are being requested.

- Methodology that was used for arriving at rates.

- After the first year of enrollment, all annual rate adjustments must be submitted to PDA for approval.

- The Contracts Management and Appeals Division will notify the AAA in writing regarding its recommendation for enrollment. If it is decided to enroll the AAA the appropriate forms will be forwarded to DPW, Bureau of Long Term Care.

j. Fraud

- If an AAA becomes aware of a situation in which a provider agency is billing for services that have not been rendered, the AAA will report this to the Department of Public Welfare. This would include instances where consumers have participated in signing for services that have not been received. All reports must be made in writing and should contain:

  1. Name and telephone number of the person filing the report.

  2. AAA name and location.

  3. Provider name and telephone number and MA Provider ID number.
  4. Consumer's name and consumer identification number, telephone number and address.

  5. Description of the alleged activities. The report must be complete. Report may be sent or faxed to:

Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Attention: Bureau Director
Or
FAX (717) 772-4655

Direct questions to (717) 772-4602. The AAA should <u>not</u> notify the provider that a report is being filed.

k. Care Plan Payment Authorization Via Mamis

- Instructions regarding negotiating MAMIS are contained on the AS 400 in the **AAA excel folder** in **MAMISIN1** and **MAMISIN2**.

l. Slot Allocation

- When an AAA reaches its' slot allocation, staff must submit a request to the PDA Division Chief of Managed Care for additional slots based on PA 162's received by the AAA from the CAO indicating that consumers are eligible for the Waiver.

m. PDA Waiver Services In Domiciliary Care

- Residents of Dom Care are eligible to receive PDA Waiver services as appropriate for their plans of care. All requests to serve residents must be submitted in writing to the Secretary of Aging. PDA Clinical Consultant will be involved in the process, as they will be exercising professional judgment to make a recommendation to the Secretary concerning the appropriateness of the placement. Requests should include how the individual fits the criteria for clinical eligibility for the PDA Waiver and why the individual's needs can best be met in the Dom Care setting.

NOTE: In the event that there is a conflict between the procedures described in any of the Chapters contained in this Manual and the regulations as specified in **Chapter 3, E.** - Domiciliary Care Services for Adults, the STRICTER of the two standards will apply.

n. Inter-County Transfer of PDA Waiver Consumers

If a care manager is notified that a consumer intends to move to another county, the following protocol applies:

- The current AAA care manager should contact the AAA at the new address. The MA-51, the Consumer Determination Report, and the current Care Plan information should be forwarded to the AAA and the CAO must be notified. The current Care Plan authorization must be closed effective the date of the move.

- The consumer must be served in the new county. The consumer will take his/her slot into the new county. Both counties must contact the Chief of the Division of Managed Care, if needed, following the procedure outlined under Slot Allocation above.

- Whenever possible, the care plan must be duplicated exactly in the new county.

B. THE BRIDGE PROGRAM

The Bridge program provides an alternative to institutional care for older Pennsylvanians who are ineligible for the PDA Waiver program due to excess resources (assets). Services provided under the Bridge are identical to those provided under the PDA Waiver. The goal is to provide these services in the home or other community setting, while reducing the excess resources to the point where the consumer will be financially eligible for the PDA Waiver. Once the consumer is determined eligible for the PDA waiver the consumer will be placed in a guaranteed waiver slot. **(See Appendix- Bridge Operations Memorandum- Administrative OPS0011206)**

1. **Bridge Cost Sharing Scale** – The cost share of services to consumers participating in the Bridge program is 50% of the monthly cost of services received. The consumer will decide whether to use his/her r income or resources to pay the 50% share.

   a. The AAA will recommend to the consumer that the 50% cost share come from resources. The consumer may choose to pay some or the entire 50% fee out of their income.

   b. The service plan cost cap is identical to that in the PDA Waiver program.

2. **Resources** – Only the resources of the Bridge consumer will be considered. The County Assistance Office will determine financial eligibility. The resource limit for the Bridge program is $40,000. Estate recovery does not apply for services received in the Bridge program.

3. **Income** – Only the income of the Bridge consumer is considered for eligibility. Income amounts may be averaged over a 12-month period where monthly variations exist. The AAA's role is to assist the consumer in identifying and gathering verification of their income.

   a. The following types of income and necessary verification are to be counted and documented for the CAO's eligibility determination:

   - Social Security benefits
   - Wages, salaries, tips
   - Private Pensions, annuities, and union benefits
   - Government retirement pensions
   - Veteran's pensions
   - Railroad retirement, Disability
   - Dividends or interest from stocks, bonds, savings, etc.
   - Alimony
   - Boarder/Roomer or Rental income
   - Public Assistance or SSI grants
   - Net self-employment income
   - Unemployment compensation
   - Estate and trust funds
   - Black Lung Benefits
   - Workman's Compensation payment
   - Property tax and rent rebates

   b. The following types of income will not be considered as income for the cost sharing program:

   - Low Income Home Energy Assistance payments
   - Food Stamps
   - Medicare, Medicaid, FCSP, and PACE benefits
   - The first $5,000 of the total of death benefit payments received upon the death of each person from whom the benefits may be due.
   - Income tax refunds

   c. Consumers who refuse to disclose income and/or resources, fail to cooperate with the verification process, or refuse to enter the program will be ineligible for Bridge services and be liable for 100% of the cost of their services.

   - At its discretion, the AAA may develop a care plan providing limited services to consumers who decline to participate. Expenditures on behalf of this consumer will be limited to no more than $200.00 per month for services. Consumers will cost share at the rate to be determined by the OPTIONS cost sharing scale. **(See Cost Sharing policy - Chapter 1, D)** The AAA will determine what services, if any, to include in that $200 limit. Services that may be considered for the limited level of services include: Home Delivered Meals, Assessment, and Care Management. This section does not limit services provided as a result of a protective services investigation.

   - The AAA will assist the consumer in monitoring the spending of their resources to ensure a smooth transition into the PDA Waiver.

   Note: Actions taken to ensure payment of the consumer's share of the service costs will be designed to minimize any embarrassment or distress to the consumer. 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 will not assign past due cost share accounts to a commercial collection agency

4. **Appeals** – Termination of services for non-payment is not appealable. Appeals may be made based only on alleged incorrect application of Bridge cost sharing rules.

C. OPTIONS

Home and community based services funded primarily through the Aging Block Grant. Appropriate care alternatives are identified and discussed with the consumer to determine preference. Care management is provided to monitor service delivery, re-determine need, and provide advocacy and support.

D. FAMILY CAREGIVER SUPPORT PROGRAM (FCSP)

The Family Caregiver Support Program (FCSP) is designed to assist family and other adult primary caregivers caring for functionally dependent older persons and cognitively impaired adult relatives. Both the primary caregiver and the care receiver are service recipients and share the designation as "consumer". The program's goal is to reduce caregiver stress and burden through benefits and resource counseling, access to support groups, care giving skills training and education, support and financial assistance with expenses incurred in purchasing care giving related services (including respite), supplies, durable goods, home modifications and assistive technology. The FCSP cost sharing guide applies to consumers in this program. A standardized scale is used to determine the amount of the consumer cost sharing. **(See Appendix- FCSP Cost Sharing Guide)**

Applicants already enrolled in or new applicants for the Family Caregiver Support Program (FCSP) who are determined to be NFCE but are **NOT** interested in obtaining other services in conjunction with the FCSP are exempt from mandated guidelines for participation in the PDA Waiver or BRIDGE Program. However, at such time the caregiver is interested in obtaining supplemental Home and Community Based Services (HCBS), is age 60 or older and has been assessed and found nursing facility clinically eligible, then the HCBS Application Process applies. **(See Chapter 1- Section C. Outcomes)**

The FCSP, consumer-driven and flexible, is meant to support the primary caregiver and family in ways that are specific to their individual needs and preferences. An expense can be considered for reimbursement if it can be justified as a related care giving supply, good and/or service. It allows more options for respite care to meet the individual needs of each consumer (i.e. hiring a neighbor or friend rather than a staff person from an agency to provide the service).

The FCSP is governed by both Pennsylvania statute (62 P.S 3061-3068,Pennsylvania Code: Title 6, Aging, Chapter 20: Family Caregiver Support Program) **(See Appendix- FCSP-Pennsylvania Code)** and Federal law (Older Americans Act, As Amended in 2000: Title III (E), (National Family Caregiver Support Act, Subpart 1, Caregiver Support Program, Sections 372-374). **(See Appendix- FCSP-Part E- National Family Caregiver Support Program)**

Significant requirements and provisions in the Pennsylvania FCSP statute:

- Functionally dependent older care receiver must be 60 years of age or older and must require assistance with one (1) or more activities of daily living (ADL).
- Primary caregiver and care receiver must be related and live in the same household.
- Serves adult care receivers with chronic dementia such as Alzheimer's disease in addition to over age 60 functionally dependent persons.

Significant requirements and provisions in the National FCSP Act:

- Functionally dependent older care receiver must be 60 years of age or older and have two (2) or more ADL deficiencies to receive respite and additional supplemental services.
- No requirement for primary caregiver and older care receiver (age 60 and older) to be related or live in the same household.
- No provisions for care receivers between the ages of 18 to 59 (with or without dementia). All care receivers must be age 60 or older or age 18 and younger.
- Provides services for older (age 60 and above) related primary caregivers of children age 18 and younger, living in the same household with priority given to those older related primary caregivers of children with mental retardation and/or developmental disabilities.

For the purposes of the FCSP, primary caregiver is defined as the one identified person who has assumed the primary responsibility for the provision of continuous care needed to maintain the physical and mental health of the care receiver. In addition, the primary caregiver provides daily, hands-on personal assistance and supervision (even after FCSP services begin) and receives no personal financial compensation for care provided.

Eligibility for the FCSP reimbursement is based on the total household income of the care receiver. If income is above 380% of poverty, 100% cost sharing for hard services only (this includes respite) will be incurred.-**(See Appendix- FCSP Cost Sharing Guide)**. Assessment, care management, training, education, counseling, support resources, information and assistance etc., will be provided at no cost.

For most FCSP consumers, it is recommended that the $200/month cap be maintained. Recognizing that there are some who would benefit from a higher cap, it can be raised to $500/month, with the provision that an aggregate caseload cap is maintained at no higher than $300/month. When authorizing services, there must be documentation justifying services that exceed the recommended cap. Both federal and state FCSP funds may be used for one consumer, as long as eligibility criteria are met, but the AAA may not exceed $200 of state FCSP funds per consumer, per month. Also, only one reimbursement per primary caregiver/care receiver match is allowed. For example: one primary caregiver, one care receiver, one reimbursement. If there are two care receivers and one primary caregiver, the one reimbursement rule still applies. There is only one match of caregiver and care receiver and there can only be one primary caregiver.
The one time $2000 reimbursement for assistive devices and home modifications remains the same for all consumers receiving FCSP funds (federal, state or combination of both). Consumers may receive services funded with both FSCP and Aging Block Grant the latter must be cost shared using the OCSS. When total care plan costs exceed the OPTIONS care plan cap the consumer may no longer participate in the FSCP. Cost sharing policy for care plan costs in excess of the cap will apply **(See Chapter 1).**

Special instructions and sections for assessment of the caregiver are contained in the COAF. An assessment supplement is not required. A full COAF is not required for the caregiver. The full COAF is to be completed for the care receiver. The information gathered through completion of the COAF will be the basis for the decision that the consumer's needs can best be met through the FCSP. FCSP priority will be based on FNM scores **(See FNM Chapter 1)**.

All AAAs will offer a grand parenting/intergenerational care giving type program, which meets the federal guidelines. Though it is not mandated that the grandchild have a disability or chronic illness, it is required that priority be given to older individuals in greatest social and economic need caring for a child/children with mental retardation and/or developmental disabilities. AAAs that already have existing intergenerational care giving programs can expand and/or enhance these using federal dollars, as long as guidelines are followed. (A list of frequently asked questions can currently be found at http://www.aoa.gov/Oaa/status/faq-caregiving.html) For those who would like assistance with the development of such a

program, it is recommended that local MH/MR, ARC and/or UCP offices be contacted for information and ideas for programs as well as information on local needs in the area. It is also recommended that AAAs partner with these and other similar local agencies in the development and implementation of the programs.

Points to consider and keep in mind when developing new programs and/or using federal dollars in existing intergenerational care giving programs:

- Information/results regarding needs assessments and what AAAs deem appropriate to address needs must be documented.
- Demographic standards for eligibility must be in place with supportive documentation provided.
- Program justification must be fully documented
- Primary caregiver must be age 60 and above.
- Primary caregiver and care receiver must be related (grandparent or older relative) and must reside in the same household.
- Caregiver must be "primary" caregiver.
- Care receiver must be age 18 or younger.
- Priority must be given to those older relative caregivers providing care to children with mental retardation and/or developmental disabilities.

No more than 10% of federal dollars can be used to provide these services. The 10% is at the state level, so some AAAs may do more or less than others, as long as the state level of expenditure for these programs remains at 10%.

E. PERSONAL CARE/DOMICILIARY CARE HOMES (PCH/DC):

Personal Care Home are regulated by PA Code- Title 55, Public Welfare, Chapter 2620: Personal Care Home Licensing. **(See Appendix- Personal Care Home Licensing- Pennsylvania Code)** Domiciliary Care Homes are regulated by PA Code- Title 6, Aging, Chapter 21: Domiciliary Care Services for Adults **(See Appendix- Domiciliary Care Services for Adults- Pennsylvania Code).** The eligibility requirements for the Special State Supplement for PCH/Dom Care are found in the Medical Assistance Handbook for Chapter 391 issued by the Department of Public Welfare and found in the Appendix. **(See Appendix- PA 1-D- Application for Domiciliary Care Supplement)**
Social Security Administration is responsible for determining financial eligibility.

An applicant for the Special State Supplement must complete the appropriate sections and sign either PA-761 Application for Personal Care Supplement or PA I-D Application for Domiciliary Care Supplement. The AAA must date stamp these forms with the date the signed application was received. Form 761 is date stamped on the bottom of page one in the appropriate area (#4). Form PA 1-D should be date stamped on the bottom of page two in the blank area.

AAA's are permitted to accept and date stamp a Faxed PA-761. However, both the Faxed and original PA-761 must be submitted to the CAO along with the MA-51 and Consumer Determination Report following the assessment.

In conjunction with the completion of the PA-761 or PA 1-D, the AAA may request that the applicant complete form SSA 1610 Public Assistance Information Request. The form should be completed as outlined in the MA Eligibility Handbook. In addition, the request for benefits and consumer signature should be annotated in the Remarks section. When submitted to the Social Security Administration (SSA), this form can act as the application for a determination of financial eligibility. The AAAs must establish that the applicant is receiving SSI or has completed the application for the determination of financial eligibility, which is made by SSA.

This can be done by phone contact to SSA or other locally developed procedure. To meet this requirement, a copy of the signed SSA 1610 may be faxed to SSA, if the local SSA approves this procedure. The AAA is only to establish that the applicant is already receiving SSI or has made application for the State Supplement by completing an application at the local SSA office.

Following the completion of the application forms, the applicant must have a (MA-51) Medical Evaluation form completed by a licensed physician and submitted to the site within 60 days of the examination.

The assessment, COAF, is to be completed and is to include the Decision Narrative.

Following the completion of the assessment, the assessor is to complete a Determination Report.

It will also be necessary for the AAA to have the provider sign the PA-761 or PA 1-D to verify the date the applicant entered the home. The PA-761 has been revised to include an area in section #3 where the date that the consumer entered the home can be added. As per the MA Eligibility Handbook, the AAA is to forward the PA-761 or PA 1-D, the Consumer Determination Report, the MA-51, the SSA 1610, and the Certificate of Compliance to the CAO. Copies of this information should be retained in the consumer record.

There will be cases when the AAA receives a completed PA-761 or PA 1-D prior to receiving the MA-51. The AAA must notify the consumer in writing of the date that the required information is due and the consequences if the deadline is not met. The established date, i.e. the date the MA-51 is due, is either 60 days from receipt of the PA-761 (or PA 1-D) or a later date if the consumer makes a request. If the consumer does not submit the MA-51 by the established date or contact the AAA to establish a new date, the AAA is to notify the CAO. The AAA is to forward to the CAO the PA-761 (or PA 1-D) and a copy of the notification sent to the consumer with a notation that the MA-51 was not received by the established date. The CAO will formally notify the consumer that their application has been rejected.
The assessor may release a copy of the assessment information to the home provider with consent of the consumer. The AAA is responsible for annually recertifying consumers who wish to continue to receive the Special State Supplement for PCH/Dom Care. The AAA must notify the consumer and/or home provider two months prior to the annual recertification date to allow time for the completion of the new MA-51. The AAA must develop a system to track when the recertifications are due. Specific procedures are outlined in the RECERTIFICATION Section – **Chapter 1**.

F. NURSING FACILITY PLACEMENT

- The MA-51 and PASRR-ID must be obtained prior to completion of the assessment (NF OAF or NF Express Screen) if the request/referral is specifically for NF placement.

- The MA-51 is a medical evaluation that must be completed and signed by a licensed physician; the individual to be assessed or designated representative is responsible for providing the completed MA-51. If the MA-51 provided is incomplete and/or does not provide sufficient information, it is to be returned either to the individual (or designated representative) or directly to the physician responsible for completing the form.

- AAA Care managers do not write on the MA-51 except for items #21.A, #21.B, and #22 (Signature). Instructions for completion of the MA-51 are found in Appendix. **(See Appendix- MA-51 Instructions and Form)**

- For OBRA NF applicants see the OBRA section in this Chapter for instructions on required OBRA forms and their completion and routing and special instructions regarding the MA-51.

- Following the assessment process, if the consumer is a regular (not OBRA) NF applicant, the original MA-51 is forwarded to the CAO; the original Determination Report is sent to the consumer or designated representative, and a copy to the CAO; a copy of each of these forms is to be retained in the consumer's AAA record.

- If applications are being made for retroactive reimbursement beyond thirty days, AAA's will notify their respective program consultant when concerned about a developing pattern of requests for retroactive reimbursements. The AAA will notify the program consultant when they are seeking Department intervention.

G. OMNIBUS BUDGET RECONCILIATION ACT (OBRA)

A Federal statute, the Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990, requires States to implement a preadmission screening and annual resident review (PASARR) of individuals, of all ages, with mental illness, mental retardation or other related conditions prior to admission to nursing facilities that are Medicaid certified. The purpose of the statute is to prevent the placement of individuals with the above listed conditions in a nursing facility unless their medical needs clearly indicate that they require nursing facility services (NF) and the NF can provide specialized services as identified. **(See Appendix- [MH] Mental Health Bulletin, OMH-93-12 and MR Bulletin 93-30).**

The Pennsylvania Department of Public Welfare, through its Office of Mental Health, Office of Mental Retardation and Office of Social Programs, is the identified state Medicaid unit responsible for determining if a consumer with a target diagnosis requires NF services and/or specialized services for their condition. The various Program Offices review documentation provided by designated evaluation agencies throughout the Commonwealth in order to make a determination of need. The Pennsylvania Department of Public Welfare (DPW) through the Office of Medical Assistance Programs (OMAP) designated the AAAs as the evaluation agencies responsible for the pre-admission screening of the PASARR process. All of the regulations for the process are promulgated by DPW, therefore this chapter will be dedicated to providing a basic outline of the process as put forth by DPW. The DPW Bulletins and DPW forms in the **appendices** contain the program requirements necessary for conducting the OBRA process.

COMPONENTS OF THE OBRA PROCESS

PASRR-ID Identification Form (PASRR-ID) - The form is designed to evaluate whether a consumer, requesting admission to a nursing facility, is subject to the determination requirements of the OBRA or document the basis for exempting the individual from the process. Completion of this form is critical to determining the direction of the assessment process. All referrals for a preadmission assessment must contain a completed ID. The OBRA process will address individuals identified as part of one or more of the target group(s), (mental illness, mental retardation or other related condition). PASRR-ID's do not need to be completed for PDA Waiver consumers unless institutional respite is a service that he/she will be receiving as part of the PDA Waiver plan of care. In that situation a completed PASRR-ID is required by the Nursing Facility (designated provider of respite) at the time of admission; the "Exceptional Admission" section can be signed by the AAA caseworker (assessor) for PDA waiver respite; it is not required that it be signed by a physician. Institutional respite is limited only by the 80% cost of the care plan cap. **(See Appendix- PASARR- ID Instructions and Form)**

Special Concerns

***Exceptional Admission**:* An individual with a target diagnosis that enters a nursing facility based on an ID exemption as indicated in Section V of the form represents an exceptional admission. There are four exceptions for identified consumers that require nursing facility services: exempted hospital discharge for convalescent care (not more than 30 days), respite care (not more than 14 days), persons requiring emergency placement, as certified by the AAA Protective Services Unit (not more than 30 days) or persons in a coma or functioning at a brain stem level. Only under these circumstances can an AAA exempt an individual with a target diagnosis from the OBRA process.

***Dual and Multiple Target Diagnoses**:* Special protocols have been established for interoffice collaboration on the performance of pre-admission screenings and annual resident reviews as required by OBRA of 1987. This protocol was developed because AAAs have identified individuals who may be appropriately served by more than one program office. The protocol provides a standard guideline for the assignment or reassignment of people with multiple needs to the lead program offices. (**See Appendix- Protocols for Interoffice Collaboration on OBRA Pre-Admission Screening/Annual Resident Review (PASARR).**

- Medical Evaluation (MA-51) - The physician completes this medical evaluation form as part of the referral process for preadmission assessment or for possible placement in a Medicaid certified nursing facility. Office of Social Programs, Office of Mental Health or Office of Mental Retardation will review and sign the MA-51 as part of the final OBRA determination process. **(See Appendix- MA 51 Instructions and Form)**

- PASARR Screening Instrument (PASARR-EV) - The PASARR-EV is used by the AAA to gather additional information and confirm the target diagnosis. The form also allows the evaluating agency to again consider exceptional admission of a consumer with a target diagnosis. **(See Appendix- PASARR-EV Preadmission Screening Instrument for Compliance with OBRA)**

- Assessment Forms (COAF, NF OAF, and NF Express Screen) - Standardized forms used to assess OBRA individuals seeking nursing facility placement. The entire assessment form is forwarded to the appropriate program office in accordance with this chapter. **(See Appendix)**.

- Decision Narrative - This page summarizes the level of care decision process and can be found in the last pages of the COAF and NF OAF

- Transmittal Form - Two types of this form are currently being used for the transmission of information from the AAA to the Program Offices or County MR Office. The transmittal form relays the AAAs recommendation regarding the consumer's need for nursing facility services and need for specialized services. The form must accompany all of the initial OBRA documentation sent to the Program Offices or County MR Office. **(See Appendix- Transmittal From Evaluation Agency to Program Office, and Transmittal – Preliminary Evaluation Report Recommendations for the MR Target Population)**

Special Concerns:

- ***MR Transmittal Form**:* A special transmittal form required by the Office of Mental Retardation for transmission of information to the County MR Office. **(See Appendix- Transmittal-Preliminary Evaluation Report Recommendations for the MR Target Population)**

    - A copy of the form must also be forwarded to the Regional Program Office.

- ***Concurrence / Non-Concurrence Form***: As part of the package of information sent to the County MR Office, the AAA must also attach this form. The form should be completed by the county MR Office and a copy sent to the AAA. **(See Appendix- County Mental Retardation Office Concurrence / Non Concurrence Form)**

- Notification of the Preadmission Screening Program (PASARR-YN) - The PASARR-YN is generated by the Program Office to notify the consumer and the AAA of its final determination. The form identifies whether the consumer requires a nursing facility level of care and if specialized services for either mental illness, mental retardation or other related conditions is required. **(See Appendix- PASARR-YN- Notification of Preadmission Screening Form)**

- Your Right to Appeal and to a Fair Hearing (PASARR -RA) - Along with the PASARR-YN, the PASARR-RA is sent to consumers by the Program Office as a notification of their hearings and appeals rights under the OBRA process. **(See Appendix- PASARR-RA- Your Right to Appeal and to a Fair Hearing)**

- Request for Verification (PASARR-OK) - Providers may request verification of the PASARR-YN from the evaluation agency indicated on the form, but must include the control number indicated on the PASARR-YN in any such a request. **(See Appendix- PASARR- OK- Designated Evaluation Agency)**

- Consultations - Psychological, psychiatric, neurological and other evaluations can all be components of the OBRA process. These evaluations and other documentation may be required or requested by the various Program Offices.

- Documentation – The AAA, in accordance with the PDA General Terms and Conditions of the Aging Block Grant, must maintain all information used in both the formulation of a recommendation by the AAA and the determination by the Program Office

GENERAL OBRA PROCESS

The following process can be used only as a general guideline because a number of variables can impact on the process, (e.g. Program Offices or County MR Office may request additional information, a change in the identified primary target condition, refusal of specialized services, etc.).

STEP 1

Referral to the AAA - Required forms:

a. PASRR-Identification Form (PASRR-ID)
b. Medical Evaluation (MA-51)

STEP 2

Review of MA-51 and PASRR-ID by the OPTIONS/AAA site - Possible outcomes:

a. PASRR-ID does not identify any target condition - continue as a regular assessment.
b. PASRR-ID identifies target condition - continue as an OBRA assessment.
c. PASRR-ID identifies a target condition and a reason for an exceptional admission - continue as a regular assessment.
d. MA-51 or another source of information indicates a target condition not addressed on PASRR-ID - continue as an OBRA assessment.
    - Return to referral source for correction.
    - Complete a new PASRR-ID.

NOTE: In a, b, and c above, it is assumed that the PASRR-ID is correct.

STEP 3

Completion of the preadmission assessment - Required forms:

a. Comprehensive OPTIONS Assessment Form (COAF), Nursing Facility OPTIONS Assessment (NF OAF) or Nursing Facility Express Screen.
b. PASARR-Evaluation Form (PASARR-EV).
c. Request consultant involvement (as necessary)
   - Consultants can review documentation to determine the appropriateness for or type of specialized services required.
   - Consultants can conduct evaluations to determine the appropriateness for or type of specialized services required.

STEP 4

Recommend an appropriate level of care and/or need for specialized services - Complete the following required forms:

a. Decision Narrative.
   - Include a description of specialized services recommended along with justification of NF services.
b. Transmittal Form.

STEP 5

Information and forms that are required to be sent along with the transmittal to the appropriate Program Office, (a person with mental illness) Office of Mental Health and Substance Abuse Services (OMHSAS), (a person with another related condition) Office of Social Programs (OSP) and (a person with mental retardation) County Mental Retardation Office (County OMR):

a. PASRR-ID.
b. Medical Evaluation (MA-51 - unsigned by OPTIONS/ AAA site.)
c. PASARR-EV.
   - Include any information/consultations obtained to document the need for specialized services on the PASARR-EV.
d. Copy of the Assessment Form (COAF, NF OAF or NF Express Screen).
e. Decision Narrative.
f. Transmittal form with recommendation.
g. Other relevant information.

STEP 6

OBRA process complete when the agency receives a determination from the Program Office (PASARR-YN).

NOTE: AAA should review each case individually and contact the appropriate Program Office with any question about what information should be included in the transmittal. As always, you should contact your Aging Clinical Consultant with any questions regarding this process.

H. PROTECTIVE SERVICES

Information regarding PS is set forth in the PS regulations, Title 6 – Aging, Department of Aging (6 PA Code Ch 15) Protective Services for Older Adults (32 PA Bulletin 2412), Older Adults PS Self-Study Manual, APD's and policy updates. **(See Appendix- APD #00-24-01-Protective Services)**

NOTE: Protective Services consumers or consumers at risk of becoming PS due to domestic violence, abuse, neglect, exploitation or abandonment, who need a level of care determination and/or community based long term care services must receive a COAF assessment in addition to completion of required PS forms. If receiving PS services only, a COAF is not required. Once the community services are implemented, the PS case can be closed, if appropriate, and transferred to care management for ongoing services. This is to prevent PS consumers, and those at risk of becoming PS, from being placed on a waiting list for community services, as it may have been lack of community services that precipitated the need for PS services originally.

1. Report of Need

The Report of Need is an intake form completed by a trained individual to include enough information so that the intake worker, and subsequently the protective service worker, can identify and support the referral category assigned to each case:

- Emergency
- Priority
- Non-Priority
- Another PSA
- No Need for Protective Services

The intake worker must satisfy the following requirements when completing the Report of Need form:

- Complete all sections of the form
- Complete all sections in a manner that, as a whole, will identify and support the assigned category.

The intake worker cannot expect the reporter to have an understanding of the Older Adult Protective Service Act (OAPSA) or casework for the elderly. The intake worker must therefore ask probing questions to identify what the reporter is alleging, the presence or absence of risk, the older adult's environment and any other pertinent information that may help determine the appropriate referral category.

The "Problem" section of the form should clearly indicate the type and extent of risk associated with the need for protective service intervention. The intake worker must accurately record the information obtained from the reporter on the Report of Need form so that the protective service worker will be able to accurately change or confirm the referral category. The intake worker may make some additional follow-up calls to complete the form (re: to obtain addresses or phone numbers), but must not make additional calls to evaluate risk as doing so constitutes the initiation of an investigation that the worker may not be qualified to conduct.

The intake worker should avoid the following terminology in the "Problem" section of the form as it does not clearly identify risk:

- Older adult lives alone and is at risk. Investigate for self-neglect.
- Older adult lives in poor conditions. Investigate for self-neglect.
- Older adult does not take medications and does not eat well. Investigate for self-neglect.

The following terminology would be more appropriate:

- The older adult lives alone, has no heat, his lips are turning blue, breathing is labored, and it is very cold in the house. The older adult refuses to leave the

home. This older adult may be experiencing hypothermia, requires medical treatment and emergency energy assistance.

- The older adult lives in deplorable conditions and there are signs of rodent and insect infestation. The older adult has numerous bite marks and appears extremely confused. The only food available is rotten and moldy. He is lying in his own bodily waste. Investigate for self neglect to determine the extent of medical and environmental needs and ability to obtain required help. Investigate for self-neglect and to determine the extent of insect infestation.

- The older adult is a brittle diabetic. He is refusing to take insulin or seek medical attention. The older adult is not following his diet; his last blood sugar was 532 and he is exhibiting signs of diabetic shock. Investigate for self-neglect to determine the possibility of a medical crisis and need for intervention.

The second set of examples clearly identifies the risk to the older adult and suggests the need for a protective service investigation.

The protective service worker, upon receipt of the Report of Need, must review the document and decide if the referral category should be changed or confirmed. The worker must make this decision immediately and base it solely on the information documented in Report of Need. Any additional phone contacts or field visits would constitute the initiation of an investigation that worker must complete in its entirety within the guidelines of the Older Adult Protective Services Act.

Under no circumstances should a protective service worker receive the Report of Need, make additional calls or home visits, and classify the case as no need by changing the category on the report to "No Need for Protective Services." It is required that the case be fully investigated and then classified as unsubstantiated if it is found the older adult does not fit the criteria of an older adult in need of protective services.

2. Protective Service Investigation

It is first very important to note that this process is not an assessment or any other type of casework; it is an investigation. The protective service worker is responsible for determining by a preponderance of the evidence if the allegations in the Report of Need are accurate or if there is any other reason why the older adult may fit the criteria of an older adult in need of protective services as defined in the Act. If by a preponderance of the evidence the protective services worker's investigation does confirm the details of a report or determines that the subject of the report is an older adult in need of protective services, the report shall be classified as a substantiated report. It is also important to note that confirming the allegation(s) does not by itself require the case to be classified as substantiated. Confirming the allegations would warrant substantiation only if the older adult fits the criteria for an older adult in need of protective services when the "abusive action" took place.

There are three very important issues regarding a Protective Service Investigation:

- Although the older adult has the right to refuse to participate in an investigation, the protective service worker must complete the investigation in a manner that will satisfy the intent of the Older Adults Protective Services Act and provide sufficient information to determine the final classification. The Department of Aging (PDA) advocates the client's right to self-determination. PDA recognizes that there are <u>rare</u> occasions when a protective service worker may find an older person who presents as a reliable reporter, requests a termination of the investigation, or

claims the allegations are not true and there is nothing to support that the older adult may fit the criteria of an older adult in need of protective services. On the rare occasions that this occurs, the protective service worker may terminate the investigation after obtaining written confirmation by a supervisor trained in protective services and written acknowledgement by the AAA Director. This "abbreviated investigation" is addressed at the end of this section.

- The protective service worker is not required to obtain written or any other form of permission, to interview friends, relatives, neighbors, and anyone else pertinent to the investigation.

- In most cases, PDA will not consider investigations restricted to interviews with only the older adult (or the older adult and the alleged perpetrator) as sufficient within the guidelines of Older Adults Protective Services Act. Protective service workers have a limited caseload that affords them sufficient time to conduct a thorough investigation. It is understood, however, that there are older adults that are so isolated that it is impossible to locate significant others to interview. In these circumstances, the Protective Service worker should clearly document his/her effort to conduct an in-depth investigation and clearly outline the rationale of his/her conclusion.

There are several reasons why an older adult and the alleged perpetrator(s) are considered poor reporters:

- The older adult may have difficulties with cognitive functioning.
- The older adult may not want to implicate the perpetrator/relative out of fear, dependence, etc.
- The perpetrator may be threatening the client.
- Perpetrators rarely implicate themselves.

Every case is different and it is not possible to outline a specific process for conducting a protective service investigation. The intent of this section of the manual is to establish a minimum standard for AAA to model its performance after.

a. **Timeframes**

The Older Adults Protective Services Act identifies specific timeframes for the initiation of the investigation, the initial face-to-face interview with the older adult, and the conclusion of the investigation. The protective service worker is responsible for the timing of each interview. The worker must comply with the timeframes specified in the Act in order to assure that the investigation is conducted expeditiously.

b. **Interviews**

1. Alleged Abuse Or Neglect

Investigations of alleged abuse or neglect must include the accumulation of information on the older adult's medical condition, at least as it relates to the allegation(s). The client's physician is an excellent resource and protective service workers should interview the physician early in the investigation. (Even if medical issues are not alleged, the client's physician is an excellent source of information about the client.)

When interviewing the older adult's physician, the protective service worker must also ask questions that will solicit information about potential abuse or neglect, for example:

- Dr. Smith, have you ever observed any suspicious bruising or other symptoms that may be associated with abuse?

- Dr. Smith, have you observed any symptoms of malnourishment, dehydration or other symptoms associated with neglect?

- Dr. Smith, is your patient's condition such that you may question how reliable he/she has been in appropriately medicating himself/herself?

- Dr. Smith, what is your opinion on your patient's ability to make an informed decision? In your opinion, is your patient capable of making an informed decision?

These questions should be a routine part of a protective service investigation. The last question is important because it gives the protective service worker a professional opinion on the older adult's cognitive functioning ability. This is important when developing the care plan.

Unfortunately, many elderly fail to see a physician on a regular basis and pertinent information from a physician may not be available. Therefore, the protective service worker should take advantage of other available resources. For example:

- Home Health Agency
- Nurse Supervisor
- Home Health Aide
- Personal Care Worker
- AAA Consultants (Physician and Registered Nurse)
- Mental Health/Mental Retardation Agencies
- Significant Others
- Relatives
- Friends
- Neighbors

The protective service worker should carefully document all interviews and efforts, especially if, after a thorough investigation, the protective service worker is unable to detect any pertinent medical information.

2. Financial Exploitation

Investigations of alleged financial exploitation must include the accumulation of information on the older adult's financial status. In all cases, the protective service worker must review bank records or whatever else may be available that would indicate or support mismanagement or actual exploitation.

The following additional items are examples of documents that the protective services worker should consider when investigating allegations of financial exploitation:

- Deed(s)
- Mortgage(s)
- Certificates of Deposit
- Stocks, Bonds and Mutual Funds
- Power of Attorney, Guardianship Records for Review

It is advisable that if the financial standing of an older adult is extremely complicated, the protective service worker should attempt to use the agency or county accountant (who must first sign a confidentiality agreement) to assist in the protective service worker's evaluation.

Aside from professionals, the protective service worker can gain an important perspective by interviewing relatives, friends, or neighbors. To do so objectively, however, requires the protective service worker to interview several of the significant others. The protective service worker has the discretion to determine when it is necessary to interview such collateral resources and who to interview. These interviews should occur when the protective service worker has been unsuccessful in gathering other pertinent information from professionals. It is important to note that it is not the quantity of information obtained from collateral resources, but the quality, that is important.

Many protective service workers have voiced a concern about breaching the older adult's rights or confidentiality by interviewing friends, neighbors or relatives. Protective service workers can effectively interview these people without breaching rights/confidentiality by using appropriate questions. The following is an example of how to initiate an interview:

- My name is Dennis DeSantis and I work for the local office on aging. We received a referral for your [friend/neighbor/relative], Mrs. Smith. I am visiting you today to see if you have any concerns about her or if there is any information that you could provide me so I can determine if there are any services our agency can offer to her.

Such an opening, with additional probing questions based on the response (without providing details of the Report or other confidential issues), should generate usable information.

Keep in mind that the investigation is occurring to protect a vulnerable person where there is evidence of a risk. It would further the risk to the older adult to limit the scope of the investigation and close the case without evaluating any corroborating "evidence." It would also be damaging to the alleged perpetrator if a case with a limited investigation implicates the perpetrator without the benefit of evaluating corroborating "evidence."

Once again, the protective service worker should carefully document all contacts and/or attempts, especially if after a thorough investigation he/she is unable to identify many (or any) significant others who can offer corroborating information. The protective service worker must describe the contacts with all collateral resources and a brief description of their impressions and the worker's findings in the case narrative sections of the file. They are to include a list of collateral contacts in the Older Adults Protective Service Investigation Summary and Assessment form.

Summary

A Protective Service investigation is just that, an investigation. The goal of the investigation is to gather sufficient information to permit the protective service worker to evaluate and conclude whether or not the worker should substantiate the case or not. Substantiation is determined by the “preponderance of evidence." It must come, however, as the result of a thorough investigation. Medical professionals must be included in investigations of abuse and neglect. Various financial documents must be examined in cases of financial exploitation. In most cases, the protective service worker also must interview significant others to obtain a balanced perspective in the allegation. This is especially important if the protective service worker ultimately classifies the case as unsubstantiated, since he/she will not be providing the older adult with additional services for protection.

c. Abbreviated Investigation

The Department's position has been and will continue to be that <u>all</u> reports of need must be thoroughly investigated. Interviews with appropriate collateral contacts should be pursued based on the case presented. In those limited instances where a protective

services worker interviews the older adult and is satisfied that no other contacts are necessary to conclude that there is potentially no abuse, neglect, exploitation or abandonment occurring, the discretion of the protective services worker is controlling. The basis for this conclusion, however, must be clearly documented in the record.

An example of this scenario is when an individual constantly reports a problem that has been thoroughly investigated on numerous occasions. The problem lies with the reporter, not the alleged victim, and the issue of bad faith reporting surfaces.

The protective service worker can close the case and classify it as unsubstantiated. The protective service supervisor and the Area Agency on Aging Director must review and initial the case record that will indicate their respective concurrences in the classification of the case. This does not apply to those instances where abuse, neglect, exploitation or abandonment is observed or suspected by the protective services worker, regardless of the assertions of the alleged victim or the victim's request for termination of the investigation. In those instances, the Department expects a full and complete investigation.

3. Assessment

Assessment activity for protective service cases is documented in the "Older Adult Protective Service Investigation Summary/Assessment form. **See Appendix** for directions on completion of the form.

4. Care Plan

See Chapter 2.

5. Perpetrator

a. Definition

A perpetrator is an individual who, as a result of a protective services investigation resulting in substantiation by a standard of clear and convincing evidence, has been determined to be responsible for the abuse, neglect, exploitation or abandonment (ANEA) of an older adult AND has been either specifically designated as a perpetrator of ANEA in the official protective services case record or referred to a law enforcement agency, court or regulatory agency for the purpose of initiating action against the individual.

It must be clearly understood that there are two separate determinations involved in a protective services investigation:

1. Substantiation of the need for protective services
2. Designation of a perpetrator.

The standard of evidence for **substantiation of the need for protective services is "Preponderance of the Evidence."** Preponderance of the Evidence is described by imagining weighing evidence on a balanced scale. If the evidence offered in support of the claim (allegation) is so much more weighty than the evidence offered in opposition to it that it tips the scales on the side of the claim, then the claim (allegation) is proven by the fair weight of evidence.

The standard of evidence for **perpetrator designation is "clear and convincing."** Clear and convincing is described as evidence so clear, direct, weighty and convincing as to enable a jury to come to a clear conviction, without hesitating, about the truth of the precise facts at issue.

It is NOT necessary that an individual be identified in a report of need for protective services to be designated as a perpetrator. Perpetrators "discovered through investigation" are to be treated the same as those "identified in a report of need for protective services". A person identified as being associated with a need for protective services should not be designated as a perpetrator until an investigation has been conducted, his/her responsibility verified by clear and convincing evidence and the need for protective services substantiated.

The process must ensure that all officially-designated perpetrators are notified that they have been officially designated as perpetrators and that they have certain appeal rights.

On the other hand, the process should not label individuals attempting to help an older person as perpetrators when such things as human frailty, lack of knowledge or uncontrollable events cause their helping efforts to fall short of the older person's needs.

Not every individual involved in circumstances that result in the creation of a need for protective services is necessarily a perpetrator. He/she may be a person who is more appropriate for agency assistance than for labeling as a perpetrator.

b. Notification

Since the inception of the Protective Services program under the mandate of the Older Adults Protective Services Act, perpetrator designation and notification have been issues responsible for significant concern and sometimes confusion. The law was intended to protect the due process rights of perpetrators but was not intended to label individuals as perpetrators simply because their attempts to help an older person fell short. The perpetrator label was intended to be given only to those individuals whom the AAA had determined should have action taken against them. Those whom the AAA determined needed assistance, rather than sanctioning, were not intended to be labeled as perpetrators.

Once an individual has been officially designated as a substantiated perpetrator of ANEA, based on clear and convincing evidence, a summary of the allegations and the right to appeal must be given to the perpetrator in a timely fashion.

The AAA must not disclose to the perpetrator the name of the reporter or any other prohibited information.

The perpetrator must be given sufficient information to understand that the AAA has determined that he/she is a perpetrator of ANEA without providing details that would violate the confidentiality provisions of the Older Adults Protective Services Act.

The existence of ongoing risk to an older adult in need of protective services may appropriately be used to determine the order and timing of case-specific activities.

c. Guidelines for Required Perpetrator Designation:

When one or more of the following four actions are taken **by the AAA** against an individual determined by clear and convincing evidence to be a perpetrator in a protective service case, then that individual must be afforded all rights provided by the OAPSA concerning perpetrator notification:

1. The individual is reported to law enforcement for the purpose of initiating action against him/her.

2. The individual is reported to a regulatory "agency" for the purpose of initiating action against him/her.
3. The individual is reported to a court for the purpose of initiating action against him/her.
4. Subsequent to substantiation of a case through investigation by the AAA, the individual is specifically labeled as a perpetrator of ANEA in the official protective services case record even though no referral has been made to law enforcement, court or a regulatory agency.

If one or more of the actions listed above (1-4) are taken against an individual(s) who has not, by clear and convincing evidence, been designated as a perpetrator of abuse, then perpetrator notification is not required.

6. Confidentiality

Protective service workers, supervisors, stand-by and clerical staff must complete and sign a confidentiality statement. Before execution of the form, the employee should be fully advised of confidentiality provisions and penalties set forth at 15.101-15.105 of the Protective Services Regulations. Subsequent to execution, the form should be maintained in the employee's personnel file. See Appendix

It should be noted that standard forms have not been developed for client assessments, service plans, informed consent, refusal of protective services, emergency petitions, access petitions, or notification of clients or perpetrators. The agency should continue to use those forms currently in use or develop forms that comply with the regulations and meet local needs.

I. INDEPENDENCE WAIVER REQUIREMENTS

- The AAA process for assessment of persons applying for Independence Waiver services has not changed because of revised age eligibility criteria for persons to be served. The process remains the same no matter when the age of onset of the disability. The only change in the process is that there is no longer a requirement for completion of the PASSR ID, unless and until it is determined that a consumer chooses to go to a Nursing Facility.)

- There will be no express screen assessments.

- NF clinical eligibility “yes or no” is the only determination to be made without regard to availability and feasibility of using more economical alternative facilities and services. AAAs are acting as agents for DPW to simply determine NF clinical eligibility which in turn determines eligibility for Independence Waiver services.

- Community services already being provided by a DPW contractor are not to be considered.

- The Independence Waiver contractor carries primary responsibility for completion of the PA-600. However, DPW and PDA have agreed that whatever arrangements are mutually agreed to locally between the Independence Waiver contractor, CAO and AAA regarding completion of the PA-600 will govern how it is locally completed.

- Prior to referring the Waiver applicant to the AAA, the Waiver contractor:

- Conducts an in-person interview in the applicant's home to establish need for Waiver services, including a pre-screen for NF clinical eligibility.

- Provides the MA-51 to the person applying for Wavier services and assumes primary responsibility for its completion.

- Sends the referral, completed MA-51 and green color-coded face sheet to the AAA

NOTE: If the AAA is contacted directly by a person applying for the Independence Waiver, before doing the assessment, the AAA must first refer the person to the Waiver contractor so that he/she is given the opportunity to choose the Independence Waiver without having to go through the OBRA (ID/EV) process. If the applicant presents with a completed PASSR ID, it is not required, but it can be sent to the Waiver contractor. If the applicant does not present with a completed ID, there is no need for the AAA to complete an ID at this point in the process. The Waiver contractor will provide the applicant with a Consumer Preference Form. Once the Waiver contractor determines the applicant's needs and choices, the Waiver contractor will refer the applicant back to the AAA for the assessment to determine clinical eligibility for services of consumer's choice, be it Independence Waiver or Nursing Facility. If it is Nursing Facility, then the full OBRA assessment must be completed which includes completion of the PASSR ID and, if the applicant is found to have a target diagnosis, the PASSAR EV. The PASSR ID and PASSAR EV are not completed for consumers accessing the Independence Waiver.)

- An assessment interview is scheduled in coordination with the Waiver contractor, as someone (whoever the Waiver contractor designates) from the Waiver contractor is to be present to facilitate the interaction (but NOT co-assess) with the face-to-face NF OAF assessment.

- The assessment is to be completed with the following changes to the NF OAF instrument:

  - Use the Independence Waiver modified green color-coded face sheet **(See Appendix- Independence Waiver Face Sheet Instructions and Independence Waiver Options Assessment Face Sheet Form).**

  - Remove the Decision Narrative. The logic for NF yes/no will be documented on the Independence Waiver NFCE Determination Report **(See Appendix- Independence Waiver Determination Report Instructions and Form)**. Be as comprehensive as necessary in order to provide adequate information in case of an appeal.

- MA-51: Q.21.A, check Medically Eligible "Yes" box; Q.22., "Comments", write in "OSP/Independence Waiver"; Reviewer's signature = assessor or assessor's supervisor.

- Send completed NF OAF, Determination Report, and signed MA-51 to the CSPPPD contractor.

- AAA has no further responsibility for follow-up once the assessment is completed and sent to the Waiver contractor.

J. DPW ATTENDANT CARE (AC) WAIVER ASSESSMENT REQUIREMENTS

- There will be no express screen assessments.

- NF clinical eligibility "yes or no" is the only determination to be made without regard to availability and feasibility of using more economical alternative facilities and services. AAAs are acting as agents for DPW to simply determine NF clinical eligibility which in turn determines eligibility for DPW AC waiver services.

- Services already being provided by the Attendant Care Program (ACP) contractor are not to be considered.

- The ACP contractor carries primary responsibility for completion of the PA-600. However, DPW and PDA have agreed that whatever arrangements are mutually agreed to locally between the ACP, CAO and AAA regarding completion of the PA-600 will govern how it is locally completed.

- The ACP contractor is responsible to obtain the completed MA-51.

- A referral, completed MA-51 and lavender color coded face sheet is received from the DPW ACP contractor.

- An assessment interview is scheduled in coordination with the ACP contractor, as someone (whoever the ACP contractor designates) from the ACP is to be present to facilitate the interaction (but NOT co-assess) with the face-to-face NF OAF assessment. Local AAA procedures prevail in coordination with local ACP contractor.

- The assessment is to be completed with the following changes to the NF OAF instrument:

  - Use the face sheet with the ACP modified lavender color-coded face sheet **(See Appendix- DPW Attendant Care Program Face Sheet Instructions and Form)**.

  - Remove the Decision Narrative. The logic for NF yes/no will be documented on the ACP Determination Report **(See Appendix- DPW Attendant Care Waiver Program Determination Report Instructions and Form)**. Be as comprehensive as possible to provide adequate information in case of an appeal.

- MA-51: Q.21.A, check Medically Eligible “Yes” box; Q.22., “Comments”, write in "ACP Waiver"; Reviewer's signature = assessor or assessor's supervisor.

- Send completed NF OAF, Determination Report and signed MA-51 to the ACP contractor.

- AAA has no further responsibility for follow-up once the assessment is completed and sent to the ACP contractor.

K. DPW COMMCARE WAIVER ASSESSMENT REQUIREMENTS

- There will be no express screen assessments.
- NF clinical eligibility "yes or no" is the only determination to be made without regard to availability and feasibility of using more economical alternative facilities and services. AAAs act as agents for DPW to simply determine NF clinical eligibility, which in turn determines eligibility for DPW COMMCARE waiver services.

- If community services are already being provided, the services are not to be considered.

- The applicant's provider service coordinator **(defined in Chapter 3)** carries primary responsibility for completion of the PA-600. However, DPW and PDA have agreed that whatever arrangements are mutually agreed to locally between the current provider, CAO and AAA regarding completion of the PA-600 will govern how it is locally completed.

- The applicant's provider service coordinator is responsible to obtain the completed MA-51.

- A referral, completed MA-51 and blue color-coded face sheet is received from the DPW provider service coordinator.

- AAA staff and the provider service coordinator must work together to schedule an appointment with the applicant (and guardian, if applicable) to complete the NF OAF together.

- Provider service coordinators who work with potential COMMCARE consumers must participate in the NF OAF assessment, whenever possible, to provide any additional information necessary to determine nursing facility clinical eligibility. Service coordinators must also inform AAA staff of any special circumstances that may be relevant to any behaviors exhibited by the consumer that may affect the assessment process.

- The assessment is to be completed with the following changes to the NF OAF instrument:

  - Use the face sheet with the COMMCARE modified blue color-coded face sheet found in Appendix. **(See Appendix- COMMCARE Face Sheet Instructions)**

  - Remove the Decision Narrative. The logic for NF yes/no will be documented on the COMMCARE Determination Report found in Appendix. **(See Appendix- COMMCARE Determination Report Instructions and Form)** When completing the Determination Report, be as comprehensive as possible to provide information to support the determination.

- MA-51: Q.21.A, check Medically Eligible "Yes" box; Q.22., "Comments", write in "COMMCARE Waiver"; Reviewer's signature = assessor or assessor's supervisor.

- Send completed NF OAF, Determination Report and signed MA-51 to the provider service coordinator.

- AAA has no further responsibility for follow-up once the assessment is completed and sent to the service coordinator.

L. LONG TERM CARE CAPITATED ASSISTANCE PROGRAM REQUIREMENTS (LTCCAP):

The AAAs act as agents for DPW to determine NF clinical eligibility.

- There will be no express screen.

- NFCE yes or no is the only determination to be made.

For LTCCAP program, the following must be completed:

- MA-51.
- NF OAF as revised for LTCCAP assessments.

- Determination Report as revised.
- PASSAR-ID not completed.
- No Express Screens
- NF clinically eligible "yes and no" is the only determination to be made.

The assessment is to be completed with the following changes to the NF OAF instrument:

-Use face sheet with the LTCCAP modified orange color-coded face sheet **(See Appendix- LTCCAP Face Sheet)**, as provided by the LTCCAP provider.

- Remove the Decision Narrative. The logic for NF "Yes/No" will be documented on the LTCCAP Determination Report **(See Appendix- LTCCAP Determination Report Instructions and Form).** Be as comprehensive as possible to provide adequate information for appeals.

- MA-51: Q21A check medically eligible "yes" box. Q22 "Comments" write in "LTCCAP". Reviewers signature = assessor <u>or</u> assessor's supervisor.

- Send completed NF OAF, Determination Report and signed MA-51 to the LTCCAP provider.

- LTCCAP provider may assist eligible applicants with 600L as needed and forward MA-51, consumer determination report and completed 600 to the CAO.

- Consumers who are participating in the LTCCAP may also be residents of a Domiciliary Care Home. The process for waiving section 21.21(3) of Chapter 21 Domiciliary Care Services for Adults is the same as outlined for the PDA Waiver. **(See Appendix- Domiciliary Care Services for Adults- Pennsylvania Code).** The PDA Clinical Consultant will work with the LTCCAP provider in addition to the person who certifies Domiciliary Care residences for the AAA.

M. ASSISTIVE TECHNOLOGY/RISK REDUCTION HOME MODIFICATION PROGRAM

In the provision of home and community based services to older individuals, it has been recognized that there are a number of consumers being served by the Area Agencies on Aging who would benefit from assistance in purchasing assistive technology and/or home modifications. These consumers usually live alone at or below the poverty level and, though frail and elderly, are <u>not</u> clinically eligible for nursing facility care and services. Their lack of resources presents a risk in that they cannot afford to purchase devices or make home modifications that would insure safety and well being at home, helping to prevent the risk of becoming nursing facility clinically eligible (NFCE), thus delaying or preventing placement in a nursing facility for as long as possible.

Eligibility criteria for this program are:

- Consumer is age 60 and older.
- Income at 125% of poverty or lower.
- Nursing Facility <u>In</u>eligible (NFI) at time of assessment.

Prevention and risk reduction practices and more emphasis on assistive technology and home modifications must be incorporated into assessment care planning and care management. The assessment for these consumers should be focused on safety and prevention issues, with the objective being the provision of a one-time reimbursement of no more than $2,000 for the purchase of assistive technology and/or home modification. AAA's may seek the services of an Occupational Therapist (O.T.) to assess the consumer and their home environment, to

recommend home modification(s) or assistive device(s) and that part of the $2,000 would be used for the O.T. consultation fee.

Area Agencies on Aging will be required to complete a request for funding for each individual that has a need for service(s). The request submitted by the AAA will identify each individual, the assistance to be provided, and the planned cost per individual (not to exceed $2,000). The request must be e-mailed to PDA, specifically to the Division of Contract Management and Appeals. The AAA will receive approval for the expenditure from the Department and may then purchase the service(s) for the consumer. A final cost report identifying the individual(s) served, the assistance provided and the actual cost per individual incurred will be completed by the AAA and submitted to the Department following the actual purchase of the service.

The Department will reimburse AAAs semi-annually. The reimbursement to the AAA will be based on submitted final cost reports.