

ENTRY INTO AND MOVEMENT WITHIN SERVICE SYSTEM

Directive 1.7

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Forms: 818 and 818B

Directive Purpose

The purpose of this directive is to set forth a systematic and consistent procedure for when the Division of Services for People with Disabilities (Division) transitions a person into and out of waiver and non-waiver services as well as moves them within the service system.

Definitions

Level of Care – The intensity of supports needed from the physician, health care facility, or other service provider in order to deliver services that meet the care needs of a person.

Division/External Support Coordinator – Individual who monitors the health and safety of a person in a waiver or non-waiver service in accordance with program requirements and the person’s assessed service needs. Support coordinators inform a person of available services, help them select providers that offer those services, assist a person in obtaining the services they selected and coordinate and monitor the delivery of quality services. A Division support coordinator is an employee of the Division and a support coordinator external is a private contractor.

State Eligibility Review Committee (ERC) – A committee that is responsible to review and recommend the eligibility of a person applying for Division waiver programs. Upon request, when eligibility is in question or is difficult to determine, the ERC reviews and makes recommendations to determine ongoing eligibility for individuals receiving waiver services through any of the Medicaid waiver programs or for individuals receiving only non-waiver Division funded services. See Directive 4.0 for further information.

Federal Medical Assistance Percentage (FMAP) – The specified percentage of program expenditures that the federal government pays states for Medicaid programs that are jointly funded by the federal government and states.

Policy

1. In transitioning and moving a person within the service system, the support coordinator will ensure that a person has an appropriate choice of services and supports.
 - a. The Division is to provide non-waiver Division funded services to a person who are financially ineligible for or choose not to receive waiver services. In cases where a person chooses not to receive waiver services, the Division will inform the person of the option to receive only the Division funded portion of their total budget for waiver services.
 - i. The Division funded portion of the person's budget should be approximately 1/3 of the total budget for waiver services and shall be calculated using the most current FMAP rate. Any increase in non-waiver Division funded services will be subject to the availability of funds and based on documented and assessed individual needs.
 - ii. A person participating only in non-waiver services may be required, as provided by Section R539-1-10, to pay a fee as established by the graduated fee schedule.
 - iii. A person participating only in non-waiver services or a person participating in waiver and non-waiver services may have reductions in non-waiver service packages or be discharged from non-waiver services completely, due to budget shortfalls, reduced legislative allocations and/or reevaluations of eligibility.
2. A person may receive non-waiver Division funded services, subject to the availability of funds, in the following circumstances:
 - a. The person does not meet the financial eligibility requirements for Medicaid because the person exceeds the allowable income or asset amounts;
 - b. The person is over 19 years old and does not yet have an adult disability determination from the Supplemental Security Income (SSI) program or has been denied SSI;
 - c. The person is temporarily ineligible for Medicaid as a result of the following:
 - d. Decisions issued by the Department of Workforce Services (DWS); or
 - e. Incarceration, hospitalization, or stay in a rehabilitation facility with an expected length of stay exceeding 90 days.
 - f. Due to personal income or assets the person has a required spend-down in order to receive Medicaid and chooses not to pay that spend-down;
 - g. The person meets Division eligibility requirements, but is otherwise ineligible for Medicaid; or
 - h. The person voluntarily chooses not to receive waiver services.
3. Division support coordinators will ensure the continuity of services for a person receiving non-waiver services or a person who do not have an external support coordinator.

4. The Division support coordinator assigned to a person receiving only non-waiver Division funded services must continue to review:
 - a. The person's waiver eligibility by evaluating the person's circumstances at least annually and assisting the person in applying for Medicaid if those circumstances change.
 - i. This review must be documented in an activity log note or in the Person-Centered Support Plan (PCSP).
 - b. The person's Division eligibility and level of care at least annually.
 - i. If level of care requirements for waiver services are met, but the person is not enrolled in waiver services, the Division support coordinator shall record the decision as "Eligible" and note the reason why the person is not enrolled in waiver services.
 - ii. If the Division support coordinator believes that the person no longer meets Division eligibility or level of care requirements, the case shall be referred to the ERC.
 - A. Services will continue to be provided pending the review.
 - B. Services may continue to be provided during any subsequent appeal or transition period, provided all other necessary requirements of the NOA and Hearing Rights process are complied with.
5. A person receiving non-waiver services who experiences a change in circumstances qualifying that person for waiver services may elect to transition into waiver services.
 - a. A person who is transitioning from receiving non-waiver services to receiving waiver services will not be required to go through the intake and waiting-list process in order to receive those waiver services.
6. A person does not need a new psychological evaluation when transitioning from non-waiver services into waiver services if the person has a psychological evaluation that was done within five years of the original level of care determination.

Procedures

1. Entry into Funded Supports
 - a. When a person is selected to come off the waiting list and eligibility for Division funded services has been confirmed, the Division will determine whether the person meets the level of care criteria before enrolling the person in the appropriate Medicaid waiver program. The level of care determination must be done by: a Qualified Intellectual Disability Professional (QIDP) as defined in R432-152-3 for a person entering the Community Supports Waiver; an Acquired Brain Injury support coordinator (ABISC) for a person entering the Acquired Brain Injury Waiver; or an Administrative Case Manager for a person entering the Physical Disabilities Waiver;

- i. Regardless of whether the person meets the level of care criteria, the level of care determination must be recorded in USTEPS by the professional who made the determination.
 - ii. The Division support coordinator shall ensure that the appropriate financial eligibility is recorded based on the person's qualifying diagnosis:
 - A. SG - Intellectual Disability or Related Condition;
 - B. BG – Acquired Brain Injury; or
 - C. PG – Physical Disability.
- b. The Division support coordinator coordinates an initial planning meeting with the person and the person's representative and other team members selected by the individual.
- c. If the person meets the level of care necessary to qualify for waiver services the person will be presented with a choice of receiving services through an appropriate Home and Community Based Services (HCBS) waiver program or through an Intermediate Care Facility (ICF) or Nursing Facility.
- i. The Division support coordinator will document the person's selection on the Choice of Service System Form 818 by obtaining the person's, or the person's legal guardian's, signature and uploading the form into UPI.
 - ii. If the person chooses to receive services through a waiver, the Division support coordinator will assist them in establishing Medicaid eligibility.
 - iii. If the person chooses to receive services through an ICF or Nursing Facility, the person will be given the option of remaining on the Division waiting list or being removed from the waiting list altogether and being designated as episode closed. The person's decision will be documented in a USTEPS Log Note.
- d. If the person chooses a waiver service the Division support coordinator will start the process of establishing Medicaid waiver eligibility by:
- i. Completing the Waiver Referral Form 927 in USTEPS;
 - ii. Specifying on the Form 927 the appropriate HCBS Waiver for which the person is qualified; and
 - iii. Sending the Form 927 to the Long-Term Care Team (LTCUnit@utah.gov) at the DWS.
- e. Upon receipt of the Form 927 back from DWS, the Division support coordinator will:
- i. Review the decision to verify the accuracy of the effective Date, client ID#, and client name;
 - ii. Review the decision to verify how much the person will be required to spend-down any funds, if applicable, in order to receive Medicaid waiver services;

- iii. Record the decision in the “Medicaid Eligibility” section of USTEPS; and
- iv. If the waiver has been approved, update the financial eligibility code for the appropriate waiver:
 - A. SM for the Community Supports waiver;
 - B. BM for the Acquired Brain Injury waiver; or
 - C. PM (Legislative Appropriation) or PN (DOH Portability Funding) for the Physical Disabilities waiver;
- f. If the person will be required to spend-down any funds in order to receive Medicaid waiver services, the Division support coordinator will notify the person or person’s representative(s) of the amount prior to the start of any waiver services, and will advise that the spend-down must be paid each month in order to receive waiver services. This communication will be documented in a USTEPS log note.
- g. During the initial planning process, the Division support coordinator will:
 - i. Review all applicable records for the person;
 - ii. Conduct any new assessments necessary to determine the person’s current support needs, including the Needs Assessment Questionnaire (NAQ), Utah Comprehensive Assessment of Needs and Strengths (UCANS), and Person-Centered Profile.
- h. After conducting all necessary assessments, the Division support coordinator will develop a proposed PCSP based on those assessed needs.
 - i. A UCANS must be completed prior to developing a PCSP.
 - ii. The PCSP budget must specify both the total amount of money to be allocated as well as what portion of the total allocation will be Division funds based upon the current FMAP rate.
 - iii. The proposed PCSP budget must be submitted as a Request for Services to the Request for Services Committee for approval.

2. Moving from Non-Waiver Services to Waiver Services

- a. If a person receiving non-waiver Division funded services has a change in circumstances such that the person becomes eligible for Medicaid and wants to enroll in waiver services, the Division support coordinator shall assist the person in transitioning into waiver services.
 - i. The Division support coordinator shall document the person’s decision and choice of service system on the applicable Form 818, obtaining the person’s or the person’s legal guardian’s signature and uploading the form into UPI.

- ii. The Division support coordinator will start the process of establishing Medicaid waiver eligibility by following the process outlined in Subsection 4(a)(iv)through(vi).
- b. The Division support coordinator will submit a new proposed budget for the person that includes waiver funds and support coordinator external services.
 - i. The budget **must** specify the amount of money to be allocated and what portion of the total allocation are Division funds based upon the current FMAP.
- c. Once the person’s proposed budget has been approved and the pro-forma has been adjusted, the Division support coordinator must:
 - i. Revise the person’s PCSP;
 - ii. Add any additional services or supports needed by the person;
 - iii. Update the person’s PCSP budget with those additional services or units of service; and
 - iv. Mark all applicable services on the person’s PCSP budget as “Medicaid Reimbursable.”

3. Moving from Waiver Services to Non-Waiver Services

- a. A person may move from waiver to non-waiver services for any reason as set forth in Subsection 3(b).
- b. When the Division is notified, the applicable Program Administrator shall notify the support coordinator external to communicate with applicable service providers to not submit any service billing to the DHS/Division when a person is absent from the waiver service including, but not limited to incarceration (jail/prison) or inpatient care (SNF/ICF.ID/USH, etc.).
- c. The Division will assign a Division support coordinator to ensure a smooth transition and continuity of services.
- d. The Division support coordinator shall:
 - i. Inform DWS and the Department of Health, Bureau of Authorization and Community Based Services (BACBS) of the change in services by completing the Waiver Referral Form 927 in USTEPS and submitting to both DWS and BACBS.
 - ii. Ensure that the appropriate financial eligibility is recorded based on the person’s qualifying diagnosis:
 - A. SG – Intellectual Disability or Related Condition;
 - B. BG – Acquired Brain Injury; or
 - C. PG – Physical Disability.

- iii. Reduce the person's budget to the Division funded portion of the budget that the person was receiving when using waiver services based upon the current FMAP and using the Request for Services form.
- iv. Coordinate with the person and the person's PCSP team to determine what supports are most needed for the person and can be provided within the newly determined budget allocation.
- v. Revise the person's PCSP and budget to reflect the new choice of supports.

4. Closing an Episode

- a. For a person using only non-waiver Division funds, the Division may close a person's case, episode closed, when the person is no longer eligible for, or elects to withdraw from, Division services or if the Division determines it will exercise its right to not provide non-waiver services. The Division will not close an episode until the following conditions are met:
 - i. All billing issues are resolved;
 - ii. Any requested appeals proceedings have been completed; and
 - iii. The question of whether or not to close a person's case has been determined by the applicable Program Administrator.
- b. The Division shall ensure, to the extent possible, that transition planning out of services are provided to the person leaving services and that information pertaining to additional services outside of what the Division can offer has been supplied to the individual for them to access if they so choose.