The Commonwealth of Massachusetts
Executive Office of Elder Affairs
One Ashburton Place, Boston, MA 02108

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SECRETARY

PROGRAM INSTRUCTION

EOEA-PI-97-31
REF: EOEA-PI-97-17

TO: Home Care Corporations
Area Agencies on Aging

FROM: Franklin P. Ollivierre

DATE: September 18, 1997

RE: Medicaid Waiver Manual Clarification

As you know, Elder Affairs recently issued a revised Medicaid Waiver Manual. This Program Instruction addresses questions received regarding the revised manual.

Recipient Choice Form

- HCFA requires that the Recipient Choice Form (Attachment D) be signed by the client as a condition of participation in the Medicaid Waiver Program. This form is not optional.

Medicaid Waiver Notification Form

- The Division of Medical Assistance (DMA) recently revised all notification forms including the Medicaid Waiver Notification Form (Attachment C). DMA's goals in revising the forms included uniformity, clarity for the recipient and the ability to obtain necessary data. If DMA identifies the need to collect additional data through the Medicaid Waiver Notification Form, Elder Affairs will distribute an updated form to Home Care Corporations (HCCs).

Attachment Revisions/Clarifications

- Page four of the Medicaid Waiver Manual refers to Attachment D in regard to the Notification form. It should refer to Attachment C. The current page four of the manual should be replaced with the attached revised page four.

- The Request For A Fair Hearing Form (Attachment C) has been revised to include telephone and fax number changes. The current Attachment C of the manual should be replaced with the attached revised Attachment C.

- The Spousal Waiver Letter (Attachment E) has been revised to no longer require the signature of a Registered Nurse. The letter can be signed by any HCC representative. The current Attachment E of the manual should be replaced with the attached revised Attachment E.

- Attachments may be translated into other languages provided the HCC can ensure the content of the information is accurate and consistent with the original document.

- In accordance with Elder Affairs Documentation Standards (EOEA-PI-95-55), all documentation shall be on prescribed forms issued by Elder Affairs. Any variation made to the forms may only be used with the expressed consent of Elder Affairs.

2167 Reassessments

- The Medicaid Waiver reassessment date shall always remain the same. The Medicaid Waiver reassessment screening can be completed and billed only once a year. If a HCC chooses to "cycle up", the annual home care redetermination date is changed to coincide with the Medicaid Waiver reassessment date. The HCC annual redetermination must not be extended longer than one year. Initially during the "cycling up" process, a HCC redetermination may take place more than once within a year.

Please contact Sylvia Clark, at (617)222-7477 with any questions regarding the 2176 Medicaid Waiver Program.

Attachments

determined by calling the MEC's automated system1-800-554-0042. To access the system, the recipient's card numbers, effective date of service and provider number is needed.

ONGOING CASE MANAGEMENT AND ANNUAL REASSESSMENT FOR THE MEDICAID WAIVER PROGRAM

All Medicaid Waiver participants must be reassessed annually to establish continued Program eligibility. The reassessment process includes:

1. determining medical eligibility for nursing facility services;

2. verifying that the client is a Medicaid recipient;

3. determining that the client is in need of and receiving a waivered service.

Home Care Program regulations require that Home Care/Respite clients be reassessed annually for program eligibility. It is strongly recommended that one annual reassessment be completed to determine eligibility for the Medicaid Waiver and Home Care or Respite Programs. In order to achieve this cycle, a HCC may need to complete a reassessment or re-determination twice within the first year.

INELIGIBILITY FOR THE MEDICAID WAIVER PROGRAM

Participants are immediately ineligible for the Medicaid or Spousal Waiver Program when **at least one** of the following have been determined:

1) ineligibility for either the Home Care or Respite Program;

2) no need of a waivered service;

3) not receiving any waivered services (e.g. elder refuses waivered services);

4) financial ineligibility for Medicaid; or

5) medical ineligibility for nursing facility services.

The Notice of Action (Attachment F) shall be issued to the client if the Voluntary Assent form has not been signed (see below), when he/she has been determined ineligible for the Medicaid Waiver Program due to: 1. ineligibility for either the Home Care or Respite Program; 2. no need of a waivered service; or 3. not receiving any waivered services. If a client is no longer eligible due to **financial** ineligibility the elder must appeal directly to DMA (see Appeal to DMA below). Attachment C is used to notify clients of medical ineligibility/ eligibility. When ineligibility is determined for ***any*** of the above reasons and the client agrees with it, the case is closed from the Medicaid Waiver Program.

Reduction of Services- A decision to reduce a client's services must be based on a change in client's **status** (e.g. increased support from a family member or improved health) and not the financial situation of the HCC.

ATTACHMENT C

REQUEST FOR A FAIR HEARING

Your Right to Appeal: If you disagree with any action or inaction taken by the Division of Medical Assistance, you have the right to appeal and receive a fair hearing before an impartial hearing officer. The Division must receive your request for a fair hearing no later than *30 days* from the date you received the Division's official written notice notifying you of the action to be taken.

How to Appeal: If you wish to request a fair hearing, send this completed form to: **Division of Medical Assistance, Board of Hearings, 2 Boylston Street, Boston, MA 02116 or fax to (617) 210-5820.** Please keep the second copy of this form for your information.

If You are Currently Receiving Assistance: If the board of hearing receives your fair hearing request within *10 days* from the mailing date of the Division's written notice to you, your assistance will be continued until a decision is made on your appeal. If you receive assistance during your appeal, but lose your appeal, the Division can recover from you the amount of assistance to which you were not entitled. If you do not wish to continue to receive assistance during your appeal, please check Box A below. If you do not receive assistance during your appeal, and you win your appeal, the Division will promptly restore any loss of assistance benefits for the affected time period.

Date of Fair Hearing: You will be notified by mail at least *10 days* before the fair hearing of the *date, time and place* so that you will have time to prepare your case. If you wish to have a fair hearing scheduled as soon as possible, check Box B below. If you have a good cause of a serious nature for not being able to attend the hearing, you must contact the Board of Hearings at *(617) 210-5800 or 1-800-655-0338* at least one week before the hearing date. Failure to reschedule or appear on time at the hearing without documented good cause may result in the dismissal of your appeal.

Your Right to Be Assisted At the Hearing: At the hearing, you may represent yourself or be accompanied by an attorney or representative at your own expense. You may contact a local legal service or community agency to obtain advice or representation at no cost. To obtain information about legal service or community agencies, contact your Medical Assistance office.

If You Need an Interpreter: If you are not fluent in English and would like an interpreter, the Board of Hearings will provide an interpreter for you. Please write on this appeal request that you need an interpreter or call the Board of Hearings at *(617) 210-5800 or 1-800-655-0338* at least one week before the hearing.

Your Right to Review Your Assistance Files: You and/or your representative will be permitted to see your assistance files before the hearing by scheduling an appointment with your eligibility worker in advance of the fair hearing. You or your representative may subpoena witnesses, present evidence, and cross-examine witnesses. The hearing officer must make a decision on all evidence presented at the fair hearing.

Non Discrimination Notice For Recipients: Under federal and state law the Massachusetts Division of Medical Assistance does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age, or handicap. For help with any matter pertaining to this policy, we encourage you to contact the Board of Hearings at *(617) 210-5800 or 1-800-655-0338.*

Complete All Appropriate Sections-Print Clearly

Name of Applicant or Recipient: _____

Address: _____

Telephone No.: _____ Medical Assistance ID or SSN: _____

Cardholder's Name on MassHealth card (if different): _____

I request an interpreter (indicate language _____) to be provided by the Board of Hearings.

Signature: _____ Date: _____

My authorized Representative is: _____ Title: _____

Address: _____ Telephone No.: _____

_____

_____

I, _____ , hereby request a fair hearing before a hearing officer at the Board of Hearings. The reason I wish to request a fair hearing is: _____

_____

_____

_____

☐ A. I do not wish to receive assistance during the appeal process.

☐ B. I request an expedited hearing because: _____

_____

_____

ATTACHMENT D

LETTER HEAD

MEDICAID (AND SPOUSAL) WAIVER PROGRAM

RECIPIENT CHOICE FORM

I understand that the ___(name of Home Care Corporation)____ on behalf of the Commonwealth of Massachusetts has determined that I am clinically eligible for nursing facility services. I have been informed that I may receive services in my home and/or community as a feasible alternative to nursing facility services. Services have been explained to me and I choose to receive services in my home under the Medicaid Waiver Home and Community Based Services Program.

_____ _____

Recipient or Representative Date

ATTACHMENT E

LETTERHEAD

Date:_____

Massachusetts Enrollment Center
(address):

_____

_____

_____

Dear (name of case worker):

This is to inform you that (name of Medicaid Spousal Waiver applicant) of (address) is a client/applicant of (name of HCC) and is/will be receiving (indicate waivered services) service(s).

The Medicaid Waiver Medical Eligibility Authorization is enclosed.

Sincerely,

_____
HCC Representative

PROGRAM INSTRUCTION
SIGN-OFF SHEET

DATE SUBMITTED 9/4/97

NUMBER: EOEA- PI-97-31

SUBJECT: Medicaid Waiver Manual Clarification

SUBMITTED BY: Karen Touzjian

REVIEW MEETING DATE: _____

Check (✓) if meeting is not required ☑

ASSISTANT SECRETARY,
PROGRAM MANAGEMENT: [signature] 9/24/97

ASSISTANT SECRETARY,
POLICY AND DEVELOPMENT: [signature] 9/24

GENERAL COUNSEL: Pamela M. Dashnell 9/24/97

ASSISTANT SECRETARY,
ADMINISTRATION AND FINANCE: [signature]

FOR SECRETARY'S USE ONLY:

☐ INTERESTED PARTIES

☐ CONCERNED PARTIES

FOR BUSINESS OPERATIONS' USE ONLY:

REPRODUCTION DATE: _____ INITIALS: _____