

ACCS TRAINING OUTLINE

4452.4

January 2013

ACCS stands for Assistive Community Care Services. ACCS is a bundle of services created to provide a Medicaid coverage benefit to providers and recipients.

BACKGROUND

Provider Benefit

ACCS became a Medicaid covered service on July 1, 1999 to allow Level III homes to become Medicaid providers and receive Medicaid reimbursement for ACCS. Assistive Living Facilities (ALF) also can receive Medicaid reimbursement for ACCS. There is a list of Level III and IV Residential Care Homes at <http://www.dlp.vermont.gov/resident-list>.

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

Recipient Benefit

Residents of homes enrolled as Medicaid providers can use ACCS covered services to spend down to the Medicaid protected income level. The recipient may receive ACCS by paying privately until their spenddown is met; after their spenddown is met Medicaid will pay for costs of ACCS. Retroactive coverage is available.

Frequently Asked Questions

What is the difference between the PCS (Personal Care Services) deduction and the ACCS deduction?

ACCS is a more comprehensive bundle of services, but many overlap with PCS. The big difference is that ACCS can become a COVERED Medicaid service, whereas PCS is not a covered service for individuals over age 21 (see Procedures P-2421 D).

What does ACCS mean for eligibility determinations?

When an applicant resides in a Level III residential care home or an ALF, you should recognize that the spenddown computation might be different than for other SSI-related spenddowns.

How do I calculate spenddowns for people who receive ACCS?

Spenddown calculations are identical to those for other SSI-related applicants until the very last step. Just as with all other spenddown calculations, make sure to follow the proper deduction sequence (4442): health insurance expenses (4451); non-covered medical expenses (4452-4452.3); covered medical expenses (4453 - 4454) that exceed limitations on amount, duration, or scope of services covered (7200 - 7500); covered medical expenses (4453 - 4454) that do not exceed limitations on amount, duration or scope of services covered and are incurred by the financial responsibility group (deducted in chronological order of the date the service was received beginning with the oldest expense). The specific procedures are explained step-by step below.

Why can't I reduce the spenddown using ACCS first, instead of last?

It will prevent the residential care home providers from being able to bill Medicaid for ACCS. This deprives them of income they need to operate and supports the availability of alternatives to nursing homes.

ACCS SPENDDOWN PROCEDURES

A. Determine if retroactive coverage is needed.

B. Determine Medicaid eligibility by using DSW 203B1.

1. If the spenddown is met using allowable deductions, the individual is eligible for Medicaid and coverage of ACCS. Medicaid eligibility begins on the first day of the application month or retroactive period, if applicable. ACCS eligibility starts the date the individual started receiving services in the Level III residential care home (RCH) or ALF.

Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (PATH 225A). Send a computer generated notice of decision to the applicant. Be sure to add the "ACCS Initial Approval" text in optional paragraphs indicating ACCS coverage start date. Send the client's copy of the 225A with the notice to the client and send the facility's copy to the administrator of the home. If the case is a review, be sure to select the "Assistive Community Services Review" text in optional paragraphs to include the end date for the prior period's coverage of ACCS.

Example: Application date: Aug. 2

ACCS services began: Aug. 16

Form 220 gives the Medicaid eligible date of Aug.1

The Notice text would read; "You are eligible for ACCS effective Aug. 16."

2. If spenddown is not met using allowable deductions, compare the spenddown (after all other allowable deductions) to the ACCS deduction over six months (example: \$1,260 x 6 = \$7,560). Use the actual daily rate for ACCS services provided by the home. If they refuse to provide the amount, or to separate the ACCS services rate from the room and board rate, then use the Medicaid rate of \$42 per day for Level III homes; \$17.83 per day for Level IV homes.

a. If the individual's spenddown is less than the ACCS deduction over six months, the spenddown has been met. Medicaid is granted effective the first day of the month of application or the first day of the retroactive period, if applicable.

The ACCS start date is determined as follows:

- Divide the spenddown by the daily cost of ACCS per 225A or \$42 (Medicaid rate, or \$17.83 if a Level IV home) whichever is higher. Drop any numbers after the decimal point. The result is the number of days the client must privately pay his or her ACCS costs. Medicaid will pay for ACCS starting the following day.
- Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (PATH 225A). Send a computer generated notice of decision to the applicant. Be sure to add the "ACCS Initial Approval" optional paragraphs text indicating ACCS coverage start date. Send the client's copy of the 225A with the notice and send the facility's copy to the administrator of the home. If the case is a review, be sure to select the "Assistive Community Services Review" optional paragraphs text to include the end date for the prior period's coverage of ACCS.

Example:

- Review application date: Sept 5. Client's prior period ends Sept 30
- Client's spenddown after deductions of Medicare premiums, OTCs, and old bills: \$1500.00
- 225A states ACCS rate is \$50/day
- $\$1500 \div \$50 = 30.00$ Client must private pay 30 days.
- Medicaid start date: October 1
- ACCS private pay dates: October 1 through October 30
- Medicaid covers ACCS cost: October 31 through March 31

b. If the spenddown is greater than ACCS deduction for six months, the individual is ineligible for ACCS services for the spenddown period, but may become Medicaid eligible. If the spenddown, after deductions, exceeds the total ACCS amount over a 6 month period, ACCS will not be a covered service for that spenddown period.

- Deduct that amount from the spenddown, and the remainder is the individual's spenddown for that period. If the spenddown is met during the period, they may become *Medicaid* eligible during that time, but ACCS will not be covered.

- Send a denial letter for being over income using the language found at P2421 D1 C. Enclose Form 288 B and Form 288 C with the suggestion to complete and return. The completed 288 may provide additional deductions to help meet their Medicaid spenddown. The only additional allowable deductions would be for those already not covered by ACCS (see chart below). Calculate the expense by multiplying the number of hours required each month by the state minimum wage; multiply the result by six to calculate the expense over the six month period. Vermont minimum wage for 2013 is \$8.60 per hour.

Example:

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

Service description	Service Category	
	PCS	ACCS
Assistance with self-administered medications	X	X
Assistance w/dressing	X	X
Assistance /bathing	X	X
Assistance w/grooming	X	X
Assistance w/eating, drinking, diet	X	X
Assistance w/toileting	X	X
Assistance w/positioning	X	X
Assistance w/transferring	X	X
Assistance w/ambulation	X	X
Assistance w/use of adaptive equipment	X	X
General supervision of physical & mental well-being	X	X
Assistance w/ food prep	X	
Assistance w/limited housekeeping services	X	
Accompany individual to clinics, physician's office	X	X
Continuation of training programs	X	

Management of money	X	
Assistance in monitoring vital signs	X	X
Routine skin care	X	X
Assistance w/exercise	X	X
Medication Monitoring		X
Medication Administration		X
Restorative Nursing		X
Nursing Assessment		X
Health Monitoring		X
Routine Nursing Tasks		X
24-hr on-site assistive therapy		X
Case Mgmt		X

Additional Information:

- ★ Be sure to add an institution panel (INST) in ACCESS with code 23 “Community Care Home / ACCS”.
- ★ If an applicant fails to return the 225A form, process eligibility using the Medicaid rate of \$42 for the cost of daily ACCS services (or \$17.83 per day for a Level IV home). (Do NOT close for non-cooperation).
- ★ Be sure to CATN ACCS eligibility decisions (i.e. “Client responsible to pay ACCS from 01/01/09 – 02/16/09. Dept will pay ACCS 02/17/09-06/30/09”).

Example: Ma Kettle

Ma lives in a RCH outside Chittenden County.
 She has \$50 in cash and \$370 in her savings account.
 Her income is \$1269 from social security (SSDI) per month.
 She applies 8/1 and wants ACCS coverage effective 8/1.

Example: Uncle Ben

Uncle Ben lives in a RCH outside Chittenden County.
 He has \$50 in cash and \$900 in his savings account.
 His income is \$2740 from social security (SSDI) per month.
 He applies 8/1 and wants ACCS coverage effective 8/1.

Example: Jolly Roger

Jolly lives in a RCH outside Chittenden County.
 He does not have any resources.
 His income is \$1199 from social security (SSDI) per month.
 He applies 8/1 and wants ACCS coverage effective 8/1.