Coastal Plains Community Center

Client Benefits Plan

March 2014

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Coastal Plains Community Center provides services to people with a diagnosis of severe and persistent mental illnesses, mental retardation or pervasive developmental disorders. Services are provided to people who reside in our nine (9) county service area. The counties served are Aransas, Bee, Brooks, Duval, Jim Wells, Kleberg, Kenedy, Live Oak and San Patricio. Coastal Plains Community Center has three full-time employees designated as Eligibility Specialists. The Eligibility Specialists are supervised by the Director of Essential Services. This director is also the liaison between the Department of Assistive and Rehabilitation Services (DARS) Disability Determination Services Division. The Eligibility Specialists have received the approved training by the State Authority to ensure that they understand the process of assisting people in obtaining Medicaid and other benefits. One staff member assists people who reside in the northern counties in applying for benefits; the other is assigned to the southern counties. The third staff member floats amongst the northern counties. A flow chart reflecting the screening and application process is attached to this plan (attachment 1)

Intake and Financial Screening Process

Our agency has different intake processes, based upon the services the person is applying for, however, ultimately if the person needs assistance in applying for benefits, a standardized process is in place. A flow chart reflecting the screening and application process is attached to this plan (attachment 1). Though there are two separate intake processes that people are required to go through, depending on whether the person is applying for Mental Health or Intellectual and/or Development Disability (IDD) services, all people applying for services must complete an Financial Assessment/Benefits Screening Form, which is referred to as the financial form in this document (attachment 2). In both situations, the person or Legally Authorized Representative (LAR) is instructed to bring in proof of income, other supporting documentation related to expenses and insurance information to the intake appointment. The majority of people needing assistance in obtaining benefits are people seeking either Adult or Children's Mental Health Services. However, there are occasions in which a person with a diagnosis of an intellectual or developmental disability is not receiving benefits.

For all services, the staff members involved in the intake process assist the person in completing the financial form, review the person's ability to pay for services and will calculate the person's monthly ability to pay, per the Texas Administrative Code (TAC 412, Subchapter C) Charges for Community Services. The original financial form will be sent to the Eligibility Specialist for review or the Eligibility Specialist will review the form in the electronic medical record. The majority of the financial assessments are completed electronically. There is a notification system in the EMR to notify the Eligibility Specialist of the need to review a financial assessment.

Benefits Application Process

When a referral is made to the Eligibility Specialist (E.S.) the information is reviewed and a meeting is held with the person to determine what level of eligibility potential the person has (low, moderate, or high potential). If the person is determined to have moderate to high eligibility potential for Medicaid and SSI/SSDI, they will inform the person that they can provide them assistance with the application process, at no cost to the consumer. They will also inform the person that they can seek services through other agencies or attorneys who may charge them a fee

for the service. If the person chooses to obtain assistance from CPCC staff, the Eligibility Specialist will assist them in completing the necessary paperwork to apply for benefits. This will occur within two months of admission to services. The Eligibility Specialist will also assist the individual in accessing the Affordable Care Act (ACA) website or in calling the toll-free number to sign up for benefits through this nationwide program.

Initial Application Process

As the Social Security Administration offices in the different counties address things slightly differently, the Eligibility Specialists meet with the consumer to complete the appropriate forms. Basically, the forms completed are the same, just the submission timelines vary slightly. The following forms are completed by the Eligibility Specials and submitted to the Social Security Administration.

1) Completion of the following forms *(can be completed on-line):*

3368 (disability report)
3368 (info on alleged disability)
3369 (Work History Report)
827 (release of information)
821 form (work activity report)
8001 (SSSI Application)
1696 (representative appointment)
F-16 (SSDI Application – if widow/widower, previous work history, etc.)
3373 (function report - Adult- covers both physical and mental)

Prior to filing, the Eligibility Specialist reviews all of the forms to ensure that they are complete and accurate. Disability Determination Services (DDS) will then obtain an authorization for disclosure from the consumer to request records from CPCC. The Eligibility Specialists will assist, as appropriate, the medical records staff in ensuring relevant documentation is submitted to the DDS office. The Eligibility Specialist will also meet with the consumer and assist in obtaining all other documentation requested by DDS. Supporting documentation that may be submitted includes daily activity, work history or pain reports along with case management, rehabilitation services and psychiatric services documentation.

Approval of Benefits

As designated representative, the Eligibility Specialist receives written notification of acceptance or denial of the claim. If the claim is approved, the Eligibility Specialist will assist the person in making an appointment with the Social Security Administration. They also attend this appointment, providing transportation as necessary, to ensure that the person's benefits begin. Once approved, the Eligibility Specialist notifies the billing department with the retroactive start date of benefits and other information that is pertinent to the billing process.

The Eligibility Specialists will notify the Director of Essential Services (UM Director) by e-mail of any client's who become eligible for Medicaid benefits, with the "effective date" and the "certification date" to ensure that consumer's needing rehabilitative services are reviewed by UM staff and authorized for the medically necessary service package immediately, regardless of resource limitations. The client will be looked up in WebCARE and if service package is deviated down, they will be provided the opportunity to receive the services they are eligible for. The status of this choice will be documented in their record or on their RDM assessment.

Initial Denial/First Appeal/Reconsideration

If a claim is denied, the Eligibility Specialist will file the appeal (Reconsideration) within the sixty (60) day grace period. The forms utilized in this appeal include the Application to Appeal form 561 and Disability Report form 3441. As appropriate or upon request, additional information will be

included in the appeal packet. This may include updated or new information regarding daily activity or other assessments that have occurred since the first submission. The Eligibility Specialist assists the consumer in completing all necessary paperwork and reviews the packet of information prior to submission to ensure completeness. The reconsideration process typically takes from thirty (30) to ninety (90) days after the appeal is filed. If the appeal is approved, the Eligibility Specialist will provide assistance to the consumer in obtaining their benefits, as noted in the previous paragraph of this plan.

Second Denial/Second Appeal/Hearing

After a first appeal is completed and a second denial occurs, the Eligibility Specialist will proceed with assisting the person in filing a second appeal and preparation for a hearing. Filing for the second appeal and request for hearing will occur within sixty (60) days of the denial. At that time, the Eligibility Specialist assists the consumer in completion of the Application to Appeal form 501 and a Disability Report form 4486. These forms, as well as a summary of the persons history is submitted, along with any new information that would be supportive of the claim. *NOTE: The hearing may not take place for up to a year after submission of the appeal.* Prior to the hearing, any new supporting documentation will be submitted to the DDS office, as appropriate to the claim. The Eligibility Specialist may also submit a written request to review the file during this wait period in order to prepare for the hearing. Prior to the hearing, they will review the previous submissions, obtain any new records or documentation supporting the claim. They will also meet with the consumer to ensure that they clearly understand the consumer's needs in order to provide adequate support and representation at the hearing. The Eligibility Specialist attends the hearing with the consumer and presents information regarding the case. A written decision will typically be received anywhere from thirty (30) to sixty (60) days after the hearing. If approved, the Eligibility Specialist will follow the process outlined in the "Approval of Benefits" section of this plan. If the person's claim is again denied, the person is provided the option of starting the process over again, with our agency or seeking a private agency to assist them with their claim.

Assistance for Children

For children's mental health services, the intake process for screening is the same as what is specified previously in this plan. The parent(s) or the Legally Authorized Representative (LAR) for a child must complete a financial assessment form at admission. The financial assessment is based on the family income. The intake worker will then complete the financial form and refer the parent or LAR to the Eligibility Specialist, as appropriate. A determination will be made by the Eligibility Specialist regarding potential eligibility for Medicaid or the Children's Health Insurance Program (CHIP). If the family meets Medicaid criteria or has income considered borderline, they will be assisted in completing the application for Medicaid and Food Stamps. This will then be mailed to the Texas Department of Human Services. If they are not eligible for Medicaid assistance, assistance will be provided in completing a CHIP application. The Eligibility Specialists will then call the TDH and CHIP on a monthly basis to monitor the status of all people assistance was provided to. Once staff finds out that the child has benefits, the Eligibility Specialists will follow the process outlined in the "Approval of Benefits" section of this plan. Again, all people will be assisted with the application process to ACA benefits.

Other Benefits Assistance Provided

Anyone who has Medicare benefits will be referred to the Eligibility Specialist to determine potential eligibility for Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiaries (SQMB), Qualified Disabled Working Individuals (QDWI), Qualified Individuals 1 (QI-1), or Qualified Individuals 2 (QI-2) program benefits. The Eligibility Specialist will then

review the person's income and current benefits. If eligible for one or more of these programs, assistance with the application process will occur. People eligible for the new Medicare Drug-Discount Card will also be provided assistance in applying for this benefit, or will be provided the option of choosing to receive assistance through other providers who also assist individuals with this program.

All people who are filing for disability benefits will also be referred to the individual county indigent programs and ACA website/toll-free number. Even if the person may not qualify for assistance in applying for Medicaid or SSI/SSDI benefits, the person's income level and other factors will be evaluated. If they meet criteria for the county indigent programs they will be referred by either the Eligibility Specialist or the individual's Case Manager. These programs only provide medical assistance, however the agency recognizes that physical health impacts mental health.

If during the screening process it is determined that the person may be eligible for veteran's benefits, assistance includes linkage to the Veteran's Administration (VA). It is a requirement in applying for disability benefits for veterans to apply for V.A. benefits. Once the determination letter regarding VA benefits is received, the required information is forward to the Social Security Administration.

The Social Security Administration will send a notice to each individual when it is time for his or her disability review. Reviews are based upon the severity of the person's disability and occur either once a year, every two years or every seven years. If the consumer notifies CPCC staff of the review, the Eligibility Specialists will assist in this review process. They will provide assistance to the consumer in completing the application and in sending the supporting documentation to the DDS office.

Annual and Periodic Re-evaluation of Financial Status

All people admitted to services are advised to notify their Case Manager if there are changes in their financial status. Each Case Manager is required to meet with the consumer, at least annually and upon any changes in financial status. When this review occurs, a financial assessment and the Eligibility Screening Tool is completed to determine if assistance in obtaining benefits is needed. Based upon the results of the financial and screening, a referral will be made to the Eligibility Specialist. If this occurs, the preceding process outlined in this plan will be followed.

Collection, Aggregation and Submission of Data to State Authority(s)

Coastal Plains Community Center utilizes the Anasazi/Cerna software system for documentation and tracking of services. A system was developed and implemented for the Eligibility Specialists to enter their activities, to track the specified information that must be reported to the state office. This information is also reviewed internally, at least quarterly, to identify any trends, outliers or barriers to provision of these services. The following data elements will be tracked and submitted per the contracts with the Department of State Health Services (DSHS) and Department of Disability Services (DADS): the number of new client screenings, annual screenings, SSI/SSDI applications submitted, and applications approved. This information will be submitted via e-mail to the contract manager upon request or based upon required submission to Performance Contracts.

Notification of CPCC's Billing Staff for Retroactive Billing

The Eligibility Specialists notify the billing department supervisor, immediately via internal e-mail (which is a secure e-mail site) of any consumer that they have assisted, that becomes eligible for

benefits. In this notification, they include the date that the benefits were approved and application dates, to allow completion of any retroactive Medicaid billing. Case management staffs have also been instructed to complete a new financial screening form, upon notification that any of their consumers become eligible for benefits. As new financial forms are entered, to include benefits information, the billing department is notified of the changes in financial status.