New Jersey Department of Human Services
Division of Aging Services
Office of Community Choice Options

EARC-PAS Updates
Goal and Objectives

The goals of this Webinar are to:

- Review the changes to the EARC processes and form effective 7/1/14
- Understand the process of completing the updated EARC-PAS form and obtaining authorization for transfer to NF
- Clearly identify the new Target Population – who is eligible for EARC?
- Review PASRR considerations
EARC Form Changes

• A new EARC Form and processes effective July 1, 2014

• EARC will serve as a 30 day authorization
  – NF will be responsible for referring to OCCO for on-site PAS

• The revised tool incorporates the functional and cognitive elements of the NJ Choice Home Care assessment tool
  – The NJ Choice Home Care is the most recent version offered by the publisher (interRAI)
The EARC-PAS is completed by Certified Hospital Discharge Planners and reviewed by the Office of Community Choice Options (OCCO) Regional Offices.

Once authorized, patient may be discharged to a NF

EARC will serve as a 30 day authorization

Upon NF admission, NF initiates referral to OCCO for an onsite Pre-Admission Screening (PAS)*

*certain exclusions apply
Target Population

**Target Population**

**EARC-PAS Eligibility Guidelines**

**Target Population**

- Individuals currently in an acute non-psychiatric hospital setting who are entering a Medicaid Certified Nursing Facility, or Special Care Nursing Facility Ventilator Unit, with an expectation of billing NJ Medicaid for all or part of the stay because they are
  - Medicaid eligible, but not enrolled in a Medicaid Managed Care Organization
  - Potentially Medicaid eligible within 180 days of NF admission
    - Application should be initiated at CWA
Target Population - Exclusions

- Individuals who would not qualify for Medicaid within 6 months of NF placement
  - These individuals are not subject to Pre-Admission Screening requirements per N.J.A.C. 8:85.
Target Population - Exclusions

- Medicaid eligible individuals who are enrolled in a Medicaid Managed Care Organization (MCO)
  - The MCO is responsible for NF prior authorization for all NJ Family Care members
Target Population – Exclusions
NJ Medicaid Managed Care Organizations

As of July 1, 2014, there are 4 MCOs serving NJ Medicaid members
1. Amerigroup
2. Horizon NJ Health
3. United Healthcare
4. WellCare
Target Population - Exclusions

Persons who do not qualify for EARC-PAS and require an onsite OCCO PAS at the Hospital are:

- Persons who are being referred for Special Care Nursing Facility (SCNF) placement:
  - TBI, AIDS, Huntington’s, Behavioral, Young Adult Disabled and Pediatric Units
- Persons who are in a Psychiatric Hospital or Psychiatric Acute Care Unit
- Persons who are seeking Home and Community Based Services
Target Population - Exclusions

• Patients in Emergency Rooms
  – These individuals are to be referred to OCCO for consultation.
PASRR Process Considerations

- Include a copy of the completed PASRR Level I Screen (Form LTC-26) with all EARC-PAS requests, regardless of outcome.

- Positive Level I Screen must be sent with EARC-PAS and simultaneously forward to DMHAS and/or DDD.

- EARC-PAS referrals for Positive Level 1 Screens will not be authorized until
  - OCCO confirms a 30-Day Exempted Hospital Discharge and/or
  - Receives results of PASRR Level II Determination from DMHAS and/or DDD that Specialized Services are not required.
Special Note Regarding PASRR

- NF placement is contingent on completion of PASRR Level I Screen, and Level II Evaluation and determination if indicated.
- If patient requires Specialized Services through DDD or DMHAS, he/she cannot be transferred to NJ Medicaid NF.
Questions
FAQ’s

1. If we have a new patient to our facility who is being admitted from the hospital, who should request the EARC PAS?
   If the client meets the target population for an E-ARC PAS it should be requested from the NF prior to admission.

2. If the resident is Medicaid Pending or has no MLTSS Plan an EARC is needed?
   EARC- those pending Medicaid or those with no managed care enrollment. Those on MLTSS have an MCO.

3. EARC is good for 30 days until the MCO provides an Auth?
   If the individual is enrolled in MCO then no EARC is required, the MCO will provide the authorization.

4. If resident is being admitted to our facility on MLTSS from the Hospital and has a MCO in the community does the Hospital get an Auth and a PAS? Or just the Auth?
   IF the individual is enrolled in an MCO the MCO provides the authorization. NO PAS required.
FAQ’s

5. What happens if the Patient is admitted on Medicare A and has a MCO in the community. Does this cover the co-insurance? Does the hospital get an Authorization and PAS for the co-insurance (21st day) or do we call the MCO on the 21st day?

The hospital should be speaking with the MCO to see what is required. If enrolled in an MCO no PAS is required the MCO will provide the auth

6. What is the patient comes from the community? Who request an Authorization and PAS? Please confirm if the resident has an MCO that the MCO will issue the PAS and Authorization?

The NF would determine if enrolled in an MCO, again if enrolled in an MCO then the MCO provides the auth and payment from day one for admission and no PAS is required. IF fee for services in the community the individual would be referred to OCCO to conduct the PAS.

7. If the residents has an MCO do we still need an EARC?

If enrolled in MCO no PAS or E-ARC is required the MCO will authorize
Appendix O

New Jersey Department of Human Services
Office of Community Choice Options
EARC-PAS - ENHANCED AT-RISK CRITERIA SCREENING TOOL

If on Medicaid STOP. No EARC required. Refer to the Medicaid MCO for Authorization.

<table>
<thead>
<tr>
<th>MUST BE COMPLETED BY SCREENER</th>
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<tbody>
<tr>
<td>Type of Request</td>
</tr>
<tr>
<td>☐ NF</td>
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<tr>
<td>☐ Vent SCNF</td>
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</tbody>
</table>

NOTE: EARC-PAS referrals will not be authorized until OCCO confirms PASRR Positive Level I Screens as a 30-Day Exempted Hospital Discharge and/or receives results of PASRR Level II Determination from DMHAS and/or DDD that Specialized Services are/are not required. For all PASRR Positive Screens, include a copy of the completed PASRR Level I Screen (Form LTC-26) with this EARC-PAS request. If patient triggers positive and requires specialized services, 1) Hospital patient cannot transfer to NF and 2) NF patient cannot remain in NF. Provider to contact DDD/DMHAS to coordinate specialized services.

FOR OCCO USE ONLY

<table>
<thead>
<tr>
<th>☐ AUTHORIZED NF</th>
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</thead>
<tbody>
<tr>
<td>Authorized: ☐ NF ☐ Vent SCNF</td>
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</table>

Valid Through: ______________________ Valid for this Hospital Admission only.
Transfer to Nursing Facility if Patient Does Not Require Specialized Services.

<table>
<thead>
<tr>
<th>☐ NOT AUTHORIZED NF</th>
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<tbody>
<tr>
<td>Requires on-site OCCO PAS in Hospital. OCCO Regional Office will schedule OCCO on-site PAS assessment.</td>
</tr>
</tbody>
</table>

OCCO Reviewer Comments: __________________________________________________________

Name of Reviewer (Print)   Signature of Reviewer   Date of Review by OCCO

SECTION 1 - IDENTIFYING INFORMATION

Patient Name (Print) - Last First Social Security Number
Street Address Date of Birth (Month / Day / Year)
City, State, Zip Code County of Residence Gender ☐ Male ☐ Female
Where did the patient live at time of admission?
☐ Private Home/Apartment (alone) ☐ Private Home/Apartment, with care (family or agency)
☐ Facility (Specify): __________________________________________________________

SECTION 2 - MENTAL ILLNESS, INTELLECTUAL DISABILITY AND/OR DEVELOPMENTAL DISABILITY

1. Does the patient have any history of mental illness (such as but not limited to Schizophrenia, Bipolar Disorder, Major Depression, Anxiety Disorder, Psychotic Disorder), intellectual disability, or developmental disability (such as but not limited to Cerebral Palsy, Epilepsy, Autism, Spina Bifida)?
   a. Date of Level I PASRR Screen: ______________________
   b. Level I Screen Outcome: ☐ Negative ☐ Positive
   c. Did physician certify NF placement as 30-day exempted hospital discharge? ______________________

SECTION 3 - INSURANCE INFORMATION

1. Medicare Number: ______________________
   ☐ Traditional Medicare Coverage: ☐ Part A ☐ Part B
   ☐ Medicare HMO
   Number of Days Authorized: ______________________

2. Does the patient have other insurance that will cover 100% of the skilled nursing facility stay, including co-insurance payment at 100% if they exceed the first 20 days of Medicare?
   a. Name of Carrier: ______________________
   b. Number of Days Authorized: ______________________
   c. Type: ☐ Primary ☐ Secondary ☐ Supplemental

LTC-34
June 14
**SECTION 3 - INSURANCE INFORMATION, Continued**

1. Did patient apply for Medicaid and is application pending?  
   - Yes: [ ]  
   - No: [ ]

2. Is Medicaid expected to pay for any of the cost of the nursing facility stay?  
   - Yes: [ ]  
   - No: [ ]

3. Will the patient's funds last less than six (6) months in a nursing facility?  
   - Yes: [ ]  
   - No: [ ]

**SECTION 4 - COGNITIVE STATUS AND ADL SELF PERFORMANCE**

1. How well does patient make decisions about organizing the day (e.g. when to eat, choose clothes, when to go out)?  
   - Independent [ ]  
   - Modified Independence [ ]  
   - Minimally Impaired [ ]  
   - Moderately Impaired [ ]  
   - Severely Impaired [ ]

2. Can patient recall 3 items from memory after 5 minutes?  
   - Yes: [ ]  
   - No: [ ]

3. How well does patient express or make self-understood?  
   - Understood [ ]  
   - Usually [ ]  
   - Often [ ]  
   - Sometimes [ ]  
   - Rarely/Never [ ]

4. ADL Self Performance (score over past 3 days)  
   - Bed Mobility  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Transfer  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Locomotion (indoor/outdoor)  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Dressing (Upper and/or Lower body)  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Eating  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Toileting (toilet use and/or toilet transfer)  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

   - Bathing (over last 7 days excluding washing of back and hair)  
     - Independent [ ]  
     - Set Up [ ]  
     - Supervision [ ]  
     - Limited Assistance [ ]  
     - Extensive Assistance [ ]  
     - Maximal Assistance [ ]  
     - Total Dependence [ ]  
     - Did Not Occur [ ]

**SECTION 5 - MEDICAL**

1. Diagnosis(es):  
   - YES: [ ]  
   - NO: [ ]

2. Does the patient have catastrophic illness, a debilitating and/or a chronic illness affecting functional status that may require long term care services?  
   - YES: [ ]  
   - NO: [ ]

   Specify Major Health Needs:  
   - ____________________________________________________________  
   - ____________________________________________________________

3. Is this patient ventilator dependent?  
   - YES: [ ]  
   - NO: [ ]

**SECTION 6 - FINANCIAL**

**INCOME**

1. Patient’s monthly income is at, or below, the current NJ Care Special Medicaid Program’s maximum monthly income limit of $973, or  
   - YES: [ ]  
   - NO: [ ]

2. Patient’s monthly income is at, or below, the current Medicaid institutional cap of $2,163  
   - YES: [ ]  
   - NO: [ ]

*NOTE: If patient's income is >$2,163 and assets are minimal, patient may still qualify for NF Medicaid Reimbursement.*
**New Jersey Department of Human Services**

**EARC-PAS - ENHANCED AT-RISK CRITERIA SCREENING TOOL**

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<table>
<thead>
<tr>
<th>SECTION 6 – FINANCIAL, Continued</th>
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<tbody>
<tr>
<td><strong>ASSETS</strong></td>
</tr>
<tr>
<td>Check one: This is an indication that the patient may become Medicaid Eligible within the next (6) months by spending down assets in a nursing facility as private pay</td>
</tr>
<tr>
<td>☐ Patient has no spouse in the community and resources no greater than $4,000 (plus $1,500 burial fund), or</td>
</tr>
<tr>
<td>☐ Patient has no spouse in the community and resources at or below $53,000 (plus $1,500 burial fund), or</td>
</tr>
<tr>
<td>☐ Patient has a spouse in the community with combined countable resources at or below $117,240 (plus $1,500 burial fund).</td>
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<tr>
<th>SECTION 7 - INITIAL PLAN OF CARE</th>
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<tbody>
<tr>
<td>Provide information and counsel patient and/or patient’s family or authorized representative(s) about:</td>
</tr>
<tr>
<td>(1) long-term care supportive services including discharge to community with supportive services, referral to ADRC/AAA and placement in Nursing Facility/Sub-Acute, and</td>
</tr>
<tr>
<td>(2) how to submit an application to determine financial eligibility for Medicaid benefits.</td>
</tr>
<tr>
<td>Check off all that apply:</td>
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<tr>
<td>☐ Nursing Facility – Long Term</td>
</tr>
<tr>
<td>☐ Sub-Acute Nursing Facility Placement – Short Term</td>
</tr>
<tr>
<td>Provider feels there is a potential for discharge of the patient to the Community in the future? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Patient/family expresses an interest in returning to Community? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Was a referral made to County ADRC/AAA? ☐ Yes ☐ No</td>
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<tr>
<td>☐ Other:</td>
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*I acknowledge that I was prescreened and received counseling. I also consent to the Plan of Care proposed above.*

<table>
<thead>
<tr>
<th>Name of Patient/Authorized Representative (Print)</th>
<th>Check One:</th>
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<tbody>
<tr>
<td></td>
<td>☐ Patient ☐ Authorized Representative</td>
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<thead>
<tr>
<th>Signature of Patient/Authorized Representative</th>
<th>Date</th>
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<tr>
<th>SECTION 8 - ATTESTATION</th>
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<tr>
<td><em>I screened the above-named patient and attest to the information that appears on this At-Risk Criteria Screening Tool. I also counseled the patient on discharge options.</em></td>
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<table>
<thead>
<tr>
<th>Name of Certified EARC-PAS Assessor (Print)</th>
<th>Certified EARC-PAS Assessor Certification No.</th>
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<thead>
<tr>
<th>Certified EARC-PAS Assessor Telephone</th>
<th>Certified EARC-PAS Assessor Fax</th>
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<thead>
<tr>
<th>Signature of Certified EARC-PAS Assessor</th>
<th>Date Screen Completed by Certified EARC-PAS Assessor</th>
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<thead>
<tr>
<th>Name of Hospital</th>
<th>County</th>
<th>Date of Admission to Hospital</th>
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<tr>
<th>Fax to:</th>
<th>Date/Time Faxed</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ NRO Fax (973) 693-5046</td>
<td></td>
</tr>
<tr>
<td>☐ CRO Fax (732) 777-4681</td>
<td></td>
</tr>
<tr>
<td>☐ SRO Fax (609) 704-6055</td>
<td></td>
</tr>
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(1) FAX all three pages of the completed EARC-PAS Screening Tool to OCCO Regional Field Office.

(2) Transfer of Hospital Patient to NF cannot occur until OCCO issues EARC-PAS authorization.
INSTRUCTIONS FOR COMPLETION OF THE
New Jersey Department of Human Services
Division of Aging Services
NOTIFICATION FROM LONG-TERM CARE FACILITY FOR ADMISSION AND TERMINATION
Complete each section and fax to the Office of Community Choice Options Regional Office for notice of PAS request, admission, termination, and transfer.

Notification - Type of Notification: Check the appropriate box.

☐ Request PAS
☐ Notice of Admission
☐ Notice of Termination
☐ Notice of Transfer

SECTION I - PATIENT INFORMATION

1. Name - self explanatory
2. Social Security Number - patient’s number
   (Note: the Medicare number is NOT ALWAYS the patient’s SSN)
4. Date of Birth - self explanatory
5. HSP#-12digit Medicaid Number, if available (Confirmed By: Give name of CWA approving financial eligibility) NJ Family Care, MLTSS, FFS, MCO write in name of MCO if know.

SECTION II - PROVIDER INFORMATION

1. Provider Number- 7 digit Molina provider number
2. Facility name and address
3. Facility Phone number
4. SCNF

SECTION III - Status PASRR

1. Enter date of PASRR level I screen.
2. Check the appropriate box, negative or Positive. If positive, continue to check the appropriate box for the positive screen.
3. Date of the Positive Level II evaluation. (unless PASRR 30 Day Exempted Hospital Discharge)
4. Outcome of PASR Level II evaluation- check the applicable box for yes or no for specialized services.

SECTION IV – REQUEST FOR PAS:
Check off box indicating type of PAS Request:
   a. Private to Medicaid
   b. PAS Exempt >20 days (Physician 20 day note must accompany request or PAS will not be completed).
   c. Medicare to Medicaid
   d. Out of State Approval Admission,
   e. SCNF to NF
   f. NF to SCNF
   g. Transfer
   h. EARC PAS
   i. Other
SECTION V - ADMISSION INFORMATION
(IF THIS IS A TERMINATION, SKIP TO SECTION V)

1. Admission Date-
   - This is the date resident was admitted to the facility. **For Private to Medicaid cases this date should reflect the date the patient was originally admitted to the facility. This type of case should be sent to the field office 6 months prior to the anticipated date of conversion to Medicaid.**
   - Transfer- Check the box yes or no.
2. Date of PAS –if applicable
3. Admitted from-check appropriate location:
   - Community/Boarding Home
   - Medicare to Medicaid
   - Psychiatric Hospital
   - Private to Medicaid-complete “anticipated Medicaid Effective Date” (Note: It is no longer necessary to attach PA-4)
   - Hospital - Acute Care Hospital or Rehab Hospital-also complete #5
   - Other Long Term Care Facility (LTCF)-also complete #5
   - Other (specify)-use this category if above categories do not apply.
4. Name and Address of Hospital/LTCF Admission Date-self explanatory
5. If admitted from Hosp/LTCF, give the name/address of previous residence-self explanatory

SECTION V1 - TERMINATION INFORMATION
(IF THIS IS AN ADMISSION, SKIP TO SECTION V)

1. Discharge Date-date patient was discharged from the facility
2. Discharged to: (check one)
   - Home – Community (including relative’s home)/County of residence
   - Facility (includes NF and AL)/ County of Residence
   - Other (use this category if above categories do not apply. Include name and address of “other”/County of residence
   - Death (Date)-self explanatory
   - Check “In LTCF” or “In Hospital”

SECTION V11 - CERTIFICATION

1. By signing this certification, Provider is attesting that the facility has a “valid PAS on file”. Complete Name, Title, Phone Number, and Date

SECTION VI11 - CWA USE ONLY (TO BE COMPLETED BY CWA ONLY)

Section IX - GENERAL INFORMATION FOR NURSING FACILITIES:
Send an LTC-2 for all new admissions that have been prescreened, private to Medicaid, out of state and EARC, and PAS Exempt cases. LTC-2 is now required to be sent for PASRR notification regardless of payor source and for notice of termination.
N.J.A.C. 10:63-1.8 (k) mandates the nursing facility (NF) to submit the LTC-2 (formerly MCNH-33) form to the Office of Community Choice Options Regional Field Office, serving the county where the NF is located within two working days of status of admission, termination, request for PAS for all persons who are currently Medicaid eligible, or will be eligible within 180 day and for PASRR notification regardless of payor source.