AVS – I.E.
APD All Staff Q&A
1-23-2020

Is the AVS authorization form an actual paper form or included in the ONE application?
AVS authorization will be a stand-alone paper form. The authorization was not able to be incorporated into the full application itself at this stage of the project. However, the stand-alone form will be included in the packet which contains the application.

Will AVS be able to access Direct Express Balances in the future?
AVS is capable of receiving this information. However, the vendor who supplies Direct Express information has chosen to not participate at this time. If this changes in the future, staff will be notified.

Will we need the new AVS form for current consumer's in OSP programs or will the 539A that we currently have on file work?
A signed 539A on file that is a version 2009 or later is appropriate for applicant AVS authorization. APD Policy is reviewing AVS authorization requirements to determine if ongoing consumers will need to sign a new authorization form once they are available.

LTC NEW cases - SSI cases - are we required to wait for AVS results prior to approving cases?
The federal 5 year "look-back" period is a requirement for all initial applicants to Long Term Care services, including MAGI Medicaid recipients, SSI recipients or other assumed eligible individuals. AVS must be submitted, results reviewed, and eligibility determined timely before approving the case.

Let's say we have a consumer that reports 1 account. AVS comes back with 2 accounts. RFI goes out. We receive verification that it is an account that she signed on for her daughter years ago. The daughter still uses the account as her primary account and we also verify the consumer has no money in the account. So according to the availability rule, it is considered not available. What options will be available in ONE? Can we mark as excluded? Can it be removed from ONE?

This account should be added to integrated ONE as unavailable.

If we have consumers in the hospital and on hospice, we need to leave them in the hospitals for 15 days or longer until AVS comes back. Will there be notification going out to all hospitals.
The federal Medicaid eligibility, processing time and financial rules have not changed due to AVS. Medicaid is always the payer of last resort.

AVS is a federal requirement to administer our Aged, Blind and Disabled programs that rely on Federal Financial Participation.

As long as we are determining program eligibility within our federal timelines, DHS is not responsible to the hospital or the new service applicant regarding the length of their inpatient stay. Retroactive Medicaid payments are possible when financial and service eligibility determinations ultimately award benefits. It is not an accurate portrayal that DHS is culpable for "leaving people" in hospitals because we are determining eligibility in accordance with state and federal Medicaid regulations. A hospital's discharge planning process and the continued utilization of their services without medical necessity is beyond the control of DHS.

We would continue to expect hospitals, health systems and the staff who participate in discharge planning to engage the Department in a more proactive manner to mitigate the pressure on APD/AAA case managers to expedite Medicaid Service approvals in order to secure immediate payment for the hospital and consumer placement outside of the facility.

While we appreciate the difficulty in determining eligibility for such a complex program and balancing the needs of potentially eligible Oregonians, there is no "work-around" or "good cause" exception in federal or state rules for emergent needs like hospice or discharges from institutions like hospitals that allows us to waive parts of the financial eligibility determination.

Many people need publicly funded Long-Term Care services, but very few are financially eligible when compared to that need.

Determining Medicaid program eligibility in an “expedited” manner leads to errors, even with the best intentions. Awarding benefits to people who turn out to be non-eligible later can place the financial costs back on the Consumer in the form of a program overpayment and back to the Oregon taxpayer, as we cannot claim a federal Medicaid match for ineligible Oregonians.

Oregon has traditionally enjoyed some flexibility which may result in hospitals and health systems expecting full financial and service eligibility to be performed in hours/days compared to the federal 45-day processing time frame. This is an unrealistic expectation in the future system and operational practice. The transition will require additional communication with these providers regarding the federal requirements and the potential impact on discharge planning.

We are not getting AVS back from all banks. This is a problem.
Specific AVS errors can be reported to APD policy. Please keep in mind we need the specific request, specific bank, and how you determined the error. This information can then be sent to our vendor who will reach out to the bank and attempt to resolve the issue.

If AVS is a requirement by Congressional Act, why are the credit unions not responding without a specific request (most clients have a credit union)?
AVS is a federal requirement for state agencies that administer Medicaid. Banks and Credit Unions who participate do so voluntarily. There are over 10,000 banks and credit unions who choose to participate. In order to make AVS a viable system, a request cannot be sent to every bank automatically. AVS searches the top 12 financial institutions in the U.S. automatically, workers have the option of adding additional banks and credit unions needed via the Direct Account search, the system also performs a geographical search based on the address entered into AVS and the distance of neighboring financial institutions likely to serve that area.

Are we still not allowed to pend for bank info prior to getting AVS response? we would like to know - that for LTC intake - there are times that we are unable to get the needed info back to the date that care started - can we just go ahead and pend for the needed bank statements or still need to wait for AVS to come back before pending for ANY bank info?

The federal AVS regulation requires AVS be attempted prior to pending for banking information, that has not changed.

Are you aware of any issues as of late with AVS and US Bank? US Bank used to show on AVS after specifically requesting it (using just the right way to type "U.S." in) but lately our requests still come back with no accounts found - and then we request the statements from the client/rep and they do still have the accounts there?
U.S. Bank participates in AVS and no on-going issues have been reported. U.S. Bank is not automatically searched, so workers will need to add this institution via the Direct Account search anytime information from U.S. Bank is needed. If U.S. Bank has been added, and nothing is returned after the 15-day processing timeframe and we have confirmed the individual holds an account there, then this should be reported to APD policy as an AVS error so that the vendor can follow up with the bank.

Will DHS let all hospitals know this? Can Central Office assist with 'teaching' rural hospitals the AVS timeline requirements?
DHS is working with OHA to determine whether additional messaging or discussion is appropriate.

How are we going to serve people in hospitals and rehab facilities if we have to wait up to 15 days to get an AVS response? If someone is in the hospital, they will NOT keep them for 15 days while waiting. If the person in the hospital cannot go to skilled, we will not be able to place them ICF until AVS comes back. If someone in the hospital goes to a skilled facility as "skilled" we only have 20 days of skilled time (typically). That means someone will have to be at the NFC continuously to get signatures. Also, NFC will also typically NOT keep someone without a payer source. Making them wait will create a huge obstacle in serving those who are coming out of the hospital and those in skilled rehab. So, are we saying that the policy info we were given about MAGI clients, if they report no resources or transfers, we cannot open to LTC until AVS comes back? Because policy has said if they report nothing we can go ahead and open and still run AVS and if anything comes back then take action?
AVS is a condition of eligibility for OSIPM and/or LTC cases that require a financial review. As a condition of eligibility, staff should not open these cases before AVS has been submitted, results have been reviewed and eligibility has been cleared.

This includes reviewing for any possible disqualifying transfers within the look-back period for any long-term care service requests.

Will rules be updated regarding this, so we don't lose a hearing?
The requirement to use AVS is federal and we are still required to determine Medicaid program eligibility in 45 days (90 days for PMDDT). We are not sure from this question as to why "we would lose at hearing" for following federal rule and program policy.

42 USC 1396w

(b) Asset verification program

(1) In general For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

(A) requires each applicant for, or recipient of, medical assistance under the State plan under this subchapter on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are required by law to be disclosed to determine the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act [1] [12 U.S.C. 3415] but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act [12 U.S.C. 3401(1)]) any financial record (within the meaning of section 1101(2) of such Act) held by the institution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

For AVS: if we have requested specific bank within AVS and 15 days passes - but later during the same intake or recertification process we learn from client that

they have other bank - are we supposed to request AVS again and wait 15 days AGAIN before approving the case?
If this happened, we would need to add this additional account to AVS in order to clear financial eligibility before the case was opened. It's important that we identify any known accounts and add them to the AVS request immediately to avoid any delay.

Is SSP doing EPD, DAC and Pickle cases. As AVS is needed?
Cases that require the use of AVS will continue to be determined and redetermined by APD/AAA staff.

I understood that the AVS only report the amount at the 1st of the month... wont we almost always need to verify with the client?
The current AVS system has been in place for over a year while returning information from the first of the month. This has not caused any issues.

Will staff be trained this again in the 201 training?
201 Training is ONE system related training that will cover the resource and AVS related screen functions.

Can the Pending for Asset Verification Report be run by branch?
Yes, like other ONE reports, this reporting is available to field and central staff with the appropriate user roles in the system.

Will it be a failure to comply if they don't sign the AVS release?
Yes, an AVS release is a requirement of Medicaid eligibility for programs that require it's use.

If AVS responds with accounts info before 15 days - are we still required to wait 15 days when it states that it is still processing?
We can check AVS at 10 days and move forward if the known accounts have been returned. If the known accounts are not back at 10 days, we will need to wait until the 15th day.

Will SSP ever get access to AVS?
APD/AAA offices are currently performing all of the financial Medicaid eligibility that requires AVS. Until the training is ready and non-APD/AAA eligibility staff can

demonstrate proficiency in determining OSIPM related programs, APD/AAA will continue to provide this same level of customer service. AVS will eventually be incorporated into the ONE system, as opposed to the current web portal access.

It has been mentioned that AVS must come back before any approval of benefits happen, is this correct? Will there be actual policy come out about this?
AVS is a condition of eligibility for OSIPM and/or LTC cases that require a financial review. As a condition of eligibility, staff should not open these cases before AVS has been submitted, results have been reviewed and resource eligibility has been cleared. This includes reviewing for any possible disqualifying transfers within the look-back period for long-term care service requests.

At this time, we are allowed to open benefits prior to having AVS results if consumer voluntarily provides resource information that meets eligibility criteria. Will this continue?
It was determined that this did not meet the federal regulation. Even if an applicant reports less than $400 in total liquid resources, or provides bank statements during the initial interview, federal regulation requires that AVS still be submitted, results reviewed, and resource eligibility cleared prior to opening the case. This includes reviewing for any possible disqualifying transfers within the look-back period for long-term care service requests.

If AVS comes back with info but not with all info that client reported - and if those other accounts balance reported are below $400 - are we still required to pend for verification?
If a known account was not returned via AVS, we should pend the individual for that information unless the self-attested total value of gross liquid resources is below $400. This rule does not apply to each single account. (see OAR 461-115-0700).

There have been issues with no AVS results coming back, or the applicant's financial institution not being searched, causing a delay in processing. When that happens, will ONE generate an RFI to the client requesting resource information? Or the worker?
AVS is a stand-alone system outside of integrated ONE, so this will be the worker's responsibility to update integrated ONE accordingly and send an RFI for the appropriate information.

If a person requests LTC through the applicant portal, will the system send the AVS form, or CCU/elig worker?
New LTC requests from the Applicant Portal will generate a task for the APD Central Coordination Unit who will initiate the AVS request IF the applicant has signed the AVS disclosure before routing the referral to the closest servicing APD/AAA office.

If the AVS disclosure was **not** completed prior to the referral to the APD Central Coordination Unit, the CCU will include that information in the referral email.

The expectation would be that the receiving APD/AAA office would generate an RFI in ONE to the applicant for the form completion and request AVS when the form is received in order to process the application.

If the applicant is engaging the SSP field office or the VEC, those eligibility workers should provide the form to the applicant for signature so that APD CCU can request the initial AVS when the LTC task is received in Central office.

We will add this information to the relevant Eligibility Transformation Operational Procedure.

Can anyone sign the AVS consent on behalf of the consumer if the consumer has cognitive issues. i.e. at this time folks can sign a 539A on behalf of others to assist in the application process?
An Authorized Representative can sign in place of the consumer.