Accessing the Community HealthChoices Waiver:

A Guide to Waiver Eligibility for Advocates

Overview

People with physical disabilities and older adults seeking Medical Assistance (MA or Medicaid) funded long-term services and supports at home can apply for a Home and Community-Based Services waiver offered through the Office of Long-Term Living (OLTL). To qualify, applicants must be aged 21 or older and meet both functional and financial eligibility standards.

This guide provides an overview of the application process for one OLTL waiver – the Community HealthChoices waiver – including the functional eligibility review and the County Assistance Office (CAO) financial eligibility review. Functional eligibility is determined by looking at a person's ability to perform certain activities and tasks that are needed for daily living. Financial eligibility is determined by looking at a person's income and resources (assets), such as bank accounts, property, and retirement accounts.

What are Home and Community-Based Waivers?

Home and Community-Based Services (HCBS) waivers are Medicaid programs that provide long-term services and supports to older adults and people with disabilities to help them to remain living at home or in another community-based setting. OLTL administers two waivers: the Community HealthChoices (CHC) Waiver and the OBRA Waiver.

This guide applies to individuals seeking waiver coverage under Community HealthChoices (CHC). For information about the OBRA waiver, please call PHLP's Helpline at 1-800-274-3258

Most people getting home and community-based services from an OLTL waiver are in the CHC waiver. However, the OBRA waiver continues to

exist for some individuals who do not qualify for the CHC waiver. This guide covers the Community HealthChoices (CHC) waiver. For information about the OBRA waiver, review the OLTL's OBRA Waiver webpage or call PHLP's Helpline at 1-800-274-3258 with additional questions.

When a person is eligible for the CHC waiver, they receive both regular Medicaid benefits as well as waiver services. Behavioral health care coverage – mental health and substance use disorder treatment – is "carved out" and provided through a separate behavioral health managed care plan assigned based on county of residence. Coverage of physical health benefits, including coverage of primary care, hospital care, specialists and dental services, and home and community-based services is through a Community HealthChoices managed care plan. There are three choices of CHC plans:

- **AmeriHealth Caritas CHC** (called **Keystone First CHC** in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties)
- **Pennsylvania Health & Wellness**
- **UPMC Community HealthChoices**

Individuals receive information about their CHC plan choices at the beginning of the waiver eligibility process and may change their plan at any time. If an individual found eligible for the CHC wavier does not choose a CHC plan, they will be automatically enrolled in one. To learn about the available CHC plans, visit www.enrollchc.com.

What services does the CHC waiver provide?

The CHC waiver is an alternative to nursing home or institutional care; it is for people who would otherwise qualify for nursing home care but prefer to remain in their homes. When an individual is found eligible for the CHC waiver, they receive full Medicaid coverage as well as additional services Medicaid generally does not cover, known as waiver services or home and community-based services. Once someone is approved for the CHC waiver, a person-centered service plan (PCSP) is developed that outlines the type and frequency of waiver services the individual will get based on their individual needs. Some examples of CHC waiver services are:

- Non-Medical Transportation
- Personal Assistance Services
- Skilled Nursing Services
- Adult Day Health Programs
- Employment Services & Supports
- Personal Emergency Response System (PERS)

- Respite Care
- Home Delivered Meals
- Home Adaptations
- Assistive Technology
- Vehicle Modifications
- And more

For a full list and description of CHC waiver services and information on accessing services through the CHC waiver, please review PHLP's Person-Centered Service Planning Guide.

Who is eligible for the CHC waiver?

To be eligible for the CHC waiver, a person must be:

1. At least 21 years old;
2. Meet the CHC waiver functional eligibility requirement; and
3. Meet the waiver financial eligibility requirements.

Is everyone enrolled in a CHC plan eligible for the waiver?

No. The CHC waiver is part of the larger CHC program. The CHC program has three major components. Each CHC plan covers:

1. Medicaid physical health services, such as primary care and specialist visits, hospital services, dental, etc.
2. HCBS waiver services, **if eligible**.
3. Nursing facility services, **if eligible**.

Most people enrolled in both Medicaid and Medicare receive their Medicaid physical health services through a CHC plan. If they wish to receive waiver services, such as personal assistance services, they must apply separately and be approved for the CHC waiver.

CHC Waiver Application Process Overview

The CHC waiver application process has multiple steps and can take a few months, though it should not take more than 90 days. Below is an overview of the application process.

Step 1. **Contact the IEB:** The Applicant contacts the Independent Enrollment Broker (IEB) at 877-550-4227 to begin the application process.

Step 2. **Physician Certification:** The Independent Enrollment Broker sends a Physician Certification form to the Applicant's doctor. The doctor should return the form to the Independent Enrollment Broker within five (5) business days. The Physician Certification asks the doctor to indicate the Applicant's diagnoses, whether the Applicant has a short- or long-term condition or disability, and the Applicant's level of care needs as one of the following:

A) Nursing Facility Clinically Eligible (NFCE),

B) Nursing Facility Ineligible (NFI), or

C) Intermediate Care Facility for Persons w/ Other Related Conditions (ICF/ORC).

Step 3. **First In-Person Visit – the Independent Enrollment Broker Visit:** Within seven (7) business days of being contacted, the Independent Enrollment Broker makes a scheduled in-person visit with the waiver Applicant. While this and the second in-person visit usually take place in the Applicant's home, it can also occur elsewhere like a hospital or nursing facility. At the visit, the Independent Enrollment Broker assists with the financial application for Medicaid coverage of waiver services. The waiver application may be completed on paper using the PA 600L or online through the COMPASS application. The Independent Enrollment Broker also has the Applicant fill out other forms, explains what the CHC waiver is, and discusses choosing a health plan that will provide services through CHC.

> The waiver application may be completed on paper using the PA 600L form, or online through the COMPASS website.

Step 4. **Second In-Person Visit – Functional Eligibility Determination:** Within ten (10) business days of the first visit, an assessor from the local Area Agency on Aging conducts an in-person assessment of the Applicant's functioning using a tool called the Functional Eligibility Determination.[1] The Functional Eligibility Determination consists of a series of questions used to assess the Applicant's cognition and ability to perform activities of daily living, such as dressing, transferring and toileting. The results of the Functional Eligibility Determination are submitted to the Independent Enrollment Broker. More information about waiver Functional Eligibility can be found on page 6 of this guide.

[1] A copy of the blank Functional Eligibility Determination tool can be found here.

Step 5. **Independent Enrollment Broker Review of Functional Eligibility:** The Independent Enrollment Broker reviews the Functional Eligibility Determination results and the Physician Certification.

A. If both the Functional Eligibility Determination result and the Physician Certification show the Applicant's level of care need as "Nursing Facility Clinically Eligible," the Applicant is functionally eligible for the CHC waiver. Skip to Step 7.

B. If both the Functional Eligibility Determination result and the Physician Certification show the Applicant's level of care need as "Nursing Facility Ineligible," the Office of Long-Term Living sends a written notice to the Applicant informing them they do not qualify for the CHC waiver. The notice includes information about the right to appeal that decision.

C. If the Functional Eligibility Determination result and the Physician Certification disagree about the Applicant's level of care need, a review by the Office of Long-Term Living Medical Director occurs. Continue to Step 6.

Step 6. **Review by the Office of Long-Term Living Medical Director (if appropriate):** The Medical Director reviews the Physician Certification, Functional Eligibility Determination, and any additional medical documentation and information provided. Note that additional medical documentation or information is not requested from the Applicant. Applicants should be prepared to provide any medical information they want to be reviewed as part of their waiver application at the Functional Eligibility Determination assessment or ask their doctor to provide it along with the Physician Certification.

A. If the Medical Director determines the Applicant is Nursing Facility Clinically Eligible, the Applicant is functionally eligible for the CHC waiver. Continue to Step 7.

B. If the Medical Director determines the Applicant is Nursing Facility Ineligible, the Office of Long-Term Living sends a written notice to the Applicant informing them they do not qualify for the waiver. The notice includes information about the right to appeal that decision.

Step 7. **Approval Sent to County Assistance Office:** The Independent Enrollment Broker sends a form (the PA 1768 form) noting functional eligibility for the waiver to the Applicant's County Assistance Office.

Step 8. **County Assistance Office Financial Eligibility Review:** The County Assistance Office reviews the Applicant's income and resources to determine whether they are financially eligible for the CHC Wavier. The County Assistance Office asks for proof of income and resources if that has not already been provided with the application. The County Assistance Office also reviews how the Applicant spent their resources in the five previous years. This is done to make sure resources were not transferred or given away so the person would be eligible for a Medicaid waiver.

A. If the Applicant is financially eligible for the waiver, the County Assistance Office issues a notice to the Applicant, updates the Medicaid eligibility system, and notifies the Independent Enrollment Broker and the CHC plan the Applicant selected. If the Applicant did not choose a CHC plan, they are auto assigned to one.

B. If the Applicant is financially ineligible, the County Assistance Office sends a written notice to the Applicant informing them they are financially ineligible for the waiver. The notice includes information about the right to appeal that decision.

CHC Waiver Functional Eligibility

To qualify for the CHC waiver, individuals must be functionally eligible. A person is considered functionally eligible for the CHC Waiver if their medical condition(s) **and** their level of care needs make them **Nursing Facility Clinically Eligible** (NFCE).

Together, the Functional Eligibility Determination (FED)[2] and the Physician Certification are used to determine if someone is Nursing Facility Clinically Eligible. If a person is not found to be Nursing Facility Clinically Eligible, they will not be eligible for the CHC Waiver.

A person is Nursing Facility Clinically Eligible if the following criteria are met:

1. The individual has an illness, injury, disability, or medical condition diagnosed by a physician;
2. Because of the illness, injury, disability or medical condition, the individual requires care and services above the level of room and board. The care and services needed must be EITHER:
    a. Skilled nursing or rehabilitation services consistent with those covered by the Medicare Program; OR

[2] For additional details on how to understand and interpret the Functional Eligibility Determination tool, review the PA Bulletin implementing the FED and its attachments: the FED tool and the FED translation matrix.

b. Health-related care and services that are needed and provided on a regular basis in the context of a planned program of health care and management and were previously available only through institutional facilities. This includes individuals who need personal care assistance with activities of daily living to live in a community setting and who would be institutionalized in a nursing facility without those services; and

3. A physician certifies that the individual is Nursing Facility Clinically Eligible.

In practice, the FED conducted by the Area Agency on Aging is used as a proxy for determining whether the care and services an applicant needs meet the nursing facility clinical eligibility standard described in number 2, above.

To be considered Nursing Facility Clinically Eligible using the FED, a person's FED results should show that, based on the last three days, they either:

1. Meet one of the following:
    a. Need hands-on assistance to perform three or more activities of daily living (bathing, personal hygiene, dressing, walking/locomotion, toilet use/ transfer, or eating) [3],
    b. Are bed bound,
    c. Are frequently or always incontinent of bowel, or
    d. Are in a coma.

OR

2. Meet 3 or more of the following criteria:
    a. Need hands-on assistance to perform two activities of daily living (bathing, personal hygiene, dressing, walking/locomotion, toilet use/ transfer, or eating)[4],
    b. Are minimally to severely cognitively impaired,
    c. Have memory problems,
    d. Experience disordered thinking or awareness,
    e. Have behavioral symptoms (wandering, verbally abusive, physically abusive, or socially inappropriate/disruptive behavior),

[3] Need for assistance with activities such as meal preparation, shopping, and housekeeping are not considered in determining whether someone is NFCE using the FED.
[4] Need for assistance with activities such as meal preparation, shopping, and housekeeping are not considered in determining whether someone is NFCE using the FED.

f. Use a wheelchair or scooter, or
g. Need maximum or total assistance managing medications.

Notably, the FED's formula inappropriately does not consider skilled or rehabilitation needs when determining nursing facility clinical eligibility. The formula also does not consider a need for supervision or cueing/prompting to complete activities of daily living, which could result in someone with a cognitive impairment, such as a brain injury, being denied waiver eligibility. Applicants with skilled needs, a need for supervision and/or cueing to perform activities of daily living and those whose FED does not correctly capture their functioning and needs should consider appealing the waiver denial and contacting PHLP for assistance. See the "Appeals" section below for more information.

Waiver Financial Eligibility

In addition to being functionally eligible (i.e., nursing facility clinically eligible) for the CHC waiver, an individual must be financially eligible for waiver services. The financial eligibility determination looks at both income and resources (assets). It also looks at how resources were spent in the past five years. All Pennsylvania waivers, including the CHC waiver, use the same financial eligibility criteria.

Income

The income limit for Medicaid waivers is 300% of the Federal Benefit Rate. In 2025, that amount is $2,901 per month. Only the income of the individual applicant is counted; a spouse's income does not count toward this limit. Unlike other categories of Medicaid, there are few deductions or disregards from income for waivers, which means an individual's gross income will usually be counted toward this limit.

Waiver Income Limit (2025):

300% of the Federal Benefit Rate ($2,901 per month).

If an applicant's income is over the limit, it may still be possible for them to qualify for the waiver through the Medical Assistance for Workers with Disabilities (MAWD) program, discussed below, or by setting up a trust for the excess income. For information on using an income trust, review PHLP's factsheet, Accessing Home and Community-Based Services When Income Appears Too High.

Resources

The resource (or asset) limit for waivers depends on whether the applicant is married or single, and whether they have children under age 21 living with them.

- Unmarried applicants have a resource limit of $8,000.
- Applicants who live with their child(ren) under age 21 do not have a resource limit.
- If an applicant is married, the resources of the spouse also count, and the couple's resources are combined. The amount of combined resources the couple may keep is calculated by the County Assistance Office using a spousal impoverishment formula. Under the formula, the spouse can keep at least $31,584 (in 2025) in resources, sometimes more. The applicant can have an additional $8,000.

Not all resources are counted – some are excluded. For example, the following resources are **not counted** when determining eligibility for the waiver:

- The home in which the Applicant lives
- One motor vehicle
- Irrevocable burial accounts
- Life insurance that does not accumulate a cash value
- The non-applying spouse's pension/retirement account

For a full list of excluded resources see Section 440.6, DHS Long Term Care Handbook.

Applicants with significant assets beyond the home they live in should contact an elder law attorney for advice about how to properly handle excess resources.

Other Information About Financial Eligibility

Lookback Period: There is a 5-year "lookback" period to see if the individual applying for a waiver or their spouse transferred – sold or gave away – resources for less than fair market value. For example, if someone owned a house valued at $100,000 and they sold it to their grandchild for $1, they transferred a resource for less than fair market value.

The County Assistance Office will review the Applicant's and their spouse's tax returns, bank and other financial records for the five-year lookback period and may ask how resources and cash were disposed of when it is not clear from the records. In situations where someone is found to have sold or given away resources for less than fair market value, they may be ineligible for waiver services for a period of time. The length of this "penalty period" depends on the amount of resources that were transferred for less than fair market value. If a penalty

period is imposed, the Applicant will have a chance to appeal to show that the transfer should not be considered. They may also apply for an undue hardship to waive the penalty period.

Please note that the transfer of asset rules are complex. For advice, contact the PHLP Helpline or, for significant assets, an elder law attorney specializing in Medicaid planning. A local elder law attorney may be found using this search tool.

Medical Assistance for Workers with Disabilities (MAWD) and Waiver Eligibility: Under a special rule, an individual under age 65 who works and meets the requirements for Medical Assistance for Workers with Disabilities (MAWD), which has a higher income and resource limit than the waivers, can receive waiver services if they also meet the functional eligibility requirements of a waiver program. Similarly, people eligible for the expanded MAWD category, Workers with Job Success (WJS) may also be eligible for the waiver if they meet the functional eligibility requirements. This is important for individuals who are over the waiver income or resource limit but rely on Medicaid coverage and waiver services to work. Someone enrolled in MAWD or WJS who is seeking waiver services will still have their past use of resources reviewed as discussed above. For additional information review PHLP's MAWD and WJS guides.

> Some people who are over the income limit for the waiver can still qualify for waiver coverage if they meet the functional eligibility criteria for waiver and the financial eligibility criteria for MAWD (which has a higher income limit than waiver)!

Estate Recovery: Pennsylvania can attempt to recover the costs of nursing home care, home and community-based waiver services, and related hospital and prescription costs from a Medicaid recipient's estate after they die. This only applies to individuals age 55 and older who receive services through a waiver or in a nursing home. It may not apply to everyone's situation. Before pursuing estate recovery, the state will consider factors such as:

- How much the estate is worth,
- Whether there are dependents/a spouse still living in the recipient's house, and
- Whether someone qualifies for a "hardship waiver."

Waiver Applicants wishing to protect their assets from possible estate recovery should contact a private elder law attorney.

Appeals

Individuals have the right to appeal when a CHC waiver application is denied – either based on functional criteria or financial criteria – and when their existing CHC waiver is stopped.

Individuals also have the right to appeal when the services they are getting or request through their CHC plan are denied, reduced, changed, or stopped. Below is information on appealing CHC waiver **eligibility** denials or terminations. For information on appealing services denials by CHC plans, review PHLP's fact sheet, How to Appeal a Denial in Community HealthChoices.

All appeals regarding CHC waiver eligibility go through the Department of Human Services (DHS) Fair Hearing process. Individuals must receive written notice if their CHC Waiver application is denied. If existing CHC waiver coverage is being terminated, the individual must get a notice **before** the coverage ends.

Eligibility appeal requests must be made **in writing** and filed **within 30 days** of the date of the denial notice, or **within 15 days** to keep waiver services in place while the appeal moves forward.

The denial notice includes information about appeal rights and instructions for filing the appeal. The "Fair Hearing Form" or "Request to Appeal" form included with the denial notice should be used to file the appeal. If possible, the appeal should be sent certified mail and a copy of the mailing receipt with tracking information should be saved as proof the appeal was mailed timely. A copy of the appeal request should be kept as well. If an individual does not have the appeal form, an appeal may be filed using a letter instead. Call PHLP's Helpline for further assistance.

After an appeal is filed, DHS will schedule a hearing in person or by phone depending on the individual's preference noted on the appeal request form. During the fair hearing, an Administrative Law Judge will review the case and later issue a decision upholding or overturning the waiver denial or termination. In appeals related to functional eligibility for the CHC waiver, the Administrative Law Judge may order that a new functional eligibility determination be performed.

If the Administrative Law Judge upholds the CHC waiver denial or termination, an individual can request "reconsideration" from the Secretary of the Department of Human Services and/or appeal to Commonwealth Court.

For advice or assistance with a CHC Waiver appeal, please contact PHLP's Helpline at 1-800-274-3258.

For More Information

The Pennsylvania Health Law Project provides free legal help to consumers seeking to get or keep home and community-based services through the Office of Long-Term Living waivers. We provide advice and, in some cases, representation when eligibility for waiver is denied or stopped, or when waiver services are denied, changed, or stopped.

PLEASE NOTE: While PHLP helps people access OLTL waivers like the CHC and OBRA waivers, we **do not** assist with waivers offered through the Office of Developmental Programs (ODP).

To learn more about ODP waivers and county-based services, contact ODP at 717-787-3700 or visit www.myodp.org.

For further information or assistance in applying for OLTL waiver coverage or services, please call PHLP's Helpline at 1-800-274-3258.

This publication is intended to provide general legal information, not legal advice. Each person's situation is different. If you have questions about how the law applies to your situation, please call PHLP's Toll Free Helpline at 1-800-274-3258 or visit