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MEMORANDUM FOR ALL HOME AND COMMUNITY BASED SERVICES PROVIDERS

From: Celesta Hartgraves, Director
Division of Senior and Disability Services

Subject: Reassessment Guidance - State Plan Consumer-Directed Services 60% Cost Maximum

Pursuant to the Fiscal Year (FY) 2018 budget passed by the Missouri General Assembly effective July 1, 2017, participants receiving State Plan Personal Care Consumer-Directed Services (CDS) cannot have a Person Centered Care Plan (PCCP) with CDS in excess of 60% of the statewide average cost of nursing facility care or 511 total units/month (see PM/VM-17-39).

For any reassessment completed after July 1, 2017, provider reassessors shall work with the participant to ensure the development of a requested PCCP in compliance with the new cost maximum. Per the following guidance, reassessors shall explore the participant's potential eligibility for other HCBS options i.e., Advanced Personal Care, Adult Day Care, and Aged and Disabled Waiver services when applicable.

For Provider reassessors who use the Consumer-Directed Model Worksheet (DA-3c), the worksheet has been revised to reflect updates to the reimbursement rates for CDS.

As a reminder, **timely and thorough** case note documentation by provider reassessors will be critical to assure coordination of all contacts related to the participant and subsequent PCCP changes. Provider reassessors shall review Case Notes Documentation, see (Policy 4.30).

Questions regarding this memorandum may be directed to the Bureau of Long Term Services and Supports (BLTSS) at 573- 526-8557 or via e-mail at LTSS@health.mo.gov.

CH/tv

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60% Limitation Process Guidance for Provider Reassessors

Participants can no longer receive State Plan Consumer Directed Care Services (CDS) in excess of 60% of the monthly cost of nursing facility care.

> Note: Agency model State Plan Personal Care has always had a monthly cap of 60%. This remains unchanged. Additionally, any combination of Agency model State Plan Personal Care and CDS must be developed in compliance with the 60% cost maximum.

Provider reassessors shall review care plans that contain CDS and develop requested care plans that are in compliance with this new cost maximum.

Initial Steps

In addition to the assessor's typical preparation for a reassessment visit, the assessor may want to review the participant's HCBS Web Tool record and CDS vendor notes (for example the vendor's monthly case management activities) in order to assist the participant with the care plan reduction. Note: Area Agencies on Aging have access to the Case Notes in HCBS Web Tool; however will not have access to the CDS vendor notes. Additionally the assessor should determine:

- By how many units does the current care plan exceed the 60% cost cap?
- Does the participant currently use all of their authorized units? (Review utilization reports from the CDS vendor or review 'HCBS' from the Precertification selection in the Medical HX dropdown in the HCBS Web Tool.)
- Are there other supports that could assist the participant?
- Is the participant eligible for other HCBS:
  - *Advanced Personal Care (APC)- Agency Model (policy 3.10)* -- APC services assist with activities of daily living when this assistance requires devices and procedures related to altered body functions. Tasks include:
    - Ostomy Hygiene
    - Catheter Hygiene
    - Bowel program
    - Aseptic dressing
    - Non-injectable medications
    - Passive range of motion
    - Assistive transfer device
  - *Aged and Disabled Waiver (ADW) services* -- which includes Chore (policy 3.35), Home Delivered Meals (policy 3.40), Homemaker (policy 3.45), Respite Care (policy 3.50) and Adult Day Care (policy 3.51). Participants must be 63 years of age or older to receive ADW services.

  NOTE: APC and services in the ADW are provided through an agency. Agency model program differences will need to be explained to the participant and include:

  - The participant can select the agency of their choice. (DSDS Rev team will assist with the provider selection if the participant is unsure at the time of the reassessment.)
  - The aide that provides the service is the employee of the provider not the participant.

- The aide cannot be a member of the immediate family of the participant. Immediate family members are defined as: parent; sibling; child by blood, adoption, or marriage; spouse; grandparent or grandchild.
  - If the current attendant does not fall into any of the above categories defined as a family member, the provider may hire the attendant if they apply to work at the provider agency; however the provider is not required to do so. Additionally, there are other training requirements for agency-model aides which any potential employee would need to complete.

- *Adult Day Care Waiver (ADCW)* -- (policy 3.31). Adult Day Care is the continuous care and supervision (up to 10 hours per day for a maximum of 5 days per week) of a disabled adult in a licensed Adult Day Care setting. This waiver service is for participants between the ages of 18 – 63.
- *Independent Living Waiver (ILW) services* – (policy 3.55) which includes an extension of self-directed personal care services, specialized medical supplies, specialized medical equipment, environmental accessibility adaptations, case management and financial management services. Initial entry into the ILW is limited to those participants age 18-64.

  NOTE: Waiver enrollment is managed through Division of Senior and Disability Services' central office. The reassessor should indicate a need for ILW in their Case Notes and notification to the REV team. Provider reassessors should not enter ILW services in the requested care plan.

Home Visit with the Participant

- Upon completion of the interRAI HC review, inform the participant of the need to reduce their current care plan due to the state budget passed during the most recent legislative session. The budget limits the number of CDS units that a participant can receive on a monthly basis.

  NOTE: Should the participant inquire about appeal rights, the reassessor shall inform the participant there is not an opportunity to appeal as the reduction is a result of a change in state law affecting all participants in the program statewide. Refer any further questions to the REV team.

- Explain their current authorization of XXX exceeds the new limit of 511 units by XXX units (or XX hours per month).
- Discuss their current needs and review the current tasks authorized.
- Review the tasks listed to determine areas that can be reduced in order to reach the new monthly limit.
- If eligible, explain other available HCBS options and determine if the participant has a provider choice.
- Develop the new requested care plan with the CDS reduction.
  - When other possible HCBS options are identified, they shall be added as another service on the Requested Service Line Item in the HCBS Web Tool. The provider field can be

left blank if the participant is unable to determine a provider choice. The DSDS REV team will work with the participant to determine their provider of choice.

NOTE: When the participant is opposed or unwilling to participate in the development of a reduced care plan, the provider shall complete the interRAI HC, thoroughly document the attempts to work with the participant / other responsible person and contact the DSDS REV team for continued processing.

Completion of the New Requested Care Plan

- Update information in the HCBS Web Tool such as marital/living arrangements, formal supports, address, etc.
- Enter the interRAI HC into the HCBS Web Tool.
- Complete the requested care plan in the HCBS Web Tool to include the reduction and any other HCBS.
- Enter Case Notes; and
    - Include documentation of all attempts to reach the participant, responsible persons, and provider(s) in Case Notes.
- Upload the Participant Choice Statement (DA-3).
- Notify the REV team.