Pediatric Personal Care Benefit

Webinar for Case Managers

October 2015

COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

What you will learn

- What is the Pediatric Personal Care Benefit?
  - What is covered, who qualifies, who doesn't?
- What is my role as a case manager?
- What is the Personal Care Assessment Tool and process?
- What is the appeals process?
- Resources

What is the Pediatric Personal Care Benefit?

- Offers specific Personal Care Benefit tasks through the Medicaid State Plan (regular Medicaid) for individuals birth through 20 years old
  - Personal care tasks have been traditionally provided to individuals through Home and Community Based Services (HCBS) waivers
- Covers non-medical personal care services
- Clients who qualify for the benefit can receive support with any of 17 Personal Care tasks, based on medical necessity
- Official roll-out October 19, 2015

Why is this changing now?

- Department was directed by the Centers for Medicare and Medicaid Services (CMS) to create and implement this benefit
- Allows personal care services to be offered through State Plan Medicaid benefits to all eligible individuals birth through 20 years old statewide with or without waiver enrollment

What tasks are covered?

17 Personal Care tasks are covered by this benefit:

1. Ambulation/locomotion
2. Bathing/showering
3. Dressing
4. Feeding
5. Hygiene – hair care/grooming
6. Hygiene – mouth care
7. Hygiene – nail care
8. Hygiene – shaving
9. Hygiene – skin care
10. Toileting – bladder care
11. Toileting – bowel care
12. Toileting – bowel program
13. Toileting – catheter care
14. Meal preparation
15. Medication reminders
16. Mobility – positioning
17. Mobility – transfer

Who qualifies?

- Medicaid-eligible clients birth through 20 years old
  - Up to 21st birthday
- Must qualify for personal care service(s) as assessed by the Personal Care Assessment Tool (PCAT), and other supporting clinical documentation

Who doesn't qualify?

- Adults age 21 and older
- Clients receiving personal care services through the following programs are not eligible for this benefit and will continue to receive personal care services as they do now:
  - Consumer Directed Attendant Support Services (CDASS)
  - In-Home Support Services (IHSS)
  - Home Care Allowance
  - Children's Habilitation Residential Program (CHRP)
  - Clients enrolled in the HCBS-Developmental Disabilities waiver are not eligible due to Residential Habilitation and Support Services (RHSS)
- Reminder - IHSS offered through the Children's Home and Community Based Services (CHCBS) waiver does not allow for Personal Care services, therefore CHCBS clients may utilize the Personal Care Benefit

Supported Living Services Waiver

- The following personal care tasks are the tasks that can still be reimbursed in the HCBS-Supported Living Services (SLS) waiver for waiver participants ages 18-20:
  - Assistance with money management
  - Assistance with meal planning and grocery shopping
  - Assistance with health related services including:
    - first aide,
    - medication administration,
    - assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments,
    - support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home

Relative Personal Care

- Legally Responsible Persons cannot be reimbursed for providing Personal Care Services to a dependent or spouse
  - Legally Responsible Person – the parent or legal guardian of an individual or the spouse of a person with disabilities
- Other relatives who are not the Legally Responsible Person can be reimbursed for providing Personal Care Services

When will waiver clients transition?

- Option to transition now if they want
  - Client has a choice to get assessed sooner than the annual reassessment
- Continued Stay Review (CSR)
  - Case manager should help client/families currently receiving Personal Care Services to connect with a Personal Care Provider to be assessed for the Personal Care Benefit within 60 days in advance of their next CSR
- Is there an opt-out option?
  - No, clients who are eligible for the Personal Care Benefit must access those services through the State Plan, unless they participate in CDASS, IHSS, Home Care Allowance, CHRP, or DD Waiver

Questions about the Benefit?

What Clients Can Expect

- Client can begin process by talking to:
  - Their Physician
  - Local Pediatric Personal Care agency
  - Case manager or care coordinator, if they have one
  - Colorado Medicaid Personal Care line
    - 303-866-3447
    - personalcare@state.co.us
- Personal Care Provider will contact client/family to schedule PCAT assessment
- Personal Care Provider will coordinate with physician to complete 485 Home Health Certification

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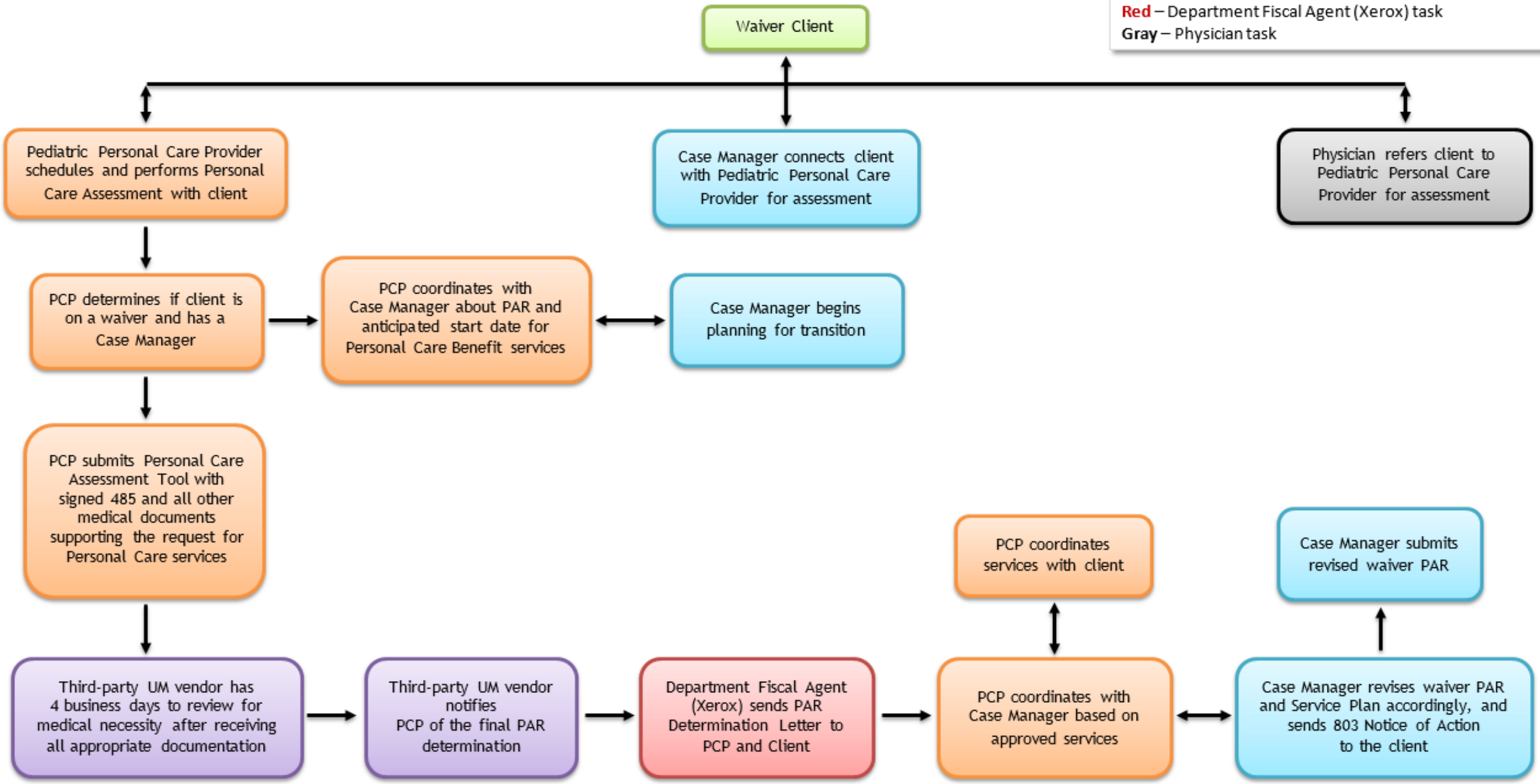
Pediatric Personal Care Benefit Process for Waiver Clients

Blue – Case Manager task
Orange – Pediatric Personal Care Provider (PCP) task
Purple – Third-party Utilization Management vendor task
Red – Department Fiscal Agent (Xerox) task
Gray – Physician task



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What is my role as Case Manager?

- Connect current waiver clients to a Personal Care Provider who can complete the Personal Care Assessment Tool (PCAT)
- Coordinate with a Personal Care Provider regarding an approved change in Personal Care Services and share information as needed
- Transition services from waiver to State Plan
  - Revise waiver PAR
  - Revise Service Plan
  - Send 803 Notice of Action to client
    - Cite regulation related to the waiver
- Similar to case manager role in Home Health
- Reach out to eligible waiver clients who are currently receiving Personal Care Services 60-90 days in advance of Continued Stay Review

How do I document this in the Service Plan?

- Utilize the State Plan Benefits section of the Service Plan
- In this section the case manager will identify or explain:
  - Service being provided
  - Medicaid provider providing the service, and
  - Frequency with which the service is being delivered
- Personal Care Provider should provide you with this information when approved

Personal Care Assessment Tool (PCAT)

- What is the PCAT?
  - A tool to consistently evaluate an individual's need for Personal Care Services
  - Assesses the need for personal care support for each of the 17 Personal Care Benefit tasks
  - Section for family to provide information about individual's needs
- Aligned with the Home Health benefit Pediatric Assessment Tool (PAT)
- How was this assessment tool developed?
  - Department staff worked together with stakeholders to create the PCAT

Assessment Process

- How are clients assessed and by whom?
  - Personal Care Providers, with client/family input, complete and submit the PCAT with the 485 Home Health Certification form and any supporting documentation from the client/family
  - Clinical reviewers at the Colorado Medicaid third-party utilization management vendor review PCAT, 485, and supporting documentation to approve or deny the amount of requested hours to provide Personal Care Services based on medical necessity
  - Colorado Medicaid third-party utilization management vendor will send a final PAR determination via the online provider PAR portal indicating what was approved or denied

Assessment Process

- Providers and clients will receive a PAR determination letter from the Department's fiscal agent (Xerox)
- Personal Care PAR can be authorized for up to a year
- Clients must be reassessed annually prior to the end of the PAR period or when a change of condition occurs

Assessment Process

- How can we find out client's PCAT score?
  - Case managers and Personal Care Providers should coordinate to share information
  - Personal Care Providers should provide you with documentation of assessment if needed
  - PCAT score isn't the only deciding factor, the 485 and supporting documentation from the client/family are also considered
- How can we find out what is approved?
  - Personal Care Providers should coordinate with case managers to share information in the PAR letter, as well as share scheduling, planning, and clinical information

Questions about the PCAT?

What If a Client is Unhappy with Assessment Results?

- Client can work with the Personal Care Provider to provide additional information documenting the need for more hours
  - Provider can request more time – with documentation – in the PAR submission process
  - If needed, a Provider can work with the case manager to obtain the Personal Care portion of a client's existing ULTC assessment to use as supporting documentation to request additional time after a denial or partial denial

What If a Client is Unhappy with Assessment Results?

- Peer-to-Peer Review
  - Before Personal Care PAR is denied or partially denied, the clinical reviewer will contact the client's physician to discuss PAR
- PAR Reconsideration
  - Client and Personal Care Provider can request a different clinical reviewer from the one who made the first PAR denial to re-review the PAR, along with any new information provided, and make a final PAR determination
- Submit a new PAR that includes additional medical information needed for the PAR review

State Plan Appeal Process

- Personal Care Provider will be notified of denials and will notify the case manager
- If a PAR is denied, a client has 30 days to submit a written request to appeal the decision
- Client will be notified of their right to appeal and the process is documented in the PAR letter received from the Department's fiscal agent (Xerox)
- Case manager should contact the client after the 30 day appeal submission period to discuss the discontinuation of waiver Personal Care Services and ask if they have submitted an appeal

State Plan Appeal Process

- Case managers cannot decrease or discontinue Personal Care Services on the waiver PAR until Final Agency Decision is issued in the State Plan appeal process
  - Wait to send waiver personal care 803 Notice of Action until after State Plan benefit has been determined
- Case managers cannot add personal care hours into the waiver if the client feels State Plan personal care hours are not sufficient
  - Exception – HCBS-Supported Living Services (SLS) waiver for waiver participants age 18-20, can still get money management and meal planning and grocery shopping through the waiver

HCBS Cost Containment

- Does the total amount for the state plan PCP benefit need to be factored in to the HCBS cost containment, similar to LTHH services?
  - No, Pediatric Personal Care does not need to be included in the cost containment figures

Resources

- Presentation / webinar recording
  - www.colorado.gov/hcpf/long-term-services-and-supports-training
- Pediatric Personal Care Benefit website
  - www.colorado.gov/hcpf/pediatric-personal-care-benefit
  - Provider list
    - www.colorado.gov/hcpf/pediatric-personal-care-services-provider-list
  - Frequently Asked Questions Document for Clients/Families
    - www.colorado.gov/pacific/sites/default/files/Member%20FAQs_1.pdf
- Pediatric Personal Care Line
  - 303-866-3447
  - personalcare@state.co.us

Wrap Up

- New Pediatric Personal Care Benefit official roll-out October 19, 2015
- Moves Personal Care services from most waivers to State Plan for individuals birth through 20 years old
  - Clients participating in CDASS, IHSS, Home Care Allowance, CHRP, DD waiver are exempt
- Personal Care Providers
  - Perform Personal Care assessment with client/families input
  - Coordinate with physician and case manager prior to PAR submission
  - Coordinate with case manager and client once PAR determination is received
- Case managers
  - Adjust waiver PAR only after final PAR determination or State Plan appeal is complete
  - Revise Service Plan to document changes
- Waiver clients have the option to wait until their next CSR to transition

Questions?

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Thank You!