COLORADO
Department of Health Care Policy & Financing

Pediatric Personal Care Benefit

Frequently Asked Questions for Medicaid Members **May 2023**

What is the Pediatric Personal Care Benefit?

The Pediatric Personal Care Benefit helps Colorado Medicaid (Medicaid) members 20 years old and younger with in-home, non-medical support with daily living activities, such as bathing, dressing, meal preparation, and toileting.

What does this benefit cover?

The Pediatric Personal Care Benefit covers support services in the home that do not require a service provider to have medical certification or a professional license to deliver services. Personal care services may take different forms, such as completing a task for someone, supervising someone to ensure a task is performed safely, showing someone how to complete a task, or reminding or cueing someone to complete a task. There are 17 personal care tasks included in this benefit. Members who qualify for the benefit can receive support with any of these 17 tasks.

Who qualifies for the Pediatric Personal Care Benefit?

These services are a benefit for Medicaid members who meet the following requirements:

- Are 20 years old or younger
- Qualify for personal care service(s) as assessed by the Personal Care Assessment Tool (PCAT) (See, "What is the Personal Care Assessment Tool (PCAT)" below), and other supporting clinical documentation.

What are the 17 Personal Care Tasks?

Personal care assistance for the following tasks are covered by this benefit:

1. Ambulation/Locomotion (such as physical support with walking or moving from place to place with or without an assistive device)
2. Bathing/Showering (such as preparing bathing supplies and cleaning up after the bath, as well as applying soap, rinsing, and drying)
3. Dressing (such as putting on and taking off clothing)
4. Feeding (such as making sure food is the right temperature and consistency)

5. Hygiene – Hair Care/Grooming (such as shampooing, conditioning, simple, non-professional styling, and combing)
6. Hygiene – Mouth Care (such as brushing, flossing, swabbing teeth, and rinsing mouth)
7. Hygiene – Nail Care (such as soaking, filing nails, and cuticle care)
8. Hygiene – Shaving (such as shaving face, legs, and underarms with electric or safety razors)
9. Hygiene – Skin Care (such as applying over-the-counter lotion or other skin care products)
10. Meal Preparation (such as preparing, cooking, and serving food)
11. Medication Reminders (such as verbally communicating that it is time for medication and opening a pre-filled container)
12. Mobility – Positioning (such as moving an individual to a new position in a wheelchair while keeping the body properly aligned)
13. Mobility – Transfer (such as physically supporting an individual to safely move an individual from bed to a wheelchair next to the bed)
14. Toileting – Bladder Care (such as assisting an individual with using a toilet or bedpan, changing a diaper, emptying and rinsing the bedpan, and cleaning skin)
15. Toileting – Bowel Care (such as changing and cleaning an individual after a bowel movement, assisting an individual using the bathroom, and changing any clothing or pads)
16. Toileting – Bowel Program (such as emptying an ostomy bag)
17. Toileting – Catheter Care (such as emptying a catheter bag)

The Personal Care Assessment Tool includes detailed information about when each of these tasks may need skilled care instead of non-skilled personal care.

Call 303-866-5638 or email HomeHealth@state.co.us if you have questions or need personal care support for any tasks not covered by this list, additional support may be available.

What is the difference between skilled care services and personal care services?

Skilled care services are in-home medical services provided to treat a medical condition. Skilled care services must be provided by a certified nursing assistant (CNA) or registered or licensed nurse. The Home Health Benefit offers skilled care services to members with a medical need.

Personal care services support members who need assistance with daily living tasks, when these services can be provided by someone without a CNA or nursing license or registration.

The Personal Care Assessment Tool lists the differences between skilled care and personal care for each personal care task to make it easier for families to understand which type of care is right for each task. Please see the "What is the Personal Care Assessment Tool (PCAT)?" section below for more information.

Visit the Home Health Benefit webpage for more information.

What is the Personal Care Assessment Tool (PCAT)?

The Personal Care Assessment Tool is a way to consistently evaluate an individual's need for personal care services. The PCAT assesses the need for personal care support for each of the 17 Personal Care Tasks. See the "What are the 17 Personal Care Tasks?" section above for more information. There is also space in the PCAT to include additional information about an individual's need for personal care services. Note: although you can participate in completing the PCAT, your personal care provider is responsible for submitting the document for the prior authorization request (PAR) process.

The PCAT is not the only document evaluated to determine the amount of personal care services that an individual is eligible to receive. The Colorado Medicaid third-party vendor will also look at the Plan of Care and any additional documents that your personal care provider submits.

What is a 485 Home Health Certification and Plan of Care?

The 485 Home Health Certification and Plan of Care (Plan of Care) is a form that allows doctors to document in detail the kinds of in-home health services that their patient needs and how often they need each service. This form is required for families applying for the Personal Care Benefit, as well as the Home Health Benefit. The same Plan of Care form may be used for requesting both personal care services and Home Health Benefits, as long as the form states the need for both of those services. Many providers use an electronic version of this form that includes the same content. As long as all elements of the 485 are included, the Plan of Care will be accepted.

I am getting skilled care services through the Home Health Benefit. How will this new benefit affect my services?

Your home health services **will not** change. You may qualify for additional services through this benefit. A Medicaid member must meet the requirements listed above to qualify for personal care services. Please see the "Who Qualifies for Pediatric Personal Care Services?" section above for more information.

Not all home health agencies offer personal care services. If you qualify for **both** home health and personal care services, you may receive services from two different providers.

Both Home Health and Personal Care Benefits provide services for defined tasks. If you are receiving skilled care for a task through the Home Health Benefit, you will **not** receive personal care for that same task. If any part of a task requires the skills of a CNA or registered or licensed nurse, the whole task will be considered a skilled care task, covered by the Home Health Benefit.

For example, if you need skilled assistance with moving into a bathtub or shower, then the bathing task is also considered a skilled task and covered under the Home Health Benefit. However, if you need a sponge bath or a shower that does not require a skilled transfer, then the bathing task is considered a Personal Care task and covered under that benefit.

I am getting services through one of Colorado's Home and Community-Based Services (HCBS) waivers. How will this new benefit affect my services?

Most of the personal care services provided for individuals enrolled in waivers will now be available through the Pediatric Personal Care Benefit.

If you currently receive personal care services through a waiver, you will need to access those services through the Personal Care Benefit when your annual Service Plan is renewed. You have the option to transition sooner if you want.

If you are receiving personal care services through the following waivers you may need to transition from waiver personal care services to the Personal Care Benefit:

- Brain Injury (BI)
- Children's Extensive Support (CES)
- Community Mental Health Supports (CMHS)
- Complementary and Integrative Health (CIH)
- Elderly, Blind and Disabled (EBD)
- Supported Living Services (SLS)

Your case manager will help you coordinate the transition from waiver personal care services to Personal Care Benefit services.

If you are on one of the following waivers, which do not include personal care services, you may now be eligible for services through the Personal Care Benefit:

- Children with Life-Limiting Illness (CLLI)
- Children's Home and Community Based Services (CHCBS)

A personal care provider will need to complete a Prior Authorization Request (PAR) for these services. Your case manager will help you start this process.

If you need personal care services for tasks not covered by the Pediatric Personal Care Benefit, you may still get those services through the standard waiver process. You should speak to your case manager for more information.

You do **not qualify** for Pediatric Personal Care Benefit services if you are currently getting services through any of the programs listed below because personal care services are provided as a primary component of them:

- Consumer-Directed Attendant Support Services (CDASS)
- In-Home Support Services (IHSS) (except through the CHCBS waiver, which does not provide personal care)
- Home Care Allowance (HCA)
- HCBS-Persons with Developmental Disabilities (DD) waiver
- HCBS-Children's Habilitation Residential Program (CHRP) waiver

See the "How can I start receiving the personal care services through this benefit?" section below for information on how to start the process of qualifying for services.

I receive a Home Care Allowance to cover personal care services. Can I also get Medicaid personal care services?

No, you can only enroll in **one** of these two programs: the Home Care Allowance program, which is managed by your county Department of Human or Social Services Office, **or** the Pediatric Personal Care Benefit.

How can I find a personal care provider?

You can find a personal care provider through home care agencies that offer personal care services. There are several home care agencies in Colorado that provide personal care services. If you don't have access to the internet, call 303-866-5638 or email HomeHealth@state.co.us. Staff will respond within one business day to help you find a provider.

If you are enrolled in a waiver program, contact your case manager for help getting connected to local personal care agencies.

I cannot find a personal care provider. What can I do?

There is at least one personal care agency operating in every county of Colorado. If you have called all the agencies that are in your region and are having trouble finding a personal care provider to work with you, call 303-866-5638 or email HomeHealth@state.co.us. Staff will respond within one business day and offer you one-on-one support.

If you are enrolled in a waiver program and/or have a case manager, contact your case manager for help connecting to local agencies.

What are the qualifications of personal care providers?

Personal care workers must meet the following qualifications:

1. Have verified experience and training for providing personal care services
2. Employed by a licensed home care agency
3. Are 18 years of age or older

Home care agencies are responsible for hiring and supervising experienced personal care workers. While there is no certification for personal care workers, their home care agency employers are licensed by the Colorado Department of Public Health and Environment (CDPHE). Home care agencies have to meet many requirements to earn their license. CDPHE monitors all home care agencies to ensure that they are providing the best possible care to their clients.

Can I provide personal care services to my family member through this benefit?

The federal Centers for Medicare and Medicaid Services (CMS) set rules about who can provide Personal Care Benefit services. According to the federal rules, an adult who is legally responsible for a dependent individual is not allowed to get paid by Medicaid for providing personal care services to that individual. This means that parents, spouses, and other legally responsible adults cannot be reimbursed for providing personal care services to their own children, spouses, or otherwise dependent individual.

How can I start getting personal care services through this benefit?

If you need personal care, you can start by talking to any of the following:

- Your case manager or care coordinator, if you have one
- Your physician
- A local home care agency that offers personal care
- Medicaid staff: call 303-866-5638 or email HomeHealth@state.co.us, and staff will respond within one business day.

Your case manager, physician, or personal care agency will be able to start the process to request personal care. Your doctor and personal care provider will need to complete two required documents:

1. Personal Care Assessment Tool (PCAT). The PCAT needs to be **completed by your personal care provider**.

2. 485 Home Health Certification and Plan of Care Form (or another form with the same content) (Plan of Care). The Plan of Care Form needs to be **completed by your doctor**.

The Plan of Care Form must order in-home personal care services and describe in detail what services are medically necessary and how often they are needed. The personal care provider will submit the completed forms in an online Prior Authorization Request (PAR). The PAR process verifies that personal care services are medically necessary and right for you. All personal care services must be requested through this process.

If Colorado Medicaid's PAR vendor approves your PAR, you can then work with your personal care provider to start getting services. Each approved PAR is valid for up to one year. If you need personal care services for the next year, your personal care provider must submit a new PAR, with a new Plan of Care from your doctor and a new PCAT.

How can I determine whether personal care services are medically necessary for me?

Your doctor will be able to tell you if your diagnosis, condition, or symptoms make personal care medically necessary for your day-to-day life.

I need personal care at an after-school program not covered by my Individual Education Plan (IEP). What can I do?

You are allowed to receive Personal Care Benefit services outside of your home, as long as those services are not covered by another program. If your IEP does not cover an after-school activity and you require personal care services while participating in that activity, you may be able to receive those services. Your PAR should include information about that activity and evidence of medical necessity for personal care at that time and place.

What should I do if my personal care needs were not fully captured in the completed Personal Care Assessment Tool (PCAT)?

If you feel that you have personal care needs beyond what was documented in the PCAT, you may use the designated space in the PCAT to identify other personal care needs. Be sure your Plan of Care adequately shows the medical need for more services. If it doesn't, include extra documentation that shows the need for more personal care services. Your personal care provider will be responsible for entering your information and documents into the online PAR.

What happens once my personal care provider submits my Prior Authorization Request (PAR)?

The PAR will be reviewed by licensed clinical reviewers who will assess personal care needs.

If the PAR is approved, then your personal care provider will receive notification of the number of hours that personal care services may be provided to you. An approved PAR is valid for up to a year, after which a new PAR must be completed and submitted.

Before the PAR is denied or partially denied, the doctor who requested the PAR will be called to discuss your PAR in a process called a Peer-to-Peer review.

If the third-party vendor does not receive the required documentation within four (4) business days, they will call the provider and request this documentation. If the vendor does not receive the needed documentation, the PAR will be denied for lack of information. The Peer-to-Peer review may help prevent this from happening. If it does happen, you should work with your personal care provider to make sure that all the required documents are included in the PAR submission.

If the Peer-to-Peer review still results in a denied or partially denied PAR, you can work with your doctor on these options:

- PAR Reconsideration: A PAR Reconsideration is similar to a second opinion and must be requested by your personal care provider. Additional documents not submitted with the original PAR may be submitted with the Reconsideration request. A different doctor than the one who made the first PAR denial will re-review the PAR, along with any new information provided, and make a final PAR decision.

- Submit a new PAR that includes additional medical information needed for the PAR review.

You also have the option to:

- Submit a written request for an appeal to the Office of Administrative Courts. For more information, see "My Prior Authorization Request was denied and I want to appeal the decision. How do I appeal the PAR decision?" below.

My Prior Authorization Request was denied and I want to appeal the decision. How do I appeal the PAR decision?

You have the right to appeal and ask for a hearing if you do not agree with the PAR decision. You will have an appeal hearing with an Administrative Law Judge. You may represent yourself, or have a lawyer, a relative, a friend, or other spokesperson assist you as your authorized representative.

How to appeal:

1. You must request an appeal in writing. This is called a Letter of Appeal.
2. Your Letter of Appeal must include:
    a. Your name, address, phone number, and Medicaid number;
    b. Why you want a hearing; and
    c. A copy of the front page of the Notice of Action (letter notifying you of the PAR decision) you are appealing.
3. You may ask for a telephone hearing rather than appearing in person.
4. Mail or fax your Letter of Appeal to:

    Office of Administrative Courts
    1525 Sherman Street, 4th Floor
    Denver, CO 80203
    Fax: 303-866-5909

5. Your letter of appeal must be received by the Office of Administrative Courts no later than thirty (30) calendar days from the date of your Notice of Action (your denial letter). The date of the Notice of Action is located on the front of the denial letter.
6. The Office of Administrative Courts will contact you by mail with the date, time, and place of your hearing.

How can I talk to someone directly about the Pediatric Personal Care Benefit?

Call 303-866-5638 or email HomeHealth@state.co.us, and staff will respond within one business day.