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To: Medicaid Providers of Personal Care Services (PCS) Service Coordination, Home and Community Based Service (HCBS) Aged & Disabled (A&D) Waiver & PCS Personal Assistance Agencies, PCS Family Alternate Care Homes, HCBS A&D Residential Assisted Living Facilities, HCBS A&D Certified Family Homes, and Home Health Agencies

From: Leslie M. Clement, Administrator
Division of Medicaid

Subject: **House Bill 701 Budget Reductions – HCBS A&D and PCS**

Effective January 1, 2011, the Department has initiated temporary rules which reflect changes in the Home and Community Based Services (HCBS) Aged and Disabled (A&D) and Personal Care Services (PCS) benefits. Modifications are intended to align with legislative direction to maintain a viable, but reduced Medicaid program.

These changes in services and benefits are being implemented to comply with House Bill 701, Section 14 A and B, that reflects legislative priorities for cost reductions. The Division of Medicaid was instructed to first review pricing to ensure it did not overpay or pay any services higher than Medicare. It was also instructed to work with all providers to review and reduce current pricing through negotiations.

The Department initiated statewide stakeholder participation regarding cost reduction ideas using teleconferencing, face-to-face meetings, and Web surveys. The temporary rule changes identified below are intended to reflect the cost reduction suggestions received through these various channels and include eliminating non-effective, non-outcome based services; reducing and simplifying administrative requirements; and making other minor benefit changes.

Adult A&D and PCS service coordination will not be available (Service Code G9001, G9002 and H2011)

Beginning with the claim date of service January 1, 2011, service coordination will no longer be an allowed benefit and will not be reimbursed for adults eligible for personal care services or A&D waiver services.

Skilled nursing home health visits will not be available for HCBS A&D participants (Revenue Code 551)

Beginning with the claim date of service January 1, 2011, for HCBS A&D waiver participants, home health skilled nursing services will no longer be an allowed benefit and will not be reimbursed. If an HCBS A&D waiver participant has a physician's order for treatment of a medical need that requires skilled nursing care, and is receiving home health skilled nursing services, the home health agencies will need to advise the participant to contact the Bureau of Long Term Care (BLTC) nurse reviewer in the local Medicaid office. Participants will be required to obtain an HCBS A&D waiver prior authorization in order to continue their skilled nursing services with the personal assistance agency of their choice.

HCBS A&D and PCS service plan rate change (Service Code S5115 and G9002)

Beginning with the claim date of service January 1, 2011, Medicaid is changing its reimbursement rates for HCBS A&D consultation and PCS registered nurse service plan code (adults and children). The new service plan rates and units are:

Service Code	Rate	Initial Service Plan	Annual Service Plan
S5115 Consultation	$7.65/unit	8 units = Plan development and placement	4 units = Plan development and placement
G9002 RN Care Plan	$7.65/unit	8 units = Plan development and placement	4 units = Plan development and placement

The participant's HCBS A&D or PCS service plan must be completed by a registered nurse (RN) within 30 calendar days of receiving the Uniform Assessment Instrument (UAI) findings and Negotiated Service Agreement or Personal Care Services for Children Assessment. The service plan is completed in the participant's home and developed by the care plan team. This team includes the participant, family, guardian, registered nurse, service providers, and others identified by the participant.

For significant changes in the participant's functioning, the agency's supervising personnel should visit the participant to assess what functioning areas have been impacted and complete the Significant Change Form. The Significant Change Form must be signed by the agency's RN who is responsible for verifying the information on the form is correct. The agency RN is also responsible for updating the service plan. The Department will not authorize RN supervisory visits or service plan units for completion of the Significant Change Form or service plan revisions. A revised Significant Change Form is posted at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/HomeCare/tabid/215/Default.aspx

Beginning January 1, 2011, the agency must use the Department's UAI generated Negotiated Service Agreement (NSA) for A&D and adult PCS participants. The NSA must include the specific type, amount, frequency and duration of Medicaid reimbursed waiver services to be provided; supports and service needs to be met by the participant's family, friends, neighbors,

volunteers, church and other community services; participant backup plans and goals; and the signature of the participant or legal representative agreeing to the service plan.

Authorization of PCS or HCBS A&D supervisory RN visits for adult participants residing in their own homes or certified family homes (Service Code T1001)

Beginning with the claim date of service January 1, 2011, for HCBS A&D or PCS in-home or certified family home (CFH) participants, services provided during a supervisory RN visit will be prior authorized based on the medical necessity and on a case-by-case basis. An example of when a supervisory RN visit may be authorized is when an unstable acute medical condition that is likely to require changes in the service plan, frequent emergency room visits or unscheduled medical appointments, or initial Idaho Training Matrix - Participant Specific Endorsements.

In-home participants who are already authorized for supervisory RN visits after January 1, 2011, will remain authorized. Supervisory RN visits will no longer be prior authorized directly to the CFH provider or included in the CFH daily rate. Authorized supervisory RN visits will remain open until either the BLTC nurse reviewer completes the annual UAI assessment or receives a Significant Change Request Form from the agency. At this time, the BLTC nurse reviewer will assess the continued need for authorization of supervisory RN visits. If supervisory RN visits are indicated, this service will be prior authorized to the personal assistance agency chosen by the participant.

Rate changes for HCBS A&D and PCS participants (Service Code S5125, S5130, S5140 and T1019)

Beginning January 1, 2011, Medicaid will change its reimbursement rates for personal assistance services (personal care, attendant, and homemaker services). The current supplemental component of 55% will be reduced to 50.4%.

The service codes and new rates are:

Service Codes	Current Rate	Effective 1-1-2011 Rate
S5125 Attendant Care	$4.01 / 15 minutes	$3.89 / 15 minutes
S5130 Homemaker Services	$3.40 / 15 minutes	$3.30 / 15 minutes
T1019 Personal Care Services	$4.01 / 15 minutes	$3.89 / 15 minutes
T1019 PCS Family Alternate Care Home	$3.34/ 15 minutes	$3.34 / 15 minutes
S5140 Adult Foster Care per diem	**	**

** Certified family homes and residential and assisted living facilities that bill this service will receive a Notice of Decision with the new rate for each participant. Approval of service by the local Medicaid services office is still required before the service is delivered.

Services provided on or before December 31, 2010, must be billed separately from services provided on or after January 1, 2011. There may be an error in your payment if you do not use separate claim forms.

Authorization of qualified mental retardation professional (QMRP)/qualified intellectual disabilities professional (QIDP) (Service Code G9001 and H2020)

Beginning with the claim date of service January 1, 2011, participants who receive personal assistance services and whose Department assessment indicates a need for oversight by a QMRP/QIDP, will be reimbursed for the assessment and plan of care (G9001) one time annually. Service supervision or oversight for children receiving PCS or a QMRP/QIDP, should only be authorized on a quarterly basis unless the medical or developmental needs of the participant indicate an increased need to ensure the safety and well-being of the participant. Based on federal guidelines 42.CFR.483.430(a) and Idaho Medicaid's Enhanced Benchmark Plan, providers who are expected to carry out training programs for developmentally disabled participants must be supervised at least every 90 days by a QMRP.

If you have additional questions about the changes please call the policy subject matter experts in the Bureau of Long Term Care:

- PCS or HCBS A&D benefits - (208) 287-1156
- Children's PCS benefits - (208) 364-1891

LMC/rs