Department of Medical Assistance Services
600 East Broad Street
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https://dmas.virginia.gov

MEDICAID MEMO

Notice of Implementation of Personal Care Cap – Effective September 1, 2011

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This memorandum is notification of a change in personal care services authorizations for the Elderly or Disabled with Consumer Directed Services (EDCD) and HIV/AIDS Waiver Programs and supersedes all previously issued provider policy manuals with respect to personal care services. These changes are targeted to be effective September 1, 2011 and have been approved by the Centers for Medicare and Medicaid Services (CMS).

The 2011 Virginia General Assembly approved budget bill language (Item 297 CCCCC) which requires the Department of Medical Assistance Services (DMAS) to develop and implement a 56 hour per week cap for personal care services under the EDCD and HIV/AIDS Waivers. The language requires DMAS to develop and implement exception criteria for those individuals who require more than 56 hours per week of personal care services.

This change applies to services provided by personal care providers and facilitated by service facilitators. These changes apply to HCPCS codes T1019 for agency directed personal care and S5126 for consumer directed personal care. In all instances, effective with dates of service July 1, 2011 and forward, when a request is made for T1019 and/or S5126, the duration of the service authorization will not exceed a 24 month period.

For All Existing and New Prior Authorizations Which Do Not Exceed 56 Hours Per Week:

Providers do not have to submit any additional documentation or request any changes for existing or any new prior authorizations which do not exceed the 56 hour per week cap.

For All New Admissions, Transfers, or Changes to Current Service Authorizations Submitted to KePRO Effective for Dates of Service On and After September 1, 2011:

The following criteria will be applied by providers when seeking an exception to the 56 hour per week cap for personal care services (whether the services are agency directed or consumer directed or a combination of agency and consumer-directed services).

The waiver individual must:

- Currently have a minimum level of care of B or C as defined in the EDCD or HIV/AIDS waiver manuals, Chapter IV; and
- Provide documentation that alternative funding resources have been explored (Medicaid funded and Non- Medicaid funded) through which personal care services may be available. Examples of alternative

resources include, but is not limited to, Department of Social Services - other social service agencies, community organizations, faith-based organizations, etc. This information may be documented on either the DMAS-97 A/B or the DMAS-99.

AND have one or more of the following which documents the increase risk of institutionalization:

1. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current pre-admission screening criteria. (Submitted to KePRO via DMAS-99.); OR
2. Documentation of dependencies in both Behavior and Orientation as defined by the current pre-admission screening criteria. (Submitted to KePRO via DMAS-99.); OR
3. Documentation from the local Department of Social Services (DSS) that the individual is known to either Adult Protective Services (APS) or Child Protective Services (CPS) (as described below) and is in need of additional services above the 56 hour per week cap (this can be in the form of a phone log contact or any other documentation supplied. (Submitted to KePRO via attestation.)
    v. For APS: A case is defined as being open to APS investigation or a substantiated APS case with a disposition of needs protective services.
    vi. For CPS: A case is defined as being open to CPS investigation if it is either founded by the investigation and the completed family assessment documents the case with moderate or high risk.

When submitting attestation information, upon post payment review and/or Quality Management Review (QMR), should documentation regarding proof of attestation submitted to KePRO be absent in the clinical record, the provider's reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit (MFCU) initiated.

When submitting a request to KePRO for over 56 hours per week for dates of service on and after September 1, 2011, in addition to the current documentation requirements, evidence of the following must be included with the request.

- The most recent **DMAS 97A/B** that reflects the current level of care (level of care B or C, as indicated above)
- The most recent **DMAS 99** that reflects Medicaid and non-Medicaid alternative funding resources that have been explored and the outcome of those resources **AND;**
- One or more of the items listed above in items 1-3.

For Individuals Currently Enrolled in the EDCD and HIV/AIDS Waivers Receiving Over 56 Hours Per Week:

For those individuals currently receiving over 56 hours per week in order to continue receiving reimbursement for these hours for dates of service September 1, 2011 and forward, providers must submit a request to KePRO and include the following information before August 15, 2011:

- The most recent **DMAS 97A/B** that reflects the current level of care (level of care B or C, as indicated above)
- The most recent **DMAS 99** that reflects Medicaid and non-Medicaid alternative funding resources that have been explored and the outcome of those explorations **AND;**
- One or more of the items listed above in items 1-3.

KePRO will review the information against the exception criteria and make a final determination.

Any case whereby the provider fails to submit information to continue the hours in excess of 56 hours per week before August 15, 2011, hours will be automatically changed to 56 hours per week effective September 1, 2011.

For New Admissions to the EDCD and HIV/AIDS Waivers with Dates of Service on July 1, 2011 Through August 31, 2011, and the Individuals in Need of Greater Than 56 Hours Per Week:

If the provider elects to submit justification for greater than 56 hours per week and includes exception criteria, KePRO will review the request against the exception criteria and make a final determination. Authorization will be provided for a period of up to 24 months. The provider should follow the guidelines as outlined above.

If the provider elects **not** to submit the justification for greater than 56 hours per week, the authorized period will extend through September 30, 2011. In order to continue hours greater than 56 per week, the provider must submit a request to KePRO, including justification of hours by utilizing the exception criteria, before September 30, 2011 or the hours will be cut back to 56 hours per week effective October 1, 2011.

General Information for Providers and Service Facilitators:

Providers and service facilitators are responsible for updating the plan of care as necessary to support the need for the hours over 56 hours per week. Providers and service facilitators are responsible for ensuring that staff providing care are aware of any changes related to service delivery based upon the implementation of the 56 hours per week cap.

Please refer to the EDCD or AIDS Waiver Provider Manual, Chapter IV for information regarding the level of care determination process. The process for determining the number of hours an individual may need has not changed with the exception of the additional documentation required to support over 56 hours per week of personal care services.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1- 800-772-9996. Both options are available at no cost to the provider.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.