Questions HCBS Update Meeting

DSDS
10.18.23

Q. How strict are vendors required to be regarding the CDS worker following care plans and tasks?

A. Authorized units are developed through a person centered care planning process with the participant in order to reflect the time necessary to complete the tasks. If a participant does not utilize all weekly units, providers should document appropriately (e.g., participant refused or ill, etc.). If the participant needs additional services throughout the month, providers can document and serve accordingly with units not previously used. However, it is not appropriate to schedule these units for the purpose of being able to bill for the entire monthly authorization. Providers should document the time actually spent delivering the services and bill accordingly.

Q. Since there is a maximum allowable cap on units, do we even really need to continue doing General Health Evaluations (GHEs)? It doesn't seem like it's really based on LOC now, but seems to be based on the cost max cap.

A. GHEs are not authorized based on LOC or the cost maximum. They are required per MO State Statute 192.2475. GHEs provide an intermittent opportunity for the nurse to provide enhanced supervision of the individual providing the services to ensure quality of care, assessment of the participant's health, and assessment of the adequacy of the participant's care plan to meet the participant's needs. Authorized nurse visits shall occur at least twice annually.

Q. Does Advanced Respite require being checked off by a nurse and if so, what tasks would be trained on because no tasks are entered?

A. Advanced Respite is provided to participants with special care needs, requiring a higher level of personal care oversight. Further information on the care provided to participants with Advanced Respite can be found in the HCBS Policy Manual – Respite Care Aged and Disabled Waiver.

Provider's are responsibility for oversight and training for aides delivering Advanced Respite. The additional training of a an advanced respite worker is determined and provided by the provider RN following assessment of the participant's condition and needs.

The MO Code of State Regulations 19 CSR 15-7.021 In Home Service Standards and the Aged and Disabled Waiver Manual (p.19) provides guidance on Advanced Respite and required training.

Q. Can a LPN complete the 6 month Advanced Personal Care assessment?

A. An LPN is allowed to complete the GHE visit under the direction of a Registered Nurse (RN) or Doctor; however, an RN must complete the six-month APC service assessments.

Q. If I have questions about payment of the recent value base payments, who should I contact?

A. Please send your question to DSDS.Surveys@health.mo.gov.

Q. How can a provider pull a report similar to the EVV incentive report used to ensure they are on track for the value based incentive. ?

A. Instructions for running an auto verification report can be found here: info-07-23-02-guide-attach.pdf (mo.gov).

Q. Why is it taking so long for PCCP requests to be resolved?

A. We're experiencing an exceptionally high volume of requests coming in from across the State of Missouri. Processing times are strongly affected by the number of requests received on a daily basis. Each request is addressed in the order it's received and by the immediacy of need. If there is a significant health, safety, and/or welfare risk due to no formal or informal supports, please provide those details by contacting HCBS Intake and & PCCP Management email at HCBSIntakeandPCCP@health.mo.gov and the case will be reviewed again. We appreciate your patience as our team works diligently to process every request received as quickly as possible.

DSDS has implemented changes to help with efficiency. Processing times are improving but additional improvement continues to be a focus of the division

Q. Why can't providers call and check status of requests anymore?

A. Providers have the ability to access Web Tool to check the status of the request. The attachments and case notes are available for review to determine if the request has been received and possible action taken. Phone lines are reserved for participants. Status checks do cause a delay in processing times as it is taking team members away from processing work.

Q. It would be helpful if the last person working on the participant's case would put their name and/or extension in Web Tool so we can contact them if additional questions arise.

A. The PCCP team are to include their name and extension after the entry of a case note. Intake team members enter notes to cases and include their name and team name, however they do not add their extension as they are not assigned to the case.

Q. Where do we update contact information in Web Tool?

A.The participants contact information is located on the Participant Case Summary Screen of Web Tool under Demographics. For guidance on updating the information visit the Web Tool Guide.

Q. I have a client who has been waiting longer than the expected timeframe. Is there a recommended process in these instances?

A. Please send the DCN/Name to the Intake & PCCP Leadership Account at HCBSIntakeandPCCP@health.mo.gov. We will look into that situation further.

Q. Do you send out a no contact form on participants to the one making the referral to clarify the request, or help the referrer know the status? Is the participant put on a recall list?

A. The "no contact form" would be mailed to the participant. The only way we would contact the "referrer" is if they are a Guardian of the participant. Referring providers are not directly contacted. Case notes in Web Tool can be reviewed to determine if action has been taken on a request at any time. Providers are highly encouraged to prepare the referred individual for the upcoming call to schedule the assessment.

Please utilize the Preparing for an Assessment materials to help guide this conversation.

- Printable Brochure: assessment-brochure.pdf (mo.gov)
- Online Graphic: Preparing for a Care Plan Change (mo.gov)

10.19.23

Q. Why do some of my clients have different providers going in and doing their reassessments instead of my nurse?

A. HCBS providers can voluntarily enroll in the provider reassessment program. Enrolled providers will conduct the reassessments during face-to-face visits. For participants whose HCBS provider is not enrolled in the reassessment program or particpants with multiple HCBS providers, the reassessment will be completed by either DSDS staff or their designee. Additional information can be found on the Provider Reassessment Information page.

Q. Can the grandchild provide respite services?

A. No, a grandchild is considered an immediate family member and cannot provide respite services.

Q. Can a vendor's office staff work for the consumer?

A. Technically yes but there are many caveats to be aware of when considering this.

1. The individual doing the in person monitoring may only assist with services up to there (3) days in a 30- day period. It is suggested to keep documentation in the event this occurs.
2. Payroll would have to be broken out for hours paid under the consumer's federal EIN number and the hours worked as office staff under the vendor's federal EIN number.
3. The vendor must ensure there is no conflict of interest for the office staff member. The purpose of the regulation is to avoid the conflict of interest for a person that is both working for the consumer and then turning around and approving/billing Medicaid for that work.

Q. How are we the vendor to recoup any tax money returned to the consumer by the IR via treasury check?

A. DSDS suggests reaching out to the vendor's accountant for guidance.