MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

June 9, 2009

MEMORANDUM

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: JOHN A. LIVERATTI, CHIEF, COMPLIANCE

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 2700 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR THE ELDERLY IN ADULT RESIDENTAL CARE

BACKGROUND AND EXPLANATIONS

Policy revisions are being proposed to Medicaid Services Manual Chapter 2700 – Home and Community Based Waiver (HCBW) for the Elderly in Adult Residential Care. The policy revisions seek to remove unintended inconsistencies between stated policy and the proper provision of waiver services to eligible recipients. These policy revisions will in no way inhibit or prevent the provision of appropriate and necessary care to recipients.

The revised policies will remain in effect for a period of one year from the date approved at public hearing or the date the Division of Health Care Financing and Policy formally adopts these policy revisions in Medicaid Services Manual Chapter 2700, whichever comes first.

MATERIAL TRANSMITTED
MTL 17/09
CHAPTER 2700 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR THE ELDERLY IN ADULT RESIDENTIAL CARE

Added "Addendum to Medicaid Services Manual Chapter 2700 – Home and Community Based Waiver (HCBW) for the Elderly in Adult Residential Care (WEARC)"

Added "1. If services documented on a Plan of Care are approved by the recipient and the case manager and the recipient signature cannot be obtained due to extenuating circumstances, services can commence or continue with verbal approval from the recipient. Case managers must document the recipient's verbal

MATERIAL SUPERSEDED
MTL - NEW
CHAPTER 2700 – HOME AND COMMUNITY-BASED WAIVER (HCBW) FOR THE ELDERLY IN ADULT RESIDENTIAL CARE

approval in the case notes and obtain the recipient signature on the Plan of Care as soon as possible."

Added "2. The number of hours specified on each recipient Plan of Care, for each specific service (except Case Management), will be considered the maximum number of hours allowed to be provided by the care giver and paid by the DHCFP, unless the case manager has approved additional hours due to a temporary condition or circumstance. Care givers are allowed to provide fewer services than stated on the Plan of Care, if the reason for the providing less service is adequately documented on the daily record."

Added "3. When recipient service needs increase, due to a temporary condition or circumstance, the case manager must thoroughly document the increased service needs in their case notes. The Plan of Care does not need to be revised for temporary conditions or circumstances. A temporary condition or circumstance is defined as an increase or decrease in service needs for a period not to exceed 30 days."

Added "4. Case managers must provide recipients with the appropriate amount of case management services necessary to ensure the recipient is safe and receives sufficient services. Case management will be considered an 'as needed' service, irrespective of what is stated on the current Plan of Care until all recipient Plans of Care are revised. For recipient Plans of Care developed or revised after the date of this policy change, case management on the Plan of Care will indicate 'as needed'. Case managers must continue to have monthly contact with recipients of at least 15 minutes, per recipient, per month. The amount of case management services billed to the DHCFP must be adequately documented and substantiated by the case manager's notes."