



**STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES**

Med-QUEST Division
Health Care Services Branch
Quality and Member Relations Improvement Section
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 19, 2017

MEMORANDUM

MEMO NO.

QI-1716

[Replaces ADMX-1419]

TO: QUEST Integration (QI) Health Plans

FROM:  Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: GUIDELINES FOR HOME AND COMMUNITY BASED SERVICES

The Department of Human Services, Med-QUEST Division (MQD) issues this memo to provide guidance for the provision and monitoring of home and community based services (HCBS) in the QUEST Integration (QI) program. This memorandum replaces QI-1419 issued as a QUEST Integration memo on December 1, 2014.

1. Chore Services (Personal Assistance Services- Level I):

Chore services may be provided up to a limit of 10 hours per week for individuals who are determined to meet the "At Risk" criteria. These criteria include living at home and being assessed to be at risk of deteriorating to the nursing facility level of care based on a functional assessment as documented on a submitted DHS 1147. Health plans may provide more than 10 hours per week of chore services if medically necessary.

2. Skilled Nursing and Personal Care Services (Personal Assistance Services- Level II):

- a. The HCBS levels are developed to assure oversight of authorizations and changes enacted by the Service Coordinator (SC) and Health Plan (HP). The total number of HCBS hours per week is a combination of Personal Assistance I, Personal Assistance II, and Skilled Nursing.
- b. The MQD role is not a decision-making role for changes in HCBS, but to provide guidance and oversight.

- c. If an increase in medically necessary service hours changes the level identified in either Table 1 or 2 below, the new level is the authority that must be followed.
- d. The following table describes that levels and oversight required for children under 21 years old receiving HCBS:

Table 1: Children under 21 years old							
Level	Hrs/wk	Initial admission to HCBS		Increase in service hours		Decrease in service hours	
		Health Plan	MQD	Health Plan	MQD	Health Plan	MQD
1	<56	SC or SC supervisor		SC or SC supervisor		SC Supervisor or UR Committee	
2	57-84	HP Medical Director		HP Medical Director		HP Medical Director or UR Committee	
3	>84	HP Medical Director	MQD*	HP Medical Director	MQD*	HP Medical Director	MQD*

- e. The following table describes that levels and oversight required for adults 21 years and older receiving HCBS:

Table 2: Adults 21 years and older							
Level	Hrs/wk	Initial admission to HCBS		Increase in service hours		Decrease in service hours	
		Health Plan	MQD	Health Plan	MQD	Health Plan	MQD
1	<21	SC		SC		SC Supervisor or UR Committee	
2	22-70	SC supervisor		SC supervisor		HP Medical Director or UR Committee	
3	71-98	HP Medical Director		HP Medical Director		HP Medical Director	
4	>98	HP Medical Director	MQD*	HP Medical Director	MQD*	HP Medical Director	MQD*

* Health plans shall send the information in No. 6 to MQD/HCSB for approval of the requested change in service hours. For appeal review, health plans shall send, in addition to documents for service hour changes, any NOA or any appeals/grievance documents.

3. Adverse Decision and Appeals:

The health plan Medical Director shall review and approve any adverse action (denial of services or reduction of services not related to eligibility). In addition, the health plan will send a Notice of Action (NOA), with appeal rights, to the member within the specified timeframe in accordance with Section 51.165 of the QI RFP. In the event of an appeal regarding HCBS, the health plan may discuss with MQD any potential appeal decision prior to proceeding with the appeal. This process will allow MQD to provide guidance and assure that the health plan knows MQD’s position if the appeal is upheld. Failure for the health plan to request review by MQD may result in overturn of the appeal by MQD.

4. Transition Plan for Reduction of Services:

The table below outlines the need for a transition plan. The goal of transition planning is a collaborative process that allows members to gradually decrease the number of hours and ensure that the reduction does not adversely affect the member’s health and safety. If a member does not want or need a transition plan, the QI health plan is not required to provide a transition plan. However, the health plan shall document any denial of a transition plan in writing and include the member’s signature or indicate the member’s refusal to sign. Service Coordinators should arrange follow-up phone calls and visits during the transition time to assess the impact of the reduction in service hours on the member and the member’s family.

Current Hours	Reduction	Transition Plan Required
<98 hours per week	≤7 hours per week	No*
<98 hours per week	>7 hours per week	Yes
>98 hours per week	≤7 hours per week	No*
>98 hours per week	>7 hours per week	Yes with MQD approval of transition plan

*Health plans shall provide a transition plan for aggregated reductions of over 7 hours a week if reductions occur over 30 days.

5. Other Guidance:

- a. If the member has a primary insurer other than Medicaid, the health plan should coordinate with the primary insurer to ensure that Medicaid does not cover services that the primary insurer will cover.
- b. The service coordinator shall use the MQD issued health and functional assessment (HFA) tool with personal assistance and skilled nursing tools, as needed when

performing an assessment. By using the 'personal assistance' and 'skilled nursing' tools, hours should be assigned objectively for both personal assistance and skilled nursing needs. When considering delegation of skilled needs/hours, assess each member on an individual basis, taking into account the availability of school supports, the availability of family/caregiver supports, and the availability of personal care supports. The health plan should document comprehensive assessment and recommendations for services clearly in the member's records.

- c. One of the primary goals of the QI program is to assure access to high quality, cost-effective care that is provided, whenever possible in a member's community. Consideration should be given to the member's social situation and support network to include contingency/back-up support (i.e., replace the primary caregiver and/or agency worker in emergency situations). The standardized tools listed in 5b (above) promote a comprehensive assessment that includes social as well as medical needs.
 - d. For members that receive home and community-based services through the Developmental Disabilities/Intellectual Disabilities (DD/ID) waiver program, the service coordinator should coordinate with the DD/ID case manager to ensure that the member receives medically necessary services through the health plan and waiver services through the DD/ID program.
 - e. The service coordinator should explore available natural supports, including family members, friends, and school. Health plans should also consider both day health and day care options.
 - f. The relationship between the service coordinator and the member/family is important. Any authorization or denial of QI covered services must be a collaborative negotiation with the member and his/her family. If the service coordinator cannot reach an agreement with the family, the QI health plan shall follow their contract for denial of services (QI RFP Section 51.100).
 - g. Fraud, waste and abuse – the QI health plan, its employees and delegates (e.g., Community Care Management Agencies (CCMAs)) must be aware of the potential for fraud, waste and abuse in the approval, provision and monitoring of HCBS, including chore services. Health plans shall report any suspected fraud, waste or abuse and corrective action taken in accordance with the QI Contract, State and Federal regulations and requirements.
6. When submitting information to MQD for increases or decreases in service hours, please remember to submit all of the following information to MQD via your FTP site for approval:
- Long Term Services and Supports Health and Functional Assessment (LTSS HFA)

- Provide the last LTSS HFA, personal assistance tool and skilled nursing tool (if applicable).
- If the services and hours which the member is currently receiving are not reflected in the last LTSS HFA and skilled nursing tools, provide these in addition.
- Current service plan.
- Progress Notes as it relates to the proposed change in services.
- Member profile: Member identification, age, diagnosis and brief summary of member's current condition.
- Primary Caregiver and support system: Describe who is responsible for member's care and others who are assisting with care (e.g., family, friends).
- Psych-social issues (if applicable): Describe how these are being addressed.
- Summary of current services by service type: Include the length of time that member has been receiving this level of services (i.e., member has had 10 hours of PA1 and 15 hours of PA2 since February 2009).
- 24/7 Color Coded Daily Activity Schedule.
- Summary of proposed increase, or reduction of services by service type and justification: Include results of secondary review process and specify proposed hours for each task (e.g., bathing, dressing, grooming, etc.).
- Explanation of what has changed:
 - Has a new support structure been identified to replace services being reduced?
 - Has member's condition improved?
 - Was a previous assessment incomplete or has new information been identified?
 - Are current services authorized not being utilized as indicated (i.e., is there waste in the current plan)?
 - Has member's informal support and/or caregiver capabilities changed?
 - Member choice (moving to facility placement)?
 - How many hospitalizations has member had in the past 12 months? (if available)
- Documentation in the Progress Notes that member is aware of the recommended increase or reduction in services being recommended by service coordinator.
- Documentation in the Progress Notes whether member agrees/disagrees with the proposed change to increase or decrease services.

If you have any question(s) regarding this memorandum, please contact Jon Fujii at 808-692-8083 or via e-mail at jfujii@dhs.hawaii.gov.