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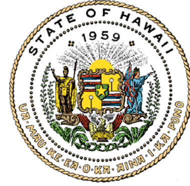


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January 7, 2025

MEMORANDUM

MEMO NO.
QI-2502

TO: QUEST Integration (QI) Health Plans
Community Care Management Agencies (CCMAs)

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

SUBJECT: MY CHOICE MY WAY – LONG TERM SERVICES AND SUPPORTS (LTSS) CHOICE FORM

This memorandum informs the health plans and CCMAs of the revisions to the content and format of the LTSS Choice Form. The LTSS Choice Form was first introduced and released with memo QI-1502, and the revisions were made to align with the requirements of the HCBS Setting Final Rule 42 CFR §441.301 (c)(4), 42 CFR §441.710 (a)(1) published on January 16, 2014, by the Centers for Medicare and Medicaid Services (CMS). Health plans and CCMAs are required to use the new version of these documents effective April 1, 2025.

Significant revisions include:

1. Adding guidance throughout the form and developing step-by-step instructions pages on how to complete the entire form.

2. Adding CCMAs as responsible entity in completing the form.

3. Adding Day Program (Adult Day Health and Adult Day Care) to the list of HCBS Service Setting.

4. Modifying the list of home settings.

5. Reiterating that HCBS settings options must include “non-disability-specific settings”.

6. Adding an attestation that member has been informed of their choice of service providers and settings with a disclaimer advising ability to secure services with preferred provider is dependent on provider’s ability to accept services.

7. Reformatting the form to improve flow and to maintain consistency.

Please submit any questions to mychoicemyway@dhs.hawaii.gov.

Enclosure

## Long-Term Services and Supports (LTSS)
## Choice Form

I, ____________________________, have talked with my <u>Health Plan/Community Care Management Agency (CCMA) staff</u>. I understand my health care needs. I also understand that I need long-term care services.

**STEP 1:** I choose to receive: (check one only)

- ☐ Home and Community-Based Services (HCBS) – see STEP 2
- ☐ Institutional Placement (Nursing Facility) - complete signature below

**STEP 2:** HCBS Setting (including non-disability-specific settings): (choose all that apply)

- ☐ Home – see STEP 3
  (Living alone or living with family)
- ☐ Residential Setting – List your choice(s) on page 2
  (Community Care Family Foster Home (CCFFH), Expanded Adult Residential Care Home (EARCH), Assisted Living Facility (ALF))
- ☐ Day Program - List your choice(s) on page 2
  (Adult Day Health, Adult Day Care)

**STEP 3:** HCBS in Home Only
Personal assistance service options: (check one or both)

- ☐ Agency - List your choice(s) on page 2
- ☐ Self-Direction (SD)
  - ☐ Provider(s): ___________________________________
  - ☐ I need help finding a provider.

I agree that services are subject to my Medicaid eligibility and meeting level of care.

_______________________________________________________ ________________________________
*Signature-Member* *Date Signed*

_______________________________________________________ ________________________________
*Signature-Legal Guardian/Representative (if applicable)* *Date Signed*

If unable to sign, verbal consent given by: _____________________________________

Relationship: ___________________________

| **Member Name:** |
| --- |
| **Medicaid ID #:** |

## Choice of Providers

Based on your assessment, you may qualify for the services checked below.
Discuss with your health plan/CCMA staff on the provider options available and write provider/agency name(s) for each checked service.

| SERVICE TYPE | 1st CHOICE | 2nd CHOICE | 3rd CHOICE | No Preference |
| --- | --- | --- | --- | --- |
| ☐ ADULT DAY CARE | | | | |
| ☐ ADULT DAY HEALTH | | | | |
| ☐ ASSISTED LIVING FACILITY | | | | |
| ☐ COMMUNITY CARE MANAGEMENT AGENCY (CCMA) | | | | |
| ☐ COUNSELING AND TRAINING | | | | |
| ☐ HOME-DELIVERED MEALS | | | | |
| ☐ NON-MEDICAL TRANSPORTATION | | | | |
| ☐ PERSONAL ASSISTANCE LEVEL 1 (Chore services)<br>☐AGENCY ☐SD ☐BOTH | | | | |
| ☐ PERSONAL ASSISTANCE LEVEL 2 (Hands on care)<br>☐AGENCY ☐SD ☐BOTH | | | | |
| ☐ RESIDENTIAL SETTING | | | | |
| ☐ RESPITE CARE | | | | |
| ☐ SKILLED/PRIVATE DUTY NURSING | | | | |
| ☐ EQUIPMENT & SUPPLIES | | | | |

| Member Initials | |
| --- | --- |
| | I have been informed of my choice of service providers and settings from a variety of options including non-disability specific settings. I understand that the service providers and settings that I listed may not be available and I will be provided other options to choose from. |
| | I do not have a preference about my service provider and setting. I want my health plan/CCMA staff to choose for me based on the service vendor(s) ability to meet my service needs and cost. |
| | I understand that I may change my mind at any time by contacting my health plan/CCMA staff and my new choice(s) will be discussed and documented in my Health Action Plan. |

**My signature below confirms that I reviewed the provider list and chose the agency(ies) written above.**

_____________________________________________ _________________________
*Signature-Member* *Date Signed*

_____________________________________________ _________________________
*Signature-Legal Guardian/Representative (if applicable)* *Date Signed*

**LTSS Options Counseling Provided by:**

_____________________________________________ _________________________
*Signature-Health Coordinator/Case Manager* *Date Signed*

_____________________________________________ _________________________
*Printed Name* *Title/Agency*

**Comments:**

_____________________________________________________________________________

_____________________________________________________________________________

**GENERAL INSTRUCTIONS**

**The Long-Term Services and Supports (LTSS) Choice Form is completed for members who are determined eligible for LTSS, including Home and Community-Based Services (HCBS) and Institutional Placement.**

**The Health Plan/Community Care Management Agency (CCMA) staff will provide options counseling and complete the form with the member or authorized representative upon initial determination of member's eligibility and per member's request, or at least annually thereafter.**

**In accordance with the Home and Community-Based Setting Final Rule issued in January 2014, the member will have the option to choose non-disability specific settings. These settings:**

- **Provide opportunities to work alongside people without disabilities**
- **Allow individuals to spend time in the community**
- **Give individuals control over their schedules and activities**
- **Ensure individuals have the same level of access to community services as those who don't receive Medicaid HCBS**
- **Allow individuals to select their settings from a range of options, including private units in residential settings**
- **Ensure individuals' right to privacy, dignity, and respect**
- **Support individuals' autonomy and independence in making life choices**

**For definitions and examples of the different settings, refer to the Health and Functional Assessment instructions, Appendix G. Glossary for living arrangement and residence.**

**PAGE 1 - Form Header**

A) Enter member's legal name and Medicaid ID number.

**STEP 1**

A) Check appropriate box to indicate member's selection to receive either home and community-based services or institutional placement.
   a. If Home and Community-Based Services selected, proceed to Step 2.
   b. If Institutional Placement selected, skip Step 2 & 3, and complete signatures at bottom of page 1. Note: The Health Plan/CCMA staff completing options counseling with the member will sign and date on page 2.

**STEP 2**

A) Check appropriate box to indicate the member's selection of setting to receive Home and Community-based Services.
   a. If Home selected, proceed to Step 3.
   b. If Residential Setting selected, complete signatures at bottom of page 1 and indicate member's choice of provider on page 2.
   c. If Day Program selected, complete signatures at bottom of page 1 and indicate member's choice of provider on page 2.

**STEP 3**

A) Check appropriate box to indicate the member's selection of HCBS home-setting provider type.
   a. If Agency selected, complete signatures at bottom of page 1 and indicate member's choice of provider on page 2.
   b. If Self-Direction selected, indicate member's self-direct provider and complete signatures at bottom of page 1.
      i. If member has a provider identified, check Provider and indicate provider's name.

ii. If member needs help selecting a provider, check the appropriate box and provide education on advertising, interviewing, and selecting a self-direct provider.

**PAGE 1 – Signatures**

A) Obtain the member's signature and date signed. If the member is unable to sign or a legal guardian/representative is assisting or completing options selection for the member, obtain the representative's signature and date signed.

**PAGE 2 – Form Header**

A) Enter member's legal name.
B) Enter member's Medicaid ID number.

**Service Type / Choice Table**

A) Check the appropriate service(s) the member is authorized to receive.
B) Health Plan/CCMA staff will discuss service provider and settings options including non-disability-specific settings available based on the member's geographic location and known provider availability. Health Plan/CCMA staff will provide the member/representative with education regarding any barriers which may prevent their limit provider selection.
B) For each service type selected, indicate the members first, second and third choice of provider in the appropriate columns.
    a. If the member/representative has no preference in provider, indicate and "X" on the No Preference column for that service(s).

**Member Attestation**

A) Health Plan/CCMA staff will review the attestation statements with the member. Upon reading each statement, the member will initial each as appropriate. If the member is unable to initial or a legal guardian/representative is assisting or completing options selection for the member, obtain the representative's initials.

**PAGE 2 – Signatures**

A) The member will review the completed form, sign, and date. If the member is unable to sign or a legal guardian/representative is assisting or completing options selection for the member, obtain the representative's signature and date signed.
B) The Health Plan/CCMA staff completing options counseling with the member will sign and date.
C) Any comments related to the options counseling discussion should be written in the Comments section.