



Impact for Potential Changes to Medicaid Personal Care Services

State of Utah
Division of Integrated Healthcare
October 2023

To: Social Services Appropriation Subcommittee
From: Jennifer Strohecker, State Medicaid Director
Subject: Impact for Medicaid Personal Care Services

Purpose

To fulfill legislative intent language implemented in S.B.0007 (2023 General Session), Item 111:

The Legislature intends that the Department of Health and Human Services report to the Social Services Appropriations Subcommittees by October 1, 2023, on the costs of changing all regular Medicaid respite (personal) care services billing units from one hour to fifteen minutes as is currently done for Medicaid waiver services. The report shall include at a minimum the cost impact to the State from the change and the rate increase that could be provided under a cost neutral scenario.

Executive summary

Personal Care Services (PCS) provides individualized medically necessary support with activities of daily living in the home setting. This allows individuals to be served in their home, which avoids costly institutionalization in long term care facilities, which would not be possible without PCS.

Individuals who qualify for these services must meet the following criteria: Must not be confined to a bed and require either prompting or hands-on support with basic activities of daily living, such as toileting, dressing, and meal preparation. The services provided must be detailed in the member's plan of care and supervised by a registered nurse.

Currently PCS are reported using Healthcare Common Procedure Coding System (HCPCS) code T1019 in 1-hour increments. This reporting methodology does not align with the code description "personal care services, per 15 minutes" as defined by the Centers for Medicare and Medicaid

Services (CMS). The current hourly reporting method can lead to overpayment, due to the possible reimbursement amount exceeding the actual time spent with members.

The Department of Health and Human Services (Department) recommends changing the reporting requirements for PCS from 1-hour increments to 15-minute increments. This change will align Medicaid's reporting policy for HCPCS T1019 with the HCPCS code description and allow more accurate reporting of PCS from Medicaid providers.

Background

Purpose of Medicaid Personal Care Services (PCS)

The purpose of PCS is to provide supportive care to members in their place of residence, maximize independence, and prevent premature or inappropriate institutionalization. Supportive care offers a range of assistance services that enable persons with disabilities (cognitive or physical) and acute or chronic conditions to perform tasks associated with activities of daily living (ADLs), such as bathing or dressing, or instrumental activities of daily living (IADL) such as grocery shopping and meal preparation.

PCS assists with ADLs, IADLs, or other tasks that do not require direct intervention or supervision of a licensed healthcare professional. PCS assistance may be in the form of hands-on assistance (performing a personal care task for a person) or cueing so that the person may perform the task by themselves. These tasks may include, but are not limited to, those health care services which an unlicensed individual may perform without delegation by a healthcare provider per [Utah Administrative Code Section 58-1-307.1](#) and [Utah Admin. Code Subsection R156-31b-701a \(1\)](#).

PCS does not include respite services. Respite care is an intermittent service provided to an individual to relieve the primary caregiver from the stress of providing continuous care, thereby avoiding premature or unnecessary placement in facility-based care.

Member Eligibility Criteria for PCS

PCS is available to eligible members who meet the following conditions:

- The member is non-bedbound (meaning the member is not confined to a bed)
- The member is unable to independently perform two or more of the following personal care tasks:
 - o Self-administration of medications due to memory lapse
 - o Toileting
 - o Bathing or showering
 - o Skincare
 - o Ambulation
 - o Personal grooming

- Nutritional requirements, including meal planning, preparation, cleanup, and motivation to eat
- The member needs personal care services:
 - to maintain the capacity to function, delay disease progression, prevent regression and complications, or
 - while recovering from an acute condition.

Coverage Requirements

PCS services must be provided through a personal care agency that is licensed under [Utah Administrative Code R432-725](#). Additionally, members must meet the following requirements to receive PCS:

- A qualified healthcare provider (QHP) must prescribe necessary PCS.
- Only a qualified personal care aide, a certified nursing assistant (CNA), a home health aide (HHA), a licensed practical nurse (LPN), or a registered nurse (RN) (performing only personal care level tasks) may provide PCS. The scope of practice for PCS is defined by federal and State of Utah requirements including 42 CFR [440.167](#), [484.80\(i\)](#) Utah Administrative Code [414-38](#), [432-700-23](#) and [R432-725-14](#).
- An RN must make a supervisory visit to the member's residence at least once every 60 days to ensure adequate care is provided according to the written plan of care. The visit may be made when the aide is present to observe and assist or when the aide is absent to assess relationships and determine whether goals are being met.
- PCS is covered in a member's residence only, not in an institutional setting.
- An RN must complete an initial personal care assessment to determine:
 - The member's level of function;
 - The adaptability of the member's place of residence to provide personal care services;
 - the capability of the member to participate in their care;
 - to identify family support systems; or
 - to identify individuals who are willing to assume the appropriate level of responsibility to care for the member when they cannot care for themselves.
- An RN must complete a personal care assessment every 60 days at re-certification or sooner if warranted by a change in the member's condition.
- Agencies must deliver PCS according to a written plan of care developed by agency staff, in consultation with the QHP and their orders.
 - The certification period for each plan of care is 60 days. An RN must perform a new nursing assessment, and the agency must review and revise the plan of care as medically appropriate to fit the member's needs every 60 days.

Reporting and Utilization Control

PCS services are reported using HCPCS code T1019 - *Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment*. Services are limited to two 1-hour units per day. PCS services are limited to a maximum of 60 hours per month. PCS reported under HCPCS code T1019 do not require prior authorization.

The following represent policy limitations and non-covered services under PCS:

- Nursing assessments are limited to one every 60 days.
 - Assessments conducted outside of this window require prior authorization.
- PCS are limited to 60 hours per month.
- PCS may not be provided for a member on the same day that home health services or capitated (meaning a set reimbursement is paid upfront for all services provided) home health services are delivered.
- Services furnished by personal care aides are restricted to those outlined under the *Division of Occupational and Professional Licensing (DOPL) [Tasks an Unlicensed Individual May Perform Without Delegation](#)*.
- PCS is non-covered if the member's needs exceed the level of care an agency is allowed to provide per policy.
 - An agency must refer a member to a licensed health care professional or an appropriate service provider who can safely meet the level of care required if the member's needs exceed that which is allowable under PCS.
- PCS should not be confused with chore services. Examples of chore services that are not PCS include:
 - Cleaning of floors and furniture in areas not occupied by the member.
 - Laundry, other than that which is incidental.
 - Care related to the member's pet(s).

Current Medicaid policy requires the reporting of HCPCS code T1019 in 1-hour increments which does not align with the HCPCS code description.

EVV Requirements

Section 12006 of the 21st Century Cures Act, added Section 1903(l) to the Social Security Act (SSA). [Section 1903\(l\)](#) requires that an electronic visit verification system must be used when PCS are provided to Medicaid members during an in-home visit.

The term *electronic visit verification (EVV) system* means a system that electronically verifies PCS provider visits and records the following information:

- the type of service performed;
- the individual receiving the service;
- the date of the service;
- the location of service delivery;
- the individual providing the service; and
- the time the service begins and ends.

Cost Impact to the State

Currently HCPCS code T1019 is reimbursed at a rate of \$22.56 per 1-hour. If this code was changed to require reporting in 15-minute increments, the code would reimburse at a rate of \$5.64/15-minutes. Limitations of 2 hour/day and 60 hours/month would remain unchanged.

For SFY 2023, 57,104 units were billed for PCS (T1019). The Office of Financial Services projects no anticipated fiscal impact for changing from 1 hour to 15-minute increments for PCS. Utah Medicaid may realize a cost savings if being able to report in 15 minute increments better reflects the true duration of billable care. However, the Department is not able to accurately estimate what these cost savings might be and therefore assumes a cost-neutral scenario. Under this cost-neutral scenario a rate increase for PCS services would not be possible without additional legislative appropriations.

Other States Comparison Data

STATE	T1019 REIMBURSEMENT RATE
California ¹	\$4.84 / 15 min
Colorado ²	\$6.11- \$7.73 / 15 min Rates vary based on type of waiver, if applicable, and region of the state.
	\$6.17 - \$6.83 / 15 min Personal care services provided by a relative. Rates vary based on type of waiver, if applicable, and region of the state.
Montana ³	\$5.86 / 15 min
Nevada ⁴	\$4.39 / 15 min
<i>Utah</i>	<i>\$5.64 / 15 min</i> <i>Rate for 15-minute increments is based on the current reimbursement rate of \$22.56 per 1-hour.</i>

Pros for Reporting Personal Care Services in 15-minute Increments

- More accurate reporting data, including actual time spent with members for personal care.
 - With EVV requirements, we will be able to analyze utilization that will assist in future policy development.
- Potential cost savings compared with paying in 1-hour, episodic sessions.
- Reporting requirements for HCPCS code T1019 would match the HCPCS code description of 15-minute increments.

- EVV compliance - With EVV requirements, PCS would be reimbursed at the amount captured through EVV charting.

Cons for Reporting Personal Care Services in 15-minute Increments

- Providers already have concerns with the low Medicaid reimbursement rate for these services. Moving to 15-minute increments could potentially decrease reimbursement and discourage providers from offering PCS to Medicaid members.

Recommendations and Conclusions

The Department recommends changing the reporting requirements for HCPCS code T1019 for PCS from 1-hour episodes to 15-minute increments. This change will allow more precise reporting of the time spent caring for members. In addition, changing the reporting requirements would bring the current policy in line with the HCPCS code description.

References

1. [Medi-Cal Rates Information](#)
2. [Colorado Provider Rates and Fee Schedule](#)
3. [DPHHS Medicaid Proposed Fee Schedules](#)
4. [Division of Health Care Financing and Policy Provider Portal](#)