North Carolina Department of Health and Human Services
Division of Medical Assistance

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Director

MEMORANDUM

TO: Adult Care Home Providers
122C Licensed Residential Providers
LME/MCO Directors
DSS Directors
ACH Stakeholder Workgroup

THROUGH: Tara Larson
Clinical ~~Operating Officer~~

FROM: Sabrena Lea
Chief Home and Community Care

SUBJECT: Guidance for Family Supplementing Payment to the Medicaid Benefit

DATE: January 29, 2013

The Consolidated Personal Care Services (PCS) program is a Medicaid State Plan benefit designed to provide personal care services to individuals residing in a private living arrangement, or a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a).G.S. 131E-101(1a); or resides in a group home licensed under Chapter 122C of the General Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency.

Consolidated Personal Care Services (PCS) is available to individuals who has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; two ADLs, one of which requires extensive assistance; or two ADLs, one of which requires assistance at the full dependence level. The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility.

PCS program eligibility is determined by an independent assessment conducted by the Division of Medical Assistance or its designee; and shall be provided in accordance with an individualized plan of care.

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Supplementing the cost of care for Medicaid beneficiaries in Adult Care Homes is permitted under certain conditions:

1. The recipient or legally responsible person chooses, **without duress or coercion**, not to bill Medicaid for the covered service. This refusal should be documented and signed by the legally responsible person. The legally responsible person may withdrawal the notice to not bill Medicaid at any point.

2. The recipient or legally responsible person wants to purchase additional amounts of services that are not covered by the Medicaid benefit. As an *illustrative* example, if the benefit or the authorization for services is 80 hours and the family wants to pay for 100, then the family may be charged for the additional 20 hours of service. The cost of care must be explained to the recipient/legally responsible person prior to the delivery of service and the purchase of additional hours must be provided in writing to the legally responsible person.

3. In accordance to 10A NCAC 13 F & G .0704 the resident contract, to which the following applies: the contract shall specify rates for resident services and accommodations, including the cost of different levels of service, if applicable, and any other charges or fees.

Additional guidance to providers:

1. If the recipient or legally responsible person chooses to bill Medicaid for the covered service, then the facility may NOT bill the family for services covered under the benefit. The agency must accept payment in full for the covered service. As an *illustrative* example, if the rate paid to the facility is $3.88 per 15-minute unit but the cost by the facility is $5.00 per 15-minute unit, the recipient may not be charged the difference between the two rates. The Medicaid rate is payment in full and no additional charges may be applied.

2. The facility may have additional cost of care charges that are outside the scope of services covered under the Medicaid program. As an example, if part of the service offered by the provider includes activities or treatments that are not in the benefit, the family may be charged for the additional activities or care. For example, a trip is planned with an admission ticket price. The recipient/legally responsible person may be charged for the ticket. Again, all recipients must be treated equally and fairly with documented policies and proper prior notice to the legally responsible person. However, in the example above, the facility is required to follow licensure rules regarding ensuring activities are provided to recipients.

In all situations, the facility may not "pick and choose" who gets charged and under what conditions. The policies must be applied uniformly for all residents regardless of payor source.

If you have questions about the information in this letter, please contact Sabrena Lea, Sabrena.lea@dhhs.nc.gov or Talbatha Myatt, Talbatha.Myatt@dhhs.nc.gov , and 919-855-4342 at DMA

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