Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 91—Personal Care Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
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13 CSR 70-91.010 Personal Care Program

PURPOSE: Personal care services are medically-oriented services provided in the individual's home, or in a licensed Residential Care Facility I or II to assist with activities of daily living to meet the physical needs of the individual. Personal care services are authorized by a physician in accordance with a plan of care or otherwise authorized in accordance with a service plan approved by the state. This rule establishes the basis for administering the personal care program, including the criteria providers of the service must meet, criteria a recipient of the service must meet, and criteria and method of reimbursement for the services. Specific details of the amount, duration, scope and limitations of services covered are included in the provider program manuals.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) Persons Eligible for Personal Care Services. Any person who is determined eligible by the Division of Family Services for Title XIX benefits and is found to be in medical need of personal care services as an alternative to institutional care. Persons must be assessed, approved and case managed by Division of Aging as described in this rule, to be eligible for personal care services. Eligibility procedures for personal care services are as follows:

(A) Recommendations for Personal Care Services.

1. The recipient must need an institutional level of care which is defined as twenty-four (24)-hour institutional care on an inpatient or residential basis in a hospital or nursing facility (NF) and approved by the Division of Aging.

2. Level of care will be determined by Division of Aging.

3. The recipient must agree to an in-home assessment as performed by Division of Aging staff of his/her physical, social and functional ability to benefit from personal care services;

(B) Obtaining Personal Care Services.

1. If the recipient meets all of the eligibility and assessment criteria, the Division of Aging staff will develop an initial personal care plan to authorize personal care services on a scheduled basis to eligible recipients in their own homes or licensed Residential Care Facility I or II as an alternative to twenty-four (24)-hour institutional care on an inpatient or residential basis in a hospital or NF. The Division of Aging will forward a copy of the personal care plan to the client's attending physician and to the personal care provider who will be delivering care. Upon the receipt of the personal care plan, the provider of care must initiate care within seven (7) days of receipt and the physician must register any comments or requests for changes, within thirty (30) days of receipt or the personal care plan will stand as written by the Division of Aging.

2. The personal care plan will be developed in collaboration with and signed by the recipient. The plan will include a list of tasks to be performed, weekly schedule of service delivery, and the maximum number of units of service for which the recipient is eligible per month.

3. A new in-home assessment and personal care plan may be completed by the Division of Aging as needed to redetermine need for personal care services or to adjust the monthly amount of authorized units. In collaboration with the service recipient, the service agency may develop a new or revised set of personal care tasks, and weekly schedule of service delivery which shall be forwarded to the Division of Aging. The service provider must always have, and provide services in accordance with, a current service plan. Only the Division of Aging, not the service provider, may increase the maximum number of units for which the individual is eligible per month. Any service plan developed in accordance with paragraphs (1)(B)2. and 3. is a state approved service plan.

4. The recipient will be informed of the option of services available to him/her in accordance with the level-of-care determination and assessment findings; and

(C) Discontinuing Personal Care Services. The following policies and procedures for discontinuing personal care services shall be followed:

1. Services for a client shall be discontinued by a provider agency under the following circumstances:

A. When the client's case is closed by the state agency;

B. When the provider learns of circumstances that require the closure of a case for reasons including, but not limited to: death; entry into a nursing home; or the client no longer needs services. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued;

C. When the client is noncompliant with the agreed upon plan of care. Noncompliance requires persistent actions by the client or family which negate the services provided by the agency. After all alternatives have been explored and exhausted, the provider shall notify the state agency case manager in writing of the noncompliant acts and request that the client's services be discontinued;

D. When the client or client's family threatens or abuses the personal care aide or other agency staff to the point where the staff's welfare is in jeopardy and corrective action has failed. The provider shall notify the state agency case manager of the threatening or abusive acts and may request that the service authorization be discontinued;

E. When a provider is unable to continue to meet the maintenance needs of a client. In these circumstances, the provider shall notify the state agency case manager in writing and request that the client's services be discontinued; or

F. When a provider is unable to continue to meet the maintenance needs of a client whose plan of care requires advanced personal care services. In these circumstances the provider shall provide written notice of discharge to the client or client's family and the state agency case manager at least twenty-one (21) days prior to the date of discharge. During this twenty-one (21)-day period, the state agency case manager shall assist in making appropriate arrangements with the client for transfer to another agency, institutional placement, or other appropriate care. Regardless of circumstances, the personal care provider must continue to provide care in accordance with the plan of care for these twenty-one (21) days or until alternate arrangements can be made by the case manager, whichever comes first; and

2. Discontinuing services for a client still in need of assistance shall occur only after appropriate conferences with the state agency case manager, client and client's family.

(2) Basic personal care services are medically-oriented, maintenance services to assist with the activities of daily living when this assistance does not require devices and procedures related to altered body functions.

(A) To be eligible for basic personal care, an individual must be in need of personal care services as an alternative to institutional care as specified in section (1) of this rule.

(B) The following activities constitute basic personal care services and shall be provided according to the plan of care:

1. Assistance with dietary needs, including meal preparation and cleanup, and assistance with eating/feeding;

2. Assisting with dressing and grooming, including helping with dressing and undressing, combing hair, and nail care;

3. Assisting with bathing and personal hygiene, including assisting with bathing, shampooing hair, oral hygiene and denture care, and shaving;

4. Assisting with toileting and continence, including assisting in going to the bathroom, and changing bed linen. This category may also include the changing of beds for persons with medically related limitations that prohibit the completion of this task;

5. Assisting with mobility and transfer, including assisting with transfer and ambulation when recipient can at least partially bear own weight;

6. Assisting with medication, including assisting with the self-administration of medicine, applying nonprescription topical ointments or lotions; and

7. Medically related household tasks, including approved homemaker and chore tasks.

(C) The encouragement and instruction of recipients in self-care may be a component of any other task as described above; however, encouragement and instruction do not constitute a task in and of themselves.

(3) Criteria for Providers of Personal Care Services.

(A) The provider of personal care services must have a valid participation agreement with the state Medicaid agency. The issuance of the participation agreement is dependent upon the Department of Social Services' acceptance of an application for enrollment. The provider must submit to the Department of Social Services, Division of Aging, the written proposal required to become a Title XX in-home services provider and be approved to provide Title XX in-home services. Once approved to provide Title XX in-home services by the Division of Aging, the provider will be allowed to execute a Title XIX participation agreement with the Division of Medical Services. Thereafter, a provider is not required to actually accept or deliver services to clients who are authorized for both programs or to clients who are authorized for Title XX services only. For residential care facilities that wish to provide services only to the eligible residents of their own facility, only the verification of a state residential care facility license will be required for the Medicaid enrollment application. Providers must maintain their approval to participate as a Title XX provider, whether or not they actually serve Title XX eligible clients, in order to remain qualified to participate in the Title XIX (Medicaid) Personal Care Program.

(B) The providers must agree to comply with any evaluation conducted by the Department of Social Services. In circumstances in which the Division of Aging has taken action to protect clients from providers who are found to be out of compliance with the requirements of its regulations and of any other regulations applicable to the Personal Care Program, when such noncompliance is determined by the Division of Aging to create a risk of injury or harm to clients. Evidence of such risk may include: unreliable or inadequate provider documentation of services or training due to falsification or fraud; the provider's failure to deliver services in a reliable and dependable manner; or use of personal care aides who do not meet the minimum training standards of this regulation. Immediate action by the Division of Aging may include, but is not limited to:

1. Removing the provider from any list of providers, and for clients who request the unsafe and noncompliant provider, informing the clients of the determination of noncompliance after which any informed choice will be honored by the Division of Aging; or

2. Informing current clients served by the provider of the provider's noncompliance and that the Division of Aging has determined the provider unable to deliver safe care. Such clients will be allowed to choose a different provider from the list maintained by the Division of Aging which will then be immediately authorized to provide service to them.

(C) The provider agency must be available to provide care in accordance with the personal care plan, utilizing universal precaution procedures as defined by the Center for Disease Control.

(D) The provider agency must monitor the overall physical care needs of the service recipient. If the client's condition warrants, contact the client's physician and inform the Division of Aging when additional Division of Aging case management activities are required.

(E) For newly employed aides, the provider agency must, at a minimum, provide twenty (20) hours of orientation training.

1. In calculating these hours, the following requirements shall apply:

A. At least two (2) hours orientation to the provider agency and the agency's protocols for handling emergencies, within thirty (30) days of employment;

B. With eight (8) hours of classroom training being completed prior to client contact;

C. Twelve (12) hours of orientation may be waived with adequate documentation in the employee's records that the aide received similar training during the current or preceding state fiscal year or has been employed as an aide at an in-home or home health agency at least half-time for six (6) months or more within the current or preceding state fiscal year;

D. If an aide is a certified nurse assistant, licensed practical nurse, or registered nurse, the provider agency may waive all orientation training, except the two (2) hours' provider agency orientation, with documentation placed in the aide's personnel record. The documentation shall include the employee's license or certification number current at the time the training was waived.

2. An additional ten (10) hours of in-service training annually are required after the first twelve (12) months of employment.

3. The provider agency shall have written documentation of all basic and in-service training provided which includes, at a minimum, a report of each employee's training in that employee's personnel record. The report shall document the dates of all classroom or on-the-job training, trainer's name, topics, number of hours and location, the date of the first client contact and shall include the aide's signature. If a provider waives any in-service training, the employee's training record shall contain supportive data for the waiver.

(F) The requirements that have been adopted by the Division of Aging at 13 CSR 15-7.021(18)(A) through (R) and (18)(U) through (W) shall apply to all providers of personal care services and advanced personal care services.

(G) The provider agency must employ an administrative supervisor of the day-to-day delivery of direct personal care services possessing at least the following qualifications:

1. Be at least twenty-one (21) years of age; and

2. Shall be a registered nurse (RN) who is currently licensed in Missouri; or have at least a baccalaureate degree; or be a licensed practical nurse (LPN) who is currently licensed in Missouri with at least one (1) year of experience with the direct care of the elderly, disabled or infirm; or have at least

three (3) years' experience with the care of the elderly, disabled or infirm.

(H) The supervisor's responsibilities shall include, at a minimum, the following:

1. Establish, implement, and enforce a policy governing communicable diseases that prohibits provider staff contact with clients when the employee has a communicable condition, including colds or flu. Assure that reporting requirements governing communicable diseases, including hepatitis and tuberculosis, as set by the Missouri Department of Health (19 CSR 20-20.020), are carried out;

2. Monitor the provision of services by the personal care worker to assure that services are being delivered in accordance with the personal care plan. This shall be primarily in the form of an at least monthly review and comparison of the worker's records of provided services with the personal care plan. The monitoring reports shall be available for review by the Department of Social Services upon request. Documentation must be kept on clients with a delivery rate of less than eighty percent (80%) of the authorized units of in-home service. For each client with a delivery rate less than eighty percent (80%) of the number of units of in-home services authorized for the time period being reviewed, the number of units of service delivered and nondelivered code will be sent to the Division of Aging regional manager monthly. Discrepancies for these clients concerning the frequency of delivered services and/or the in-home service tasks delivered, the corrective action taken, will be signed and dated by the supervisor and be readily available for monitoring or inspection;

3. Make an on-site visit at least annually to evaluate each personal care worker's performance and the adequacy of the service plan, including review of the plan of care with the recipient. The personal care worker must be present for this evaluation. A written record of the evaluation shall be maintained in the personnel file of the personal care worker. This record must contain, at a minimum, the service recipient's name and address; the date and time of the visit, personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan. In addition, the evaluation shall be signed and dated by the supervisor who prepared it and by the personal care worker. If the required evaluation is not performed or not documented, the personal care worker's qualifications to provide the services may be presumed inadequate and all payments made for services by that personal care worker may be recouped. Unless, medically, the recipient's condition supports a visit or all recipients have been visited, a service recipient shall not receive more than one (1) combined on-site supervisory visit and RN on-site visit as specified in paragraph (3)(J)1. per state fiscal year;

4. Approve, in advance, all changes to the plan of care based on supervisory on-site visits, information from the personal care worker, or observation by the RN, or a combination of these. Approval of changes shall be noted and dated in the service recipient's file;

5. Make appropriate recommendations to the Division of Aging worker including increase, reduction or termination of services; or need for increased Division of Aging case management involvement based on supervisory on-site visits, review of reports, information from the personal care worker, observation by the RN, or a combination of these;

6. Be available for regular case conferences with the Division of Aging case manager; and

7. Assist in orientation and personal care training for personal care workers.

(I) If the supervisor is not an RN, the provider agency must have a designated RN currently licensed in Missouri either on staff or employed as a consultant.

(J) The RN's responsibilities shall include, at a minimum, the following:

1. Monthly on-site visits of basic personal care recipients based on a ten percent (10%) sample of the provider agencies' combined Title XIX and Title XX caseload size as of the beginning of each month. This ten percent (10%) sample is to exclude personal care and advanced personal care recipients receiving authorized nurse visits and on-site supervisory visits, as specified in paragraph (3)(H)3., unless all clients have already been seen or the recipient condition supports a visit. A maximum of thirty (30) visits will be required for those agencies that service over three hundred (300) recipients on a monthly basis with a minimum of two (2) visits monthly for agencies servicing fewer than twenty (20) clients monthly. The home visit shall consist of an evaluation of the adequacy of the plan of care in meeting the needs and condition of the recipient, and shall include a review of the plan of care with the recipient, and assessment of the personal care worker relative to his/her ability to carry out the plan of care. The RN must maintain an on-site visiting log. The log must contain, at a minimum, the service recipient's name, address, the date of the visit, the personal care worker's name and observations of both the personal care worker's performance and the adequacy of the service plan. Unless supported by the recipient's medical condition or all recipients have been visited, a service recipient shall not receive more than one (1) combined RN on-site visit and supervisory on-site visit as specified in paragraph (3)(H)3. per state fiscal year;

2. Initial and review all on-site visit reports made by the personal care supervisor; and

3. If supervised by an RN, an LPN may perform the RN supervisory activities described in this section.

(K) An in-home personal care worker(s) shall meet the following requirements:

1. Be at least eighteen (18) years of age;

2. Be able to read, write and follow directions;

3. Have at least six (6) months' paid work experience as an agency homemaker, nurse aide or household worker, or at least one (1) year of experience, paid or unpaid, in caring for children, sick or aged individuals, or have successfully completed formal training, such as the basic nursing arts course of nurse's training, nursing assistant training or home health-aid training; and

4. May not be a family member of the recipient for whom personal care is to be provided. A family member is defined as a parent; sibling; child by blood, adoption or marriage; spouse; grandparent or grandchild.

(4) Reimbursement.

(A) Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.

1. A unit of service is one (1) hour.

2. Documentation for services delivered by the provider must include the following:

A. The recipient's name and Medicaid number;

B. The date of service;

C. The time spent providing the service which must be documented in one of the following manners:

(I) When personal care aide is providing services to one (1) individual in a private home setting and devotes undivided attention to the care required by that individual, the actual clock time the aide began the services for that visit is the start time, and the actual clock time the aide finished the care for the visit is the stop time; and

(II) When the personal care services are provided in a congregate living setting, such as a Residential Care Facility I and II, when on-site supervision is available and personal care aide staff will divide their time among a number of individuals, the following must be documented: all tasks performed for each recipient by date of services and by staff