New York State Department of Health
Guidelines for Consumer Directed Personal Assistance Services

Overview

The inclusion of Consumer Directed Personal Assistance Services (CDPAS) into the Medicaid Managed Care and Managed Long Term Care (MCO) benefit package occurred on November 1, 2012. This paper provides guidelines for the administration of this benefit.

I. Scope of Services

a. Purpose: Consumer Directed Personal Assistance Services is intended to permit chronically ill or physically disabled individuals receiving home care services greater flexibility and freedom of choice in obtaining such services.

b. An enrollee in need of personal care services, home health aide services or skilled nursing tasks may receive such by a consumer directed personal assistant under the instruction, supervision and direction of the enrollee or the enrollee's designated representative. Personal care services, home health aide services, and skilled nursing tasks shall have the same meaning as 18 NYCRR § 505.28 (b)(9), (7), & (11) respectively.

c. The terms consumer directed personal assistant and designated representative shall have the same meaning as 18 NYCRR § 505.28(b)(3) & (5).

II. Eligibility For Consumer Directed Personal Assistance Services

a. An enrollee may request a consumer directed personal assistant at the time of enrollment, assessment or reassessment or when in receipt of personal care, home care or skilled nursing services and is eligible for CDPAS when the MCO determines that the enrollee:

i. Has a stable medical condition;
ii. Is self-directing or, if non-self directing has a designated representative;
iii. Requires some or total assistance with one or more personal care services, home health aide services or skilled nursing tasks;
iv. Is willing and able to fulfill the following responsibilities:

1. manage the plan of care, recruit and hire a sufficient number of qualified individuals who can provide the member, under the member's instruction, supervision and direction or under the direction of the designated representative with the services needed in the plan of care;
2. train the consumer directed personal assistant to implement the plan of care;
3. maintain an appropriate home environment for the safe delivery of care required by the member;
4. notify the MCO of any changes in the enrollee's medical condition or social circumstances including but not limited to change in address, telephone number or hospitalization;
5. notify the fiscal intermediary of any changes in the employment status of each consumer directed personal assistant;

6. attest to the accuracy of each consumer directed personal assistant's time sheets;
7. transmit the consumer directed personal assistant's time sheets to the fiscal intermediary;
8. distribute to each consumer directed personal assistant a paycheck if needed;
9. arrange and schedule substitute coverage when a consumer directed personal assistant is temporarily unavailable for any reason; and
10. acknowledge, in writing, the respective roles and responsibilities of the enrollee and the MCO.

b. When a request for personal care, home health aide or skilled nursing is received by the MCO, the MCO must ensure the enrollee receives information about CDPAS. This can be in the form of a brochure, letter or other written documentation. Such documentation will outline how to access the service and the enrollee's and the MCO's respective responsibilities with the benefit.

Enrollees in receipt of personal care services, home health aide, or skilled nursing must also be made aware of the availability of CDPAS upon reassessment, or if options for personal care, home health aide services or skilled nursing tasks are needed but there are no longer providers available or willing to provide such services to the enrollee; and the enrollee meets the eligibility criteria in paragraph (a) above.

c. The MCO must provide an enrollee requesting CDPAS with the Medical Request form. Completion of the form by the enrollee's health care provider is the responsibility of the enrollee. However, upon request from the enrollee, the MCO will assist the member in getting the form completed.

d. The MCO must arrange for a social and nursing assessment which identifies the personal care services, home health aide services and skilled nursing tasks the enrollee needs and the amount of assistance required with a recommendation for the number of hours or the frequency of such assistance. For Managed Long Term Care, the Semi-Annual Assessment of Members (SAAM) or the Uniform Assessment System for New York (UAS-NY) must be used. For mainstream managed care, training on the Uniform Assessment System for New York will begin Spring 2013 and MCOs will be expected to use the UAS-NY beginning in winter 2013-14. More guidance pertaining to the UAS is forthcoming. The assessment also develops, in collaboration with the enrollee or the enrollee's designated representative, the plan of care. See 18 NYCRR § 505.28(d)(3)(ii). Fiscal Intermediaries are not responsible for arranging the nursing and social assessments.

Based on the assessments and medical order the MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e)(1), (2).

III. Authorization and Notice Requirements for CDPAS

a. The MCO determines the need for personal care, home health aide and/or skilled nursing tasks and if the enrollee is eligible for CDPAS. Authorization of CDPAS occurs after the MCO has received the medical request for services; completion of the nursing and social

assessments and the plan of care; and the enrollee has signed an acknowledgement about the roles and responsibilities of the enrollee and the MCO.

b. The MCO must provide phone and written notice of the Service Authorization Determination to the enrollee when the MCO determines to deny or authorize CDPAS, as required by Appendix F.1. (2)(a)(iv)Medicaid/Family Health Plus (MMC/FHP) Model Contract or Appendix K1.B.3. of the Managed Long Term Care Plan (MLTCP) Model Contract). A Service Authorization Determination notice for CDPAS should specify the number of hours or frequency of CDPAS being authorized and must include the diagnosis code. If CDPAS are authorized, a copy of the Service Authorization Determination notice must be sent to the FI chosen by the enrollee. The Service Authorization Determination must be a Notice of Action, as required by Appendix F.1(5)(a)(iii) of the MMC/FHP Model Contract or Appendix K.1.B.3. of the MLTCP Model Contract if:
    i. CDPAS are denied, even if personal care, home health aide and/or skilled nursing tasks are authorized at the level requested, or
    ii. CDPAS are authorized, but at a level that is less than requested.

c. The duration of the authorization must not exceed six (6) months. The duration for the authorization period must be based on the enrollee's needs as reflected in the required assessments. The MCO must consider the enrollee's prognosis, potential for recovery, and the expected duration and availability of any informal supports identified in the plan of care. See 18 NYCRR § 505.28(e)(3) & (4).

d. When the MCO determines that an enrollee is eligible for CDPAS the MCO will notify the enrollee with the name, address and phone number of all the Fiscal Intermediaries (FIs) available to the enrollee so the enrollee may arrange for wage and benefit processing for the enrollee's consumer directed personal assistant. The MCO will provide reasonable assistance to the enrollee to establish the relationship with the fiscal intermediary. The MCO must confirm in writing with the enrollee and the FI, which FI the enrollee has selected.

e. Level of Service:

    i. The assessment for home-based services identifies the tasks necessary to keep the enrollee safely in the home. The plan of care is developed by the enrollee with the assistance of the MCO, provider and any individuals the enrollee chooses to include.
    ii. The plan of care is developed in conjunction with the enrollee based on the assessment and considers the number of hours authorized to accomplish the tasks. These tasks may include level 1 and level 2 PCS, home health aide services and/or skilled nursing tasks.
    iii. The MCO must authorize only the hours or frequency of services that the enrollee actually requires to maintain the enrollee's health and safety in the home. The hours or frequency of services must also include receipt of services received outside of the home. See 18 NYCRR § 505.28(e).
    iv. CDPAS services are managed by the enrollee in accordance with the enrollee's plan of care. The authorization should provide the number of hours authorized however, it is the enrollee who decides how those hours are arranged over the week. The MCO does maintain the right to determine whether the number of hours is appropriate to the plan of care. <u>The FI is not responsible for assuring that the member is managing the plan of care.</u>

v. **NOTE**: As in the personal care services benefit, authorization for housekeeping-only tasks are limited to eight (8) hours per week.

f. Transitional Care (See also section VI):

i. A Local Department of Social Services authorization for CDPAS continues for enrollees in receipt of CDPAS prior to November 1, 2012 up to 60 days or until the MCO arranges for a new assessment and issues a new authorization, whichever is later. During the transition period of November 1, 2012 – October 31, 2013, the MCO may not require these enrollees to change their consumer directed personal assistant due to an existing relationship with FI that is not within the MCO's network.
The Department's policy "New Managed Care Enrollees in Receipt of an On-going Course of Treatment" applies to new enrollees after November 1, 2012. New enrollees in receipt of CDPAS prior to enrollment will continue receiving services unchanged from their current FI for a period of up to 60 days from the date of enrollment or until the MCO arranges for a new assessment and issues a new authorization, **whichever is later**; and, if applicable, the enrollee establishes a relationship with an FI under contract with the MCO.

g. Children in Receipt of Consumer Directed Services

i. When a minor child is assessed for CDPAS, the same conditions apply as they would for any assessment for home care services. The ability of the child to perform age appropriate tasks must be assessed as well as a determination of available formal and informal supports. If the child would be ineligible for personal care services, home health aide services or skilled nursing, then the child is ineligible for CDPAS.
ii. For enrollees in receipt of CDPAS and receiving Medicaid reimbursed tasks in a school setting consistent with what the child receives through CDPAS, the authorization may need to cover tasks identified in the assessment when school is not in session, such as holidays or emergency snow days. The MCO must consider this when authorizing services. The authorization must be clear to assure that timesheets submitted to the FI are accurate.

h. Monitoring during the authorization period and reauthorization.

i. MCOs must monitor the enrollee's continued eligibility for receipt of CDPAS, including prompt review of any notification from the FI enrollee or enrollee's representative of any change in circumstances that may affect the enrollee's ability to carry out their responsibilities. This may also include notification to LDSS if the enrollee falls off the roster (see Section VI).
ii. Before the end of the authorization period, MCOs should initiate a process to obtain a new medical request for services, conduct assessments and determine the enrollee's continued need for home care services and eligibility for CDPAS. MCOs are encouraged to copy the FI on correspondence to the enrollee concerning CDPAS so the FI can remind the enrollee to complete forms.

iii. MCOs must notify the enrollee and FI when there is any change in an authorization, reauthorization or denial of reauthorization. MCOs must copy the FI on

correspondence to the enrollee concerning CDPAS so the FI can remind the enrollee to complete forms and is aware of any changes in the service authorization.

IV. Claims Payment

a. Billing Codes

i. MCOs must provide the FIs with the billing codes needed for claims processing.

ii. Under fee-for-service claiming there are 10 rate codes for the CDPAS. There are **8 time increment rate codes** (hourly, quarter hourly) cross-walked to specialty code **675;** and **2 live-in rate codes** cross-walked to specialty code **676**. The reference to level 1 and level 2 refers to specialty code descriptions. These levels are NOT the same as level 1 and level 2 personal care services. Level 1 is referring to the time increment CDPAS and level 2 is referring to live-in CDPAS.

The rate codes can be used to signal the type of CDPAS that is being provided if the MCO accepts the **837-i** institutional claim form. If the MCO requires the practitioner claim form (**837-p**) the MCO must develop a HCPCS code and modifier code combination to identify the type of CDPAS provided.

MCOs that select the rate code option for claiming must provide each FI with a complete list of all 10 FFS rate codes, their descriptions and the associated specialty codes (see attached rate code listing). MCOs that select the HCPCS/ modifier code option must provide each FI with a crosswalk from the HCPCS /modifier code options to the FFS rate codes, rate code descriptions, and specialty codes.

b. ICD/Diagnostic Codes- The MCO must include on the authorization the appropriate ICD code. Errors in ICD codes provided by the MCO should not delay payment to the FI.

c. The Contractor shall inform FIs of its claims procedures. The Contractor shall process all claims and pay clean claims in a timely manner, as required by the provisions of State Insurance Law § 3224-a and implementing regulations. and the MCO shall notify FIs in writing as to the reason(s) claims are fully or partially denied, in accordance with Appendix F of the MMC/FHP Model Contract or Article VI.D.2. of the MLTCP Model Contract. SDOH may require a plan of correction, impose sanctions or take other regulatory action should it determine the Contractor consistently delays payments to FIs without due cause.

d. NPI Numbers. Fiscal Intermediaries that do not also provide health care services are not eligible for an NPI number. To apply for an NPI the entity or individual must meet the federal definition of a health care provider at 45 CFR §160.103. An FI that does not also provide health care services does not meet the definition and is therefore, ineligible to apply for an NPI number. Reimbursement alone by a health plan to an FI does not trigger the need for an NPI. The MCO can however, require the FI to submit standard transactions but cannot require these entities to obtain NPIs to use in those transactions because these entities are not eligible to receive NPIs. For further clarification, please refer to Federal Register Vol. 69, No. 15 p 3437.

Where an FI does not have an NPI the plan may assign a number to the FI that works with the MCO's claims submission logic.

V. Fiscal Intermediary Contracting

a. Fiscal Intermediaries are not providers of care, therefore the arrangement between the MCO and the FI must not include the provider standard clauses. The contract between the FI and the MCO is an administrative agreement. The parties are encouraged to use the sample administrative agreement issued by the DOH.

b. November 1, 2012 – October 31, 2013 (Transitional Period) Health Plans must contract with Fiscal Intermediaries (FIs) that currently have a contract or memorandum of understanding (MOU) with a local social services district (LDSS) and currently provide fiscal intermediary services to the health plan's members. The rate of payment must be at least the Fee for Service rate of payment provided for in the contract or MOU between the FI and the LDSS. The MCO is not required to contract with FIs unwilling to accept the applicable Medicaid FFS rate as long as the MCO maintains an adequate network. To adequately meet the needs of enrollees who are newly assessed and considered eligible to receive CDPAS, the MCO may also include in the MCO's network FIs that do not have a contract or MOU with the LDSS.

   If the FI serves fewer than five (5) enrollees in a county, MCOs may encourage the enrollees to use an alternative FI to minimize the number of FIs an MCO must have under contract. However, during the Transition Period, the expectation is that an enrollee is not required to transition to a different consumer directed personal assistant due to the lack of an MCO/FI contract. MCOs are prohibited from coercing or threatening the enrollee or the worker to change FIs.

c. Network Adequacy during the Transition Period- An MCO that does not have enrollees participating in CDPAS in a particular LDSS must have at least two (2) FI contracts per county where resources exist. This will ensure that enrollees will have the option to participate in CDPAS. Network adequacy is required for all managed long term care programs regardless of location.

d. FI Contracting and Network Adequacy- After the Transitional Period. Beginning November 1, 2013, MCOs may contract with two (2) FIs to cover enrollees in multiple counties.

   Network adequacy is required whether the county has mandatory or voluntary enrollment into a managed long term care program

e. Fiscal intermediaries are not required to have a license to provide fiscal intermediary services to MCO enrollees.

VI. Disenrollment

a. Minimizing interruption of services. Assuring that an individual does not have an interruption in services due to a disenrollment from the MCO either into another MCO or back to the fee for service program requires communication between and among the MCO, the member, the FI and either the new MCO or LDSS.
   i. Enrollees in receipt of CDPAS should be tracked by the MCO. At the time the MCO is made aware that such enrollee is no longer on the plan's roster, the MCO will notify the HRA/LDSS that a member receiving CDPAS has been disenrolled. In New York

City the HCSP 3018 (attached) will be submitted to the Home Care Services Program together with the current valid medical request and the most recent assessment. In the rest of the state, the MCO will send the information on the form provided by the SDOH (attached) to the managed care coordinator together with the current valid medical request.

ii. Such submissions must include only those enrollees for which the roster indicates a change in enrollment the current month or following month. Retroactive disenrollment cases (if known by the MCO) are not to be transmitted in this manner. If the MCO is aware that the person has enrolled in another plan, that case should not be submitted to the local district. If cases relating to MCO to MCO changes are submitted to HRA or the LDSS, neither HRA nor the local district are obligated to act on such cases involving MCO to MCO changes.

iii. The FI, at a minimum, is responsible for verifying plan enrollment and Medicaid eligibility through EPaces or eMedNY the first and the middle of the month to ensure the enrollee has had no changes in Medicaid coverage or MCO enrollment. The enrollee, with the assistance of the MCO, is responsible for letting the FI know that the enrollee has enrolled in a new MCO.

iv. Upon disenrollment from an MCO, the MCO is not responsible for payment of CDPAS provided after the effective date of disenrollment. The enrollee and the FI, on the enrollee's behalf, must notify the new MCO to obtain transitional care and provide such information regarding the care plan as requested by the new MCO. If the Managed Care Enrollment is reinstated retroactively with approval from the managed care plan OR by directive from the NYS Office of Temporary and Disability Assistance's Office of Administrative Hearings, the disenrollment is deleted and the current plan remains responsible.

b. Enrollee voluntarily enrolls into another MCO.
   i. For situations where the enrollee enrolled with a new MCO, the enrollee or the FI, on behalf of the enrollee, must contact the new MCO to determine:
      1. whether services are authorized at the same level or if there has there been a change in the amount, duration or scope of the authorization;
      2. whether the MCO has an administrative agreement with the current FI.
   ii. The new MCO must continue the current authorization and FI until the MCO conducts an assessment, authorization and arrangement for provision of the service. See Section III(f),. "Transitional Care."

c. Enrollee is disenrolled from an MCO into fee-for-service. Local districts will continue with the MCO's authorization until an assessment and new authorization is put in place.

d. MCO must provide the medical order, assessment and plan of care to the LDSS, for members returning to FFS, or an MCO for members who switched to a new MCO upon request.

Human Resources Administration
Department of Social Services

MANAGED CARE PLAN REFERRAL TO HCSP

FROM: **TO:**

NAME OF PLAN			**Home Care Services Program Central Intake Unit 253 Schermerhorn Street, 3rd Fl Bklyn, NY 11201 Telephone:(718) 722-4810 FAX: (718) 923-6733**
ADDRESS			
CONTACT PERSON	PHONE NUMBER	DATE	
NAME OF CONSUMER			CLIENT IDENTIFICATION NUMBER (CIN)
CONSUMER TELEPHONE NUMBER			CONSUMER''S EMERGENCY CONTACT NAME TELEPHONE
NAME OF PCS VENDOR			PCS VENDOR ID
SERVICE LEVEL			AUTHORIZED HOURS / BILLING HOURS
AUTHORIZATION PERIOD: .....➔ M11Q Attached: (Y) (N)			FROM: TO:

The consumer listed above is being disenrolled from our plan effective: _____

REASON FOR DISENROLLMENT (if known).

HCSP USE ONLY

Action Taken:

The consumer's coverage was converted to Medicaid fee-for-service effective: _____

The case has been referred to CASA _____ on _____

☐ This case was not previously known to HCSP

☐ M-11Q received on _____

☐ M-11Q mailed on _____

This case was previously known to HCSP

HCSP authorization provided from _____ to _____

The case was found to be no longer Medicaid eligible and/or HCSP eligible.

☐ HCSP application package mailed on _____

☐ The case was referred to the Homebound Medicaid Unit on _____

WORKER'S NAME	WORKER'S SIGNATURE	DATE

HCSP 3018 02-2012 Rev.
MANAGED CARE PLAN REFERRAL TO HCSP

Instructions to Managed Care Plans:

1) Consumers who were in receipt of personal care services immediately prior to plan disenrollment or loss of Medicaid coverage should be referred to HRA/MICSA/HCSP.

2) The Managed Care plan must complete all sections of the top portion of the form.

3) The Managed Care Plan must attach a copy of the most recent assessment, including a medical order.

MANAGED CARE PLAN REFERRAL TO HOME CARE SERVICES PROGRAM

FROM: **TO:**

<table>
<tr><td colspan="3">Name of Plan:</td><td colspan="2">Local Department of Social Services
Managed Care Coordinator:</td></tr>
<tr><td colspan="3">Address:</td><td colspan="2">Client Identification Number [CIN]:</td></tr>
<tr><td>Contact Person:</td><td>Phone Number:</td><td>Date:</td><td colspan="2">Consumer’s Emergency Contact Name:

Telephone Number:</td></tr>
<tr><td colspan="3">Name of PCS Vendor:</td><td colspan="2">PCS Vendor ID:</td></tr>
<tr><td colspan="3">Service Level:</td><td>Authorized Hours:</td><td></td></tr>
<tr><td colspan="3" rowspan="2">AUTHORIZATION PERIOD:……..→

M11Q Attached: [Y] [N]</td><td colspan="2">From:</td></tr>
<tr><td colspan="2">To:</td></tr>
</table>

The Consumer Listed Above Is Being Disenrolled From Our Plan Effective:

_____

REASON FOR DISENROLLMENT [If Known – Please include information regarding attempts to complete renewal.]

LDSS USE ONLY

Action Taken:

This case was previously known to LDSS

LDSS authorization provided from: _____ to _____

The Case was found to be no longer Medicaid eligible and/or LDSS eligible.

- LDSS application package mailed on _____
- The Case was referred to _____ on

_____

WORKER’S NAME:	WORKER’S SIGNATURE:	DATE:

INSTRUCTIONS TO MANAGED CARE PLANS

1.) Consumers who are no longer eligible to participate in a Managed Care Program and are in receipt of Personal Care benefits, should be referred to the Local Department of Social Services Managed Care Coordinator using this form. Refer only those enrollees whose change in enrollment is effective the current month or the month following the referral (no retrospective disenrollments).

2.) The Managed Care Plan must complete all Sections of the top portion of this form.

3.) If the Managed Care Plan has a current valid medical request, the medical request should be submitted together with this form. A medical request is valid if completed within 30 days of the exam date.

Fee-for-Service CDPAP Rate Codes - with Crosswalk to Specialty Code

Rate Code	Rate Code Description	Specialty Code	Specialty Code Description
2401	CONSUMER DIRECT PERS ASSIST 1 CLIENT HOURLY	675	CD Personal Assistant - Level 1
2402	CONS DIRECT PERS ASSIST 2 OR > CLNTS HRLY PER CLNT	675	CD Personal Assistant - Level 1
2403	CONS DIR PERS ASSIST 1 CLNT HRLY ENHANCED RATE	675	CD Personal Assistant - Level 1
2404	CONS DIR PERS ASSIST 2 OR > CLNTS HRLY PER CLNT EN	675	CD Personal Assistant - Level 1
2405	CONSUMER DIRECT PERSONAL ASSIST 1 CLNT LIVE-IN	676	CD Personal Assistant - Level 2
2406	CONS DIR PERS ASSIST 2 OR > CLNTS PER CLNT LIVE-IN	676	CD Personal Assistant - Level 2
2422	CDPAP 1 CLIENT, QUARTER HOUR	675	CD Personal Assistant - Level 1
2423	CDPAP 2 CLIENTS, PER CLIENT, QUARTER HOUR	675	CD Personal Assistant - Level 1
2424	CDPAP 1 CLIENT, ENHANCED RATE, QUARTER HOUR	675	CD Personal Assistant - Level 1
2425	CDPAP 2 CLIENTS, PER CLIENT, ENHANCED RATE, QTR HR	675	CD Personal Assistant - Level 1