Office of Health Insurance Programs
Division of Long Term Care

Managed Long Term Care Policy 21.02: Implementation of Fiscal Intermediary (FI) Rate Structure Enacted in the SFY 2019-20 NYS Budget

Date of Issuance: March 11, 2021
Effective Date: April 1, 2021

This Policy guidance implements changes in Medicaid fee for service reimbursement enacted through a regulatory amendment to 18 NYCRR § 505.28(j), which was issued in final on January 13, 2021 and in accordance with statutory authority in Sections 363-a(2) & 365-f of the Social Services Law and Section 201(1)(v) of the Public Health Law. This Policy applies to Fiscal Intermediaries (FIs) performing administrative services under the Consumer Directed Personal Assistance Program (CDPAP), on or after April 1, 2021 (the Effective Date) for consumers in the Medicaid fee for service (FFS) program.

As of the Effective Date, FIs will be reimbursed for their administrative costs through the Per Member Per Month (PMPM) rate structure now described in regulation and summarized below and referred to herein as "FI PMPM" or "FI PMPMs."

FI PMPM Reimbursement

Reimbursement for FI administrative costs will be made on a three-tier ("Tier") FI PMPM rate structure for Medicaid FFS members authorized for and receiving CDPAP services. Each Tier represents a range of authorized direct care hours of CDPAP services for that consumer in the month for with the FI PMPM is being billed. The Tiers are as follows:

Number of Direct Care Hours Authorized Per Month Per Consumer	FI PMPM Reimbursement	Rate Code
Tier 1 1-159 hours	$145	8400
Tier 2 160-479 hours	$384	8401
Tier 3 480+ hours	$1,036	8402

This guidance does not impact the requirements of the FI to bill Medicaid FFS the approved hourly rate for direct care services. DOH will reduce the current hourly CDPAP rates to exclude the FI administrative costs included in the FI PMPM. The following non-direct care service costs will continue to be included within the direct care hourly FFS rates and are not included in the FI PMPM:

- capital costs,
- up to 2% allowance for profit or reserves,
- workforce recruitment and retention supplements, and
- minimum wage supplements.

To clarify, nothing in this Policy guidance impacts wages or wage related requirements for CDPAP personal assistants, including State law or regulatory requirements related to minimum wage, overtime pay, or wage parity, where applicable.

Claiming Reimbursement for FI PMPM

To claim reimbursement FIs must submit a claim to the Department for its FI PMPM each month through the standard eMedNY billing process using the codes in the table above that is based on:

a. the greatest number of authorized direct care hours of CDPAS, authorized by the LDSS, or such other party as the DOH may designate, during the month for which the FI PMPM is being claimed; and
b. based on the monthly hours determined under (a) above, the Tier of utilization for each consumer.

To calculate the appropriate number of hours to be included for the FI PMPM Tier, the FI should use the examples below for guidance.

Service authorizations can be entered in eMedNY in various formats based on the needs of the consumer. A specific number of hours may be approved per day for all days of the week, or only certain days of the week. Or, a total number of hours can be approved for a specific period, such as a week, month or longer, without specifying the days of the week or the number of hours per day.

To simplify and make the FI PMPM billing process consistent, FIs should first compute the average number of hours of direct care services per day and per week based on a seven-day week. This process eliminates the need to consider how many times a specific day or the number of weeks in a given month. The average number of direct care service hours per day is then multiplied by a 31-day month to arrive at a total number of hours per month, which then translates to the FI PMPM Tier to bill. Where multiple authorizations are issued in a calendar month (e.g., there is a change in the consumer's condition) or a consumer begins receiving CDPAP services in the month, the FI should compute the FI PMPM Tier using the service authorization with the greatest number of hours and apply those hours over the entire month.

NOTE: This method of computing average hours and hours per month is only to be used for the purpose of determining the FI PMPM Tier and rate code. FIs must continue to bill direct care hours based on the actual hours and dates rendered.

FI PMPM Claim Reimbursement Examples

The following scenarios illustrate how to calculate the appropriate FI PMPM Tier and corresponding rate codes for a consumer under different authorization formats.

Scenario 1: The consumer is authorized for direct care services that equate to an average of 5.7 hours per day for a total of 177 hours per month, placing the consumer in FI PMPM Tier 2.

> ***Sample Authorization A:*** The consumer is authorized for 40 hours during a 7-day period, but the authorization does not specify the number of days or hours per day of direct care services.
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> Calculation: The average number of hours per day is 5.7 (40 hours divided by 7 days in a week) multiplied by 31 days in the month for a total of 177 hours, or Tier 2.

Sample Authorization B: The consumer is authorized for 1,048 hours over 184 days (approximately a 6-month period).

Calculation: The average number of hours per day is 5.7 hours (1,048 hours divided by 184 days) multiplied by 31 days in the month for a total of 177 hours, or Tier 2.

Sample Authorization C: The consumer is authorized for 8 hours a day, 5 days a week, Monday through Friday, but is not authorized for any hours on Saturday and Sunday.

Calculation: The average number of hours per day is 5.7 (40 hours divided by 7 days in a week) even though direct care services are not rendered on every day of the week, multiplied by 31 days in the month for a total of 177 hours, or Tier 2.

Sample Authorization D: The consumer is authorized for 8 hours of direct care services a day on Monday, Tuesday, Wednesday and Thursday, and 4 hours a day on Saturday and Sunday.

Calculation: The average number of hours per day, even though the direct care service hours are not the same each day, is 5.7 hours (40 hours divided by 7 days in a week) multiplied by 31 days in the month for a total of 177 hours, or Tier 2.

Scenario 2: The consumer is authorized for services that equate to an average of 4.3 hours per day for a total of 133 hours per month, placing the consumer in FI PMPM Tier 1.

Sample Authorization A: The consumer is authorized for 30 hours during a 7-day period, but the authorization does not specify the number of days or hours per day of direct care services.

Calculation: The average number of hours per day is 4.3 (30 hours divided by 7 days in a week) multiplied by 31 days in the month for a total of 133 hours, or Tier 1.

Sample Authorization B: The consumer is authorized for 791 hours for 184 days (approximately a 6-month period).

Calculation: The average number of hours per day is 4.3 hours (791 hours divided by 184 days) multiplied by 31 days in the month for a total of 133 hours, or Tier 1.

Sample Authorization C: The consumer is authorized for 6 hours a day, 5 days a week, Monday through Friday, but is not authorized for hours on Saturday and Sunday.

Calculation: The average number of hours per day is 4.3 (30 hours divided by 7 days in a week) even though direct care services are not rendered on every day of the week, multiplied by 31 days in the month for a total of 133 hours, or Tier 1.

Sample Authorization D: The consumer is authorized for 6 hours a day on Monday, Tuesday, Wednesday and Thursday, and 3 hours a day on Saturday and Sunday.

Calculation: The average number of hours per day, even though the hours are not the same each day, is 4.3 hours (30 hours divided by 7 days in a week) multiplied by 31 days in the month for a total of 133 hours, or Tier 1.

Timing of Claims Submission

Date of Submission. FIs will submit FI PMPM claims no earlier than the first day of the month immediately following the month for which reimbursement for services is being claimed and no later than the timeframes set forth in 18 NYCRR § 540.6. Accordingly, FIs should start billing under this new methodology on or after May 1, 2021 for FI administrative services performed on or after April 1, 2021.

Date of Service. While FI PMPM claims will be processed regardless of the date of service inputted on the claim for the month in which FI services were performed, the Department **strongly encourages** FIs to submit the FI PMPM claims using the first day of the month in which FI services were performed. For example, an FI will submit an FI PMPM claim on or after May 1, 2021 for FI administrative services performed in April 2021. On the claim form, the FI is encouraged to input April 1, 2021 for the date of service, which aligns with the capitated nature of these payments.

Direct Care Services Requirement. In order to submit an FI PMPM claim, the FI must have also billed for at least on hour of direct care services for the consumer during the month for which the FI PMPM is being billed. This requirement verifies that the consumer is receiving CDPAS services during the month for which the FI PMPM is being billed. For example, for services rendered in April 2021, the FI will submit at least one claim for direct care services in April 2021, and on or after May 1, 2021 may submit an FI PMPM claim for April.

One Claim Per Consumer. It should be noted that eMedNY will not accept more than one FI PMPM claim submitted by an FI for a consumer for any given month.

Claim Errors. Where there are issues or errors with FI PMPM claim submission (i.e., the need for voiding and resubmission of an FI PMPM claim), the FI should void the submitted claim rate code and then resubmit the claim with the correct rate code.

Individual or Batched Claims. There is no restriction on how an FI submits FI PMPM claims, the FI may submit individual claims or batched claims. There is also no need to separate FI PMPM claims by county while batching the claims.

Medicaid Managed Care Plan Consumers

Consistent with 18 NYCRR § 505.28(j)(4), Medicaid managed care plans may, but not are not required to, reimburse FIs using the tiered administrative PMPM rate structure set forth above. Alternatively, MCOs may negotiate administrative rates using a PMPM or an alternative structure with FIs pursuant to their contracts. In either case, MCOs must continue to make timely reimbursement to FIs for the direct wage costs of personal assistants including ensuring that contractual reimbursement meet NYS minimum wage and wage parity requirements. MCO capitation rates paid by the DOH will be adjusted, subject to actuarial soundness certification by the independent actuary, to reflect the change in Medicaid FFS reimbursement policy.

Questions related to this guidance document may be sent to consumerdirected@health.ny.gov and questions related to a fiscal intermediary's specific rates may be sent to personalcare-rates@health.ny.gov.