

**NYS DEPARTMENT OF HEALTH
OFFICE OF HEALTH INSURANCE PROGRAMS**

Guidelines for the Provision of Personal Care Services in Medicaid Managed Care

Overview

In response to Medicaid Redesign Team (MRT) proposal #1458, the personal care benefit was added to the Medicaid managed care (MMC) benefit package. Effective August 1, 2011, the provision of personal care services became the responsibility of the Medicaid managed care organizations (MCO). Prior to this, the benefit was managed by the local social services districts (LDSS) as the Personal Care Services Program. The following guidelines identify the roles and responsibilities of MCOs, personal care services providers, and Local Departments of Social Services (LDSS) relative to this transition.

I. Scope of the Personal Care Benefit

- a. As required by federal regulations, the personal care services benefit afforded to MCO enrollees must be furnished in an amount, duration, and scope that is no less than the services furnished to Medicaid fee-for-service recipients.[42 CFR §438.210]. Personal care services (PCS), as defined by 18 NYCRR §505.14(a) and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (MMC Model Contract), are the provision of some or total assistance with personal hygiene, dressing and feeding and nutritional and environmental support (meal preparation and housekeeping). The service must be :
 - i. essential to the maintenance of the enrollee's health and safety in his or her own home;
 - ii. ordered by a physician or nurse practitioner; and
 - iii. be based on an assessment of the member's need for the service in accordance with Section II of these guidelines.
 - iv. Enrollees receiving PCS must have a stable medical condition that is not expected to:
 1. exhibit sudden deterioration or improvement; and
 2. does not require frequent medical or nursing judgment to determine changes in the patient's plan of care; and
 3. is such that a physically disabled individual is in need of routine supportive assistance and does not need skilled professional care in the home; or
 4. the condition is such that a physically disabled or frail elderly individual does not need professional care but does require assistance in the home to prevent a health or safety crisis from developing.
 - v. Enrollees receiving PCS must be self-directing, which shall mean that the Enrollee is:
 1. capable of making choices about his or her activities of daily living;
 2. understanding the impact of the choice; and
 3. assuming responsibility for the results of the choices.
 - vi. Enrollees who are non self-directing, and who require continuous supervision and direction for making choices about activities of daily living shall not receive PCS, except under the following conditions:
 1. supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual living within the same household; or
 2. supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by a self-directing individual not living within the same household; or

3. supervision or direction is provided on an interim or part-time basis as part of a plan of care in which the responsibility for making choices about activities of daily living is assumed by an outside agency or other formal organization.
 4. A non self-directing member lacks the capability to make choices about the activities of daily living, understand the implications of these choices, and assume responsibility for the results of these choices. Characteristics of a non self directing member may include the following:
 - a. The member may be delusional, disoriented at times, have periods of agitation, or demonstrate other behavior which is inconsistent and unpredictable; or
 - b. The member may have a tendency to wander during the day or night and to endanger his or her safety through exposure to hot water, extreme cold, or misuse of equipment or appliances in the home; or
 - c. The member may exhibit other behaviors which are harmful to himself or herself or to others such as hiding medications, taking medications without his or her physician's knowledge, refusing to seek assistance in a medical emergency, or leaving lit cigarettes unattended. The member may not understand what to do in an emergency situation or know how to summon emergency assistance. [From: NYS Administrative Directive 92- ADM 49 at http://onlineresources.wnylc/net/pb/docs/92_adm-49.pdf]
 5. If the individual assuming part-time or interim supervision resides outside of the member's home, consideration should be made as to whether that individual has substantial daily contact with the member in the member's home. Substantial daily contact does not mean the individual must be physically present in the home for a specified amount of time. The frequency of contact needed to assure a safe situation as reflected in the social and nursing assessments and in the member's plan of care.
- vii. Personal care services includes some or total assistance with:
1. Level I functions as follows:
 - a. Making and changing beds ;
 - b. Dusting and vacuuming the rooms which the member uses;
 - c. Light cleaning of the kitchen, bedroom and bathroom;
 - d. Dishwashing;
 - e. Listing needed supplies;
 - f. Shopping for the member if no other arrangements are possible;
 - g. Member's laundering, including necessary ironing and mending;
 - h. Payment of bills and other essential errands; and
 - i. Preparing meals, including simple modified diets.
 2. Level II personal care services include Level I functions listed above and the following personal care functions:
 - a. Bathing of the member in the bed, the tub or the shower;
 - b. Dressing;
 - c. Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
 - d. Toileting, this may include assisting the patient on and off the bedpan, commode or toilet;
 - e. Walking, beyond that provided by durable medical equipment, within the home and outside the home;
 - f. Transferring from bed to chair or wheelchair;

- g. Preparing of meals in accordance with modified diets, including low sugar, low fat, and low residue diets;
- h. Feeding
- i. Administration of medication by the member, including prompting the member as to time, identifying the medication for the member, bringing the medication and any necessary supplies or equipment to the member, opening the container for the member, positioning the member for medication administration, disposing of used equipment, supplies and materials and correct storage of medication;
- j. Providing routine skin care;
- k. Using medical supplies and equipment such as walkers and wheelchairs; and
- l. Changing of simple dressings.

The service must be authorized with specific number of hours per day and days per week the PCS are to be provided. Authorization for solely Level I services where no Level II services are authorized may not exceed eight (8) hours per week.

- viii. Services provided outside of the home. The scope of the benefit includes PCS provided not only in the enrollee's home but also in other locations in which the enrollee's life activities may take them such as school, work, and other locations, such as a provider's office. NOTE: When a PCS worker accompanies the member to a provider office it is to assist the member with a task and not to act as a medical facilitator. A medical facilitator is someone who provides information and receives information about the member's medical condition, such as a family member or health care agent. The MCO is not required to authorize hours beyond the hours assessed as appropriate for the home, but the hours authorized can be provided in the home or other locations, such as a family gathering.
- ix. Continuous personal care services. The scope of the PCS benefit includes continuous personal care services, which means the provision of uninterrupted care, by more than one person, for more than 16 hours per day for a patient who, because of the patient's medical condition and disabilities, requires total assistance with toileting, walking, transferring or feeding at times that cannot be predicted.
- x. Live-in 24-hour personal care services. The scope of the PCS benefit includes live-in 24-hour personal care services which means the provision of care by one person for a member who, because of the member's medical condition and disabilities, requires some or total assistance with one or more personal care functions during the day and night and whose need for assistance during the night is infrequent or can be predicted and where the assessment determines that the member's home has adequate sleeping accommodations for the personal care services worker. The live-in 24 hour personal care services rate of payment is based on 12 hours of care.
- xi. The MCO may not authorize or reauthorize personal care services based upon a *task-based* assessment when the member has been determined by the MCO to be in need of 24 hour personal care services, including continuous (split-shift or multi-shift) care, 24 hour live-in care or the equivalent provided by a formal or informal caregivers. The determination of the need for 24 hour personal care, including continuous (split-shift or multi-shift) care, shall be made without regard to the availability of formal or informal caregivers to assist in the provision of such care.
- xii. The assessment process should evaluate and document when and to what degree the member requires assistance with personal care services tasks and whether needed assistance with tasks can be scheduled or may occur at unpredictable times during the

day or night. The assessment process should also evaluate the availability of informal supports who may be willing and available to provide assistance with needed tasks and whether the member's day or nighttime needs can totally or partially be met through the use of efficiencies and specialized medical equipment including, but not limited to, commode, urinal, walker, wheelchair, etc. A care plan must be developed that meets the member's scheduled and unscheduled day and nighttime personal needs.

- b. **Safety Monitoring.** Managed Care Organizations should authorize some or total assistance with the recognized medically necessary personal care services tasks. Allotment of time separate and apart from the personal care tasks authorized is not required for safety monitoring. However, there is a clear and legitimate distinction between safety monitoring as a non-required stand alone function while no PCS is being provided and the appropriate level of safety monitoring while the enrollee is receiving assistance with PCS tasks such as transferring, toileting, or walking. As an example, if a member requires assistance with getting in and out of the tub and also has a condition that limits the ability to discern temperature the PCS worker would monitor the water temperature for the member as a safety measure. As another example, if a member requires assistance with walking, the PCS worker takes appropriate measures to guard the member's safety while assisting the member with the task of walking. These are but two examples of the appropriate safety monitoring that must be provided to assure that the particular Level I or Level II task is safely completed. Safety monitoring under PCS does not, however, include monitoring an individual with dementia, for example, when no other Level I or Level II personal care services task is being provided, to assure that the individual does not wander away from home or engage in unsafe behavior. This type of safety monitoring is covered as a discrete service in the Nursing Home Transition and Diversion Waiver.
- c. The Consumer Directed Personal Assistance Program (CDPAP) will be included in the Benefit Package effective November 1, 2012. Consumer Directed Personal Assistance means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer's designated representative. If a member requests information about the program prior to it becoming an in-plan benefit on November 1, 2012, the plan must refer the member to the local social services district. Under the CDPAP a member may arrange for an aide to perform not only personal care services tasks but also home health aide and nursing tasks. Information about the CDPAP will be covered under separate guidelines.

II. Accessing the benefit

- a. **Request for Service:** A member, their designee, including a provider or a case manager on behalf of a member, may request PCS. The MCO must provide the member with the medical request form (M11Q in NYC, DOH-4359 or a form approved by the State, for use by managed long term care plans (MLTC), and the timeframe for completion of the form and receipt of request.
Note: When a request for PCS is made, the MCO must provide the member with information about the Consumer Directed Personal Assistance Program ("CDPAP") using the brochure provided by SDOH. There is a further discussion about CDPAP below.
- b. **Nursing and Social Assessment:**

- i. Initial assessment
Once the request is received the MCO is responsible for arranging an assessment of the member by one of its contracted providers. This may be a certified home health agency, CASA, licensed home health agency (LHCSA), registered nurses from within the plan or some other arrangement. The initial assessment must be performed by a registered nurse and repeated at least twice per year.
- ii. Social Assessment
In response to recent requirements by the Centers for Medicare and Medicaid Services (CMS) MCOs must also have a social assessment performed. The social assessment includes social and environmental criteria that affect the need for personal care services. The social assessment evaluates the potential contribution of informal caregivers, such as family and friends, to the member's care, the ability and motivation of informal caregivers to assist in the care, the extent of informal caregivers' involvement in the member's care and, when live-in 24 hour personal care services are indicated, whether the member's home has adequate sleeping accommodations for a personal care aide.

This nursing assessment and the social assessment can be completed at the same time. The forms in New York City are the M27-r Nursing Assessment Visit Report and Home Care Assessment form. For the rest of the state, the forms are the DMS-1 and DSS 3139. MCOs may use assessment forms approved under the MLTC program.
NOTE: All assessments will be conducted using the Uniform Assessment Tool when it becomes available.

- iii. The MCO will provide to the LHCSA a copy of the medical request form, the nursing/social assessment and the authorization for services.
 - iv. Other considerations when conducting an assessment
 - 1. Certified Home Health Agency: When an MCO is contracting with a CHHA for the purpose of requesting an assessment of personal care services need the CHHA is not required to open a case pursuant to the rules and regulations specified under 10 NYCRR § 763.5 ("opening a case"). The CHHA is subject to the terms of the contractual arrangement.
 - v. MCOs must assure, through quality monitoring and utilization monitoring, that when a LHCSA performs the assessment and is also providing the PCS to the member that the level of services are appropriate and not in excess of the level and scope of services needed by the member.
- c. Authorization of services: The MCO will review the request for services and the assessment to determine whether the enrollee meets the requirements for PCS and the service is medically necessary. An authorization for PCS must include the amount, duration and scope of services required by the member. The duration of the authorization period shall be based on the member's needs as reflected in the required assessments. In determining the duration of the authorization period the MCO shall consider the member's prognosis and/or potential for recovery; and the expected length of any informal caregivers' participation in caregiving. No authorization should exceed six (6) months. There is a more detailed discussion about authorization of services and timeframes for authorization, notices and rights when there is a denial of a request for PCS below.
- d. Arranging for Services: The MCO is responsible for notifying and providing the member with the amount, duration and scope of authorized services. The MCO must also arrange for

the LHCSA to care for the member. The MCO will provide the LHCSA with a copy of the medical request, the assessment and the authorization for services. The LHCSA will arrange for the supervising RN, the personal care services worker, the member or the member's designated representative to develop the plan of care based on the MCO's authorization.

III. Authorization and Notice Requirements for Personal Care Services

- a. Standards for review. Requests for PCS must be reviewed for benefit coverage and medical necessity of the service in accordance with PHL Article 49, 18 NYCRR §505.14 (a), the MMC Model Contract and these guidelines. As such, denial or reduction in services must clearly indicate a clinical rationale that shows review of the enrollee's specific clinical data and medical condition; the basis on which request was not medically necessary or does not meet specific benefit coverage criteria; and be sufficient to enable judgment for possible appeal. If the determination results in a termination or reduction, the reason for denial must clearly state what circumstances or condition has changed to warrant reduction or termination of previously approved services.
- b. Timing of authorization review.
 - i. An MCO assessment of services during an active authorization period, whether to assess the continued appropriateness of care provided within the authorization period, or to assess the need for more of or continued services for a new authorization period, meets the definition of concurrent review under PHL § 4903(3) and must be determined and noticed within the timeframes provided for in the MMC Model Contract Appendix F.1(3)(b).
 - ii. A "first time" assessment by the MCO for personal care service (the enrollee was never in receipt of PCS under either FFS or MMC coverage, or had a significant gap in Medicaid authorization of PCS unrelated to an inpatient stay) meets the definition of preauthorized review under PHL §4903(2) and must be determined and noticed within the timeframes provided for in Appendix F.1(3)(a).
- c. Determination Notice. Notice of the determination is required whether adverse or not. If the MCO determines to deny or authorize less services than requested, a Notice of Action is to be issued as required by Appendix F.1(2)(a)(iv) and (v), and must contain all required information as per Appendix F.1(5)(a)(iii).
- d. Level and Hours of Service. The authorization determination notice, whether adverse or not, must include the number of hours per day, the number of hours per week, and the personal care services function (Level I/Level II):
 - i. that were previously authorized, if any;
 - ii. that were requested by the Enrollee or his/her designee, if so specified in the request;
 - iii. that are authorized for the new authorization period; and
 - iv. the original authorization period and the new authorization period, as applicable.
- e. Terminations and Reductions. Authorizations reduced by the MCO during the authorization period require a fair hearing and aid-to-continue language and must meet advance notice requirements of Appendix F.1(4)(a). Fair hearing and aid-to-continue rights are included in the "Managed Care Action Taken Termination or Reduction in Benefits" notice, which must be attached to the Notice of Action. Eligibility for aid-to-continue is determined by the Office of Administrative Hearings.

- i. If the authorization being amended was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued. (See 18 NYCRR § 358-3.6).
 - ii. If the authorization being amended was issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period (see 42 CFR 438.420(c)(4) and 18 NYCRR §360-10.8). The Action takes effect on the start date of a new authorization period, if any, even if the fair hearing has not yet taken place.
 - iii. All notices must reflect the reasons for reduction, discontinuation or denial of a reauthorization for PCS. Appropriate reasons for reducing, discontinuing or denying a reauthorization of personal care services include but are not limited to:
 - 1. the client's medical, mental, economic or social circumstances have changed and the MCO determines that the personal care services provided under the last authorization or reauthorization are no longer appropriate or can be provided in fewer hours than they were previously;
 - 2. a mistake occurred in the previous personal care services authorization;
 - 3. the member refused to cooperate with the required assessment of services;
 - 4. a technological development renders certain services unnecessary or less time consuming;
 - 5. the member can be more appropriately and cost-effectively served through other Medicaid programs and services;
 - 6. the member's health and safety cannot be reasonably assured with the provision of personal care services;
 - 7. the member's medical condition is not stable;
 - 8. the member is not self-directing and has no one to assume those responsibilities;
 - 9. the services the member needs exceed the personal care aide's scope of practice.
- f. Reauthorization. Notice by the MCO for new authorization period beyond the expiration of the current authorization period requires notice of fair hearing rights if services are authorized at a level that is less than what was requested by the enrollee or the amount previously authorized. If the re-authorization request was generated by the MCO to ensure timely assessment and continuity of care, the MCO should issue notice of fair hearing rights for any reduction in service for the new period (unless such reduction was requested by the enrollee).
- i. If the authorization period that is expiring was an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, and the MCO did not conduct a new assessment or issue an authorization determination for such period, and the MCO determines to reduce the services authorized in the new period, the notice of fair hearing must include aid continuing rights ("Managed Care Action Taken Termination or Reduction in Benefits" notice). An enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued.
 - ii. If the authorization period that is expiring was issued by an MCO (either current or previous MCO), and the effective date of the Action is after the expiration of the current authorization period, the notice of fair hearing does not require aid-to-continue language ("Managed Care Action Taken Denial of Benefits Under Managed Care"

- notice). The enrollee does not have a right for aid-to-continue unchanged past the expiration of the current authorization period.
- iii. Appropriate reasons and notice language to be used when reducing, discontinuing or denying a reauthorization of personal care services include those listed in Section III (e)(iii) above.
- g. Benefit Denials. If the MCO determines that the enrollee does not meet the criteria for the provision of the personal care services benefit, a Notice of Action is issued with fair hearing rights, using the “Managed Care Action Taken Denial of Benefits Under Managed Care” or “Managed Care Action Taken Termination or Reduction in Benefits” notice, as applicable.
- i. If the Action terminates, suspends, or denies a new authorization period following an LDSS authorization for PCS made pursuant to 18 NYCRR §505.14, an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the fair hearing decision is issued.
 - ii. If the Action terminates or suspends an authorization issued by an MCO (either current or previous MCO), an enrollee requesting a fair hearing has the right for aid-to-continue unchanged until the expiration of the current authorization period.
 - iii. If the effective date of the Action is beyond the expiration of the current authorization period, the notice of fair hearing does not require aid-to-continue language (“Managed Care Action Taken Denial of Benefits Under Managed Care” notice). The enrollee does not have a right for aid-to-continue unchanged past the expiration of the current authorization period.
 - iv. Appropriate reasons and notice language to be used when reducing, discontinuing or denying a reauthorization of personal care services include those listed in Section III (e)(iii) above.
 - v. For a member who is hospitalized or admitted to a facility for short-term rehabilitation and who was receiving personal care services immediately prior to entering the hospital or rehabilitation facility, the member’s personal care services authorization is temporarily suspended during the hospital or rehabilitation stay, and the MCO must reinstate such services under the authorization immediately upon the member’s discharge from the hospital or rehabilitation facility, unless the medical discharge plan indicates otherwise.
- h. Enrollee Safety.
- i. The plan must ensure that any change to the level of personal care services does not present a safety issue for the member. If it is determined that personal care services cannot maintain an individual safely in the home, then an assessment for the appropriate level of care must be arranged by the MCO.
 - ii. As determined by the Office of Administrative Hearings, in the case of an MCO Action affecting a home bound enrollee, aid-to-continue at the same or higher level of care may be required until the time the fair hearing decision is issued.
 - iii. If the MCO is unable to arrange for personal care services for the member due to conditions in the member’s home or the member rejects all available personal care services workers there is a constructive refusal of the benefit by the member. The MCO will issue a benefit denial notice to the member providing that the plan is unable to provide the benefit to the member. The MCO must contact appropriate resources at the LDSS (such as APS), if applicable.

IV. Supervision

- a. In-home supervision of the personal care services worker occurs when on-the-job instruction is needed to implement the plan of care and is covered by the MCO as part of PCS, subject to the terms of the agreement between the MCO and its contracted provider;
- b. Supervision is provided by a registered nurse;
- c. The number of nurse supervision visits occurs no less than twice per year. More frequent in-home visits may be warranted and authorization should not be unreasonably withheld by the MCO when:
 - i. The personal care services worker is not providing care in accordance with the care plan;
 - ii. The member complains about the care received by the PCS worker;
 - iii. A change in the member's condition warrants a change to the plan of care.

V. Transitional Care

- a. Existing enrollee in Receipt of PCS Authorized by an LDSS. Enrollees who are in receipt of PCS as of August 1, 2011 continue their course of treatment as authorized by the LDSS, regardless of whether the PCS provider participates in the MCO's network, until the MCO has assessed the Enrollee's needs and an approved treatment plan is put into place. MCO requirements for prior authorization or notification may not be applied to Non-Participating Providers until an approved treatment plan is put into place by the MCO even if the approved treatment plan is delayed beyond 60 days from enrollment. After August 1, 2011 LDSS should verify whether an individual is enrolled in an MCO prior to acting upon a request for personal care services.
- b. New Enrollee in Receipt of Personal Care Services Authorized by the LDSS or another MCO. Transitional care services consistent with Section 15.6(a)(i) of the MMC Model Contract and the SDOH transitional care policy entitled, "Medicaid Managed Care and Family Health Plus Coverage Policy: New Managed Care Enrollees in Receipt of an On-going Course of Treatment," apply to newly enrolled individuals with an authorization for PCS at the time of enrollment in the MCO.

VI. Contracting

- a. Personal Care Services Providers
 - i. NYC Provider Networks. NYC area MCOs must include in their networks and utilize only home attendant vendor agencies having a contract with the HRA Home Care Services Program during the period August 1, 2011 through February 28, 2014. The MCO is not required to contract with home attendant vendor agencies unwilling to accept the applicable HRA rate or the Medicaid fee-for-service rate as long as the MCO maintains an adequate network of Participating Providers to treat members.
 - ii. Continuity of the worker. The MCO must assure continuity of the personal care services worker for the members who were enrolled in the MCO as of August 1, 2011 and were previously in receipt of PCS authorized by the LDSS, unless:
 - 1. the home attendant vendor agency is unwilling to contract with the MCO;
 - 2. the personal care services worker is no longer working for the home attendant vendor agency; or
 - 3. the member requests a different personal care services worker.
 - iii. Sole Source Arrangements. MCOs must continue Sole Source Arrangements with agencies caring for less than 10 members until there are no longer any members

receiving personal care services from that vendor. This is to assure there is continuity of the worker for members enrolled in the MCO as of August 1, 2011. The MCO may assign a member to a participating provider at the member's request or if the vendor ends the arrangement.

b. Personal Care Services Worker Parity Rules

- i. Personal Care Services Provided in New York City During the period August 1, 2011 through February 29, 2012, the MCO shall reimburse all home attendant vendor agencies currently contracting with the New York City Human Resources Administration (HRA) for participation in the Home Care Services Program for the provision of personal care services at least the personal care rate established by HRA as of August 1, 2011 minus \$.28, as so annotated on the official HRA publication of the personal care rate (not subject to any retroactive adjustments to such rate after such date).
- ii. Personal Care Services provided in Nassau, Suffolk and Westchester Counties During the period August 1, 2011 through February 28, 2013, the MCO shall reimburse all home attendant vendor agencies contracting with Nassau, Suffolk and Westchester counties at the Medicaid fee-for-service rate established by the SDOH.
- iii. The MCO will require that subcontractors employing home care aides certify annually, on forms provided by SDOH, to the MCO that wages of such home care aides is compliant with the MMC Model Contract and PHL § 3614-c.
- iv. The MCO shall certify to SDOH, in a manner determined by SDOH, that all subcontracted home attendant vendor agencies are in compliance with PHL § 3614-c.
- v. Effective March 1, 2012, home attendant vendor agencies are required to comply with the home care worker wage parity provisions of Section 3614-c of the PHL which applies to New York City on and after March 1, 2012, and to the counties of Westchester, Nassau, and Suffolk on and after March 1, 2013.
- vi. Home attendant vendor agencies subject to the provisions of any employer collective bargaining agreements in effect as of January 1, 2011 and any successor agreement which provides for home care aides' health benefits, the provisions of the collective bargaining agreements apply in lieu of the provisions described under the other sections of the statute.
- vii. MCO must certify to the Department annually that the home attendant vendor agencies are in compliance with the law. For further information and a copy of the form see DAL DHCBS 11-09 issued on August 22, 2011. The information is accessible on the Health Commerce System by entering the search term "Home Care Worker Parity."

VII. Claims payment

- a. Submission of claims for payment must be on the forms and in the manner prescribed by the MCO through the agreement between the MCO and the vendor. The MCO will provide the vendor with the appropriate ICD-9 code from which the authorization was based either at the time of authorization or by any other means prior to submission of claims by the LHCSA. An MCO cannot deny a claim merely for the lack of an ICD-9 or its successor code unless the MCO has previously provided the LHCSA with a code.
- b. Pursuant to State Insurance Law (SIL) § 3224-b(a)(4) Licensed Home Care Agencies may obtain information about claims editing software utilized by the MCO at the provider section of the MCO's website.

- c. Pursuant to SIL § 3224-a(a) MCOs are required to pay claims to providers for health care services within 30 days for clean claims submitted electronically or 45 days for clean claims submitted by paper or facsimile.
- d. Licensed Home Care Services NPI number place holder

VIII. 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 LHCSA and either the new MCO or LDSS.
 - i. Enrollees in receipt of PCS 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 PCS 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 the enrollees impacted by the roster for change in enrollment the current month or following month; retrospective disenrollment cases (if known by the MCO) are not to be transmitted in this manner. If the plan is aware that the person has enrolled in another plan, that case should not be submitted to the local district. If cases relating to plan changes are submitted to HRA or the LDSS, neither HRA nor the local district are obligated to act on such cases involving plan changes.
 - iii. The LHCSA is responsible for verifying plan enrollment and MA 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.

Upon disenrollment from an MCO, the MCO is not responsible for payment of PCS provided after the effective date of disenrollment. The enrollee or the LHCSA 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 Office of Administrative Hearings, the disenrollment is deleted and the current plan remains responsible.

- b. Member voluntarily enrolls into another MCO.
 - i. For situations where the member enrolled with a new MCO, the LHCSA 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 will continue with the existing PCS vendor or is intending to assign the member to a different PCS vendor.
 - ii. The new MCO must continue the current authorization and vendor until the MCO conducts an assessment, authorization and arrangement for provision of the service. See Section V. Transitional Care.

- c. Member 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 where:
 - i. the district has a contract with the vendor currently providing the service;
 - ii. the request for services was signed by a physician; and
 - iii. the assessment meets the requirements of 18 NYCRR §505.14.
 - iv. The local district may also provide transitional care where the LHCSA does not have a contract with the LDSS but the assessment otherwise meets the criteria of (ii) and (iii) above. Information will be forthcoming from the Department concerning the process for how a validly licensed home care agency, but without a contract with the LDSS, will seek reimbursement from the fee-for-service program.
 - v. In situations where the LDSS cannot accept the MCO authorization (e.g. the request for services has expired) the LDSS will contact the LHCSA directly and inform them that there will not be any transitional care. The LHCSA is responsible for a safe discharge plan. This may require working with the member's family or contacting programs administered by the local social services districts.

IX. Loss of Medicaid Eligibility

- a. Retention efforts. MCOs are responsible for conducting activities to promote retention of eligibility for all enrollees. It is especially important that the MCO reach out to members in receipt of personal care to encourage recertification as necessary to maintain eligibility and prevent interruption of services. However, in the event the member has lost MA eligibility, the LHCSA is responsible for arranging a safe discharge plan for the member.
- b. Recertification: MCOs may work with the LHCSA to encourage members to recertify for Medicaid. MCOs are encouraged to provide the LHCSA with a copy of any correspondence provided to members concerning recertification for Medicaid eligibility to facilitate the process.
- c. Failure to recertify:
 - i. Members who fail to recertify timely will lose Medicaid eligibility. The MCO will send a Referral form to the LDSS contact as described above in Section VIII above whenever the MCO becomes aware of any member in receipt of PCS who is no longer on their roster and the coverage period noted on the roster has passed. This is an indication that the member may have failed to recertify.
 - ii. Members who lose eligibility are not eligible for PCS through the MCO or the LDSS. For those situations the LHCSA must determine how to safely discharge the individual.
- d. In some instances a member may regain Medicaid eligibility retroactively. Retroactive eligibility will not necessarily re-enroll the member into the same MCO. The LHCSA must verify whether the member is enrolled in the same or different MCO and what month the enrollment takes effect.
 - i. Upon disenrollment from an MCO, the MCO is not responsible for payment of PCS provided after the effective date of disenrollment. If Medicaid eligibility is reinstated, the enrollee, their designee or the LHCSA on the enrollee's behalf, must seek transitional care from the LDSS or new MCO to continue or regain PCS and provide a copy of the medical request for services, assessment and the original MCO's authorization for personal care services.

X. Encounter Data

- a. The MCO will submit encounter data in accordance with Section 18.5(a)(iv) of the MMC Model Contract. Instructions for encounter reporting can be found at www.emedny.org under Provider Manuals and at the DOH Health Commerce System portal (https://commerce.health.state.ny.us/hcsportal/hcs_home.portal) under Medicaid Encounter Data System Reports.

XI. PERS Personal Emergency Response System

- a. Personal Emergency Response System (PERS) is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center.
- b. Assessment of need for PERS services must be made in accordance with and in coordination with authorization procedures for home care services, including personal care services. Authorization for PERS services is based on a physician or nurse practitioner's order and a comprehensive assessment which must include an evaluation of the client's physical disability status, the degree that they would be at risk of an emergency due to medical or functional impairments or disability and the degree of their social isolation.

PERS is not provided in the absence of personal care or home care services.

- c. For services initiated prior to January 1, 2012, the local department of social services is responsible for processing the prior authorization code for PERS in the FFS payment system, based on a personal care services needs assessment conducted by or on behalf of the MCO. The MCO must submit all applicable needs assessment documentation to the local district. The MCO must notify the LDSS of any Enrollee in receipt of PERS whose personal care services have been terminated, no later than the effective date of the termination.
- d. For services in place or initiated on or after January 1, 2012:
 - i. The MCO will be responsible for authorizing and arranging for PERS services through network providers.
 - ii. The MCO must have a contract with at least one PERS vendor if it meets the needs of the enrolled population
 - iii. The MCO is not required to contract with the PERS vendors currently providing services through the fee for service program. However, the MCO must ensure that any changes to vendors will not result in an interruption of service for the enrollee.
 - iv. The PERS vendor is responsible for installing and maintaining the equipment.
 - v. The enrollee must be alert and self-directing and capable of using the PERS equipment effectively. Authorization of PERS is not a substitute for or in lieu of assistance with PCS tasks such as transferring, toileting or walking.

XII. Mutual Cases

- a. Mutual Cases Defined. A mutual case is one where two or more members of the household receive care from the same personal care aide.
 - i. For the period August 1, 2011 – January 14, 2012, where an MCO enrollee had LDSS authorization for a mutual case, claims for services provided to the MCO enrollee

were be paid by the MCO at half the appropriate mutual rate for the number of authorized hours unless otherwise instructed by the SDOH.

- ii. After January 14, 2012 the MCO and LDSS will not share mutual cases. Each case will be assessed individually and an authorization based on the number of hours the member requires to remain safely in the home will be determined. The assessment for the number of hours needed and the level of services may take into account what other services are provided in the home.

- b. Mutual Cases with another MCO. The MCOs may confer to assess the number of hours of services that are necessary and whether any of the services would be duplicative.

- c. MCOs are encouraged to work with the LHCSA when an MCO becomes aware that more than one person in the household is in need of personal care services to develop an efficient plan for each case, as appropriate.

- d. Except for mutual cases during the transitional period August 1, 2012 – January 14, 2012, a LHCSA cannot submit claims to two different payors for the same worker for the same hours.

MANAGED CARE PLAN REFERRAL TO HOME CARE SERVICES PROGRAM

FROM:

TO:

Name of Plan:			Local Department of Social Services Managed Care Coordinator:
Address:			Client Identification Number [CIN]:
Contact Person:	Phone Number:	Date:	Consumer's Emergency Contact Name: Telephone Number:
Name of PCS Vendor:			PCS Vendor ID:
Service Level:			Authorized 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 – Please include information regarding attempts to complete renewal.]

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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.



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
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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 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 the form.
- 3) The Managed Care Plan must attach a copy of the most recent assessment, the current valid medical request, and the care plan for the services.