



**Personal Care Option (PCO)
and
Disabled & Elderly (D&E) Waiver homemaker Providers
February 17, 2009**

On December 17, 2008, the State of New Mexico issued a letter of direction (LOD) to the Managed Care Organizations (MCO) who participate in the Coordination of Long Term Services (CoLTS) program. Those MCOs are Evercare and AMERIGROUP. The letter of direction was intended to provide direction regarding authorization of personal care services to members who enrolled in CoLTS as either PCO or D&E Waiver recipients. The LOD was effective January 19, 2009.

This document is intended to clarify how this LOD sent to the CoLTS MCO will affect PCO and D&E Waiver homemaker providers.

The following historical background is provided to give context to this document. Prior to Phase I implementation of CoLTS:

- *PCO consumer delegated* services were billed under Billing Code T1019 at \$3.55 (inclusive of Gross Receipts Tax (GRT)) per 15 minute unit.
- *PCO consumer directed* services were billed under Billing Code 99509 at \$12.63 (inclusive of GRT) per 1 hour unit.
- *D&E Homemaker* services were billed under Billing Code 99509 at \$15.77 (inclusive of GRT) per 1 hour unit. Billing Code modifiers were used to indicate billing for specific services, i.e. 99509 U1 was used for Respite services, and 99509 UA was used for supplemental homemaker services.

Per direction from the Centers for Medicare and Medicaid (CMS), the CoLTS program waivers indicate that homemaker services for CoLTS members are to be provided under the 1915b waiver as opposed to the 1915c waiver. Since the PCO services and D&E homemaker services are virtually indistinguishable, all homemaker services are provided under the 1915 b waiver. As a result, the homemaker services previously provided by the D&E waiver providers under a 1915c waiver are now subsumed under the 1915b waiver.

Per CMS direction, there will no longer be separate D&E Homemaker services provided under CoLTS. Therefore, there will not be a need to have separate billing codes and separate rates for any of the homemaker services. Consumers receiving homemaker services will continue to receive those services, but under the PCO services label/umbrella. Services should be billed using code 99509 for consumer-directed PCO or under T1019 under consumer-delegated PCO.

In order for the CoLTS MCOs to meet the obligations of this LOD they are doing the following:

Evercare: Effective January 19, 2009, Evercare will honor all existing prior authorizations (PA) for D&E waiver recipients issued by the state. Providers should bill Evercare using the state issued PA using the 99509 billing code at the homemaker rate of \$15.77. Once Evercare has conducted an in-home assessment, they will issue the provider a new authorization to bill for personal care services and will reimburse the provider at the negotiated contracted rate. New authorizations for personal care services will be issued in CoLTS Phases I, II and III and Evercare will continue this practice for phases IV & V rollouts. Evercare's standard procedure is to issue PAs in 6 month intervals. 30 days prior to an authorization expiring, the Service Coordinator (SC) performs a 6 month assessment to determine hours. The SC will work with the personal care provider to gather medically necessary documentation for any changes in services. The SC submits the authorization request to Evercare's Utilization Management (UM) for processing. UM sends a new authorization to the provider prior to authorization expiring.

AMERIGROUP: Provider contracts are being amended and will be sent out to providers at the end of February 2009. Amended contracts will be effective April 1, 2009. Providers should continue to bill AMERIGROUP using the existing PA issued either by AMERIGROUP or by the state through March 31, 2009, whichever was received last. AMERIGROUP's standard procedure is to issue PAs in 6 month intervals. Providers must submit a request to AMERIGROUP 30 days prior to the existing PA expiring, so that a new authorization for services can be issued.

STATE: Providers that are currently contracted with the D&E Waiver program to provide homemaker services will now have to contract with the CoLTS MCOs as a **PCO provider**. The D&E Waiver program will no longer accept provider applications for homemaker services. Homemaker providers interested in participating in the CoLTS or fee-for-service programs, who do not already participate, must contact Christine Baca, PCO Provider Liaison at ALTSD, at (505) 476-4760 to obtain information on how to become a PCO provider. Providers who currently operate their business under a Home Health license do not have to be credentialed by the PCO program to participate in the CoLTS program and can contact either or both CoLTS MCOs directly to become an in-network provider. Home Health Agencies do, however, have to be credentialed by the PCO program if they want to participate in the fee-for-service PCO program. Providers who are not licensed Home Health Agencies must be credentialed by the PCO program to participate in both CoLTS MCO provider network and PCO FFS program.

The D&E Waiver program will also no longer accept provider applications for respite services. The CoLTS MCOs will use their PCO in-network provider list for respite services. Providers wanting to offer both personal care and respite services should inform the CoLTS MCO regarding participation.

ADDITIONAL CLARIFYING INFORMATION FROM THE STATE

Once providers receive an authorization from the CoLTS MCO for personal care services, a Personal Care Service Plan (PCSP) must be developed with the consumer to reflect authorized services that will be provided on a weekly basis. (A template of the PCSP can be found at

www.nmaging.state.nm.us; go to the EDSD; under links related to pages click on Personal Care Option; the form number is MAD 058)

PCO regulation is to be followed. Providers should no longer follow D&E Waiver standards for homemaker services. PCO regulations can be found at www.state.nm.us/hsd/mad/Index.html click on provider information (left hand side of webpage); click on program policy manual (center of webpage); personal care services (previously 738, now 8.315.4). Providers should still follow the applicable D&E Waiver standards for all other “c” waiver services. Because all homemaker services are being converted to personal care services under the state plan, the following will be affected:

Family member justifications: There are no family member justification requirements for personal care services. Providers must request approval for a power-of-attorney to be a paid caregiver as stated in the PCO regulations. Requests are to be submitted to: Monica Madrid, PCO Consumer Liaison at ALTSD (505) 476-4780.

Delegated vs. Directed Models: The PCO program allows consumer choice of consumer-directed or consumer-delegated models. The CoLTS MCOs will allocate personal care services based on the consumer’s choice. Providers will receive authorizations from the MCOs with billing codes of either T1019 for delegated or 99509 for directed services. Providers are responsible for developing a PCSP MAD058 with the consumer based on the allocation hours received from the CoLTS MCO. Additionally, supplemental hours for homemaker services will no longer be allocated. The CoLTS MCOs will assess consumers and allocate personal care services based on need. Providers who are not currently credentialed by the PCO program to offer directed services may contact Ms. Baca for assistance.

Reimbursement and billing changes: Once the conversion has taken place (the provider has received an authorization for personal care services) from the CoLTS MCO, the provider must bill the CoLTS MCO using the negotiated personal care rate. Providers are obligated to follow the mandate under the PCO regulations to reimburse personal care attendants a minimum of \$8.00 per hour, unless there is a higher minimum wage law, then the provider is obligated to pay the higher rate. The state is currently working on revising the PCO regulations and will remove the mandated rate language.

Historically the D&E Waiver has reimbursed providers separately for supervisory visits. Because homemaker services are being converted to personal care services and PCO regulations do not reimburse providers separately for supervisory visits, supervisory visits are no longer a separate reimbursement.

Transfers: Providers have asked for clarification to the transfer process because transfers are approved by the CoLTS MCO, not the Third Party Assessor (TPA). The following transfer processes are in affect by each CoLTS MCO:

Evercare: Uses the state's MAD 062 transfer/closure form.

- It is the Service Coordinator's (SC) responsibility to see that it is completed prior to the transfer ;
- If a member wishes to transfer, they are to contact the SC with the request.

- The SC completes the top portion of the MAD 062 form including:
 - **Date,**
 - **Consumer (Member) name;**
 - **Consumer (Member) SSN;**
 - **Agency currently receiving services from;**
 - **Agency member wishes to transfer to; and**
 - **Date of agreed transfer.**
- If the new provider agency contacts EVC regarding a member's wish to transfer, the SC will contact the member to ensure there has been no solicitation and the member sincerely wishes to be transferred and proceed with the transfer process.
- Date of transfer should be 10 business days from the date of signatures unless prior arrangements are made among, EVC SC, member and new provider agency
- SC will make a brief visit to member's home to secure signature and written reason for transfer.
- SC will fax form to Originating and Receiving Agencies for signature
- Both agencies will return the form by fax to the SC.
- It is the SC responsibility to ensure the timely completion of the transfer process.
- The completed forms must be received by EVC before a UM Request will be submitted and authorization sent to Receiving agency.
- SC completes and UM Request for services from the new agency, indicating the date the auth is to start in the notes section.
- The UM Request along with the completed transfer forms are submitted to UM.
- A copy of the completed transfer form will be sent to originating and receiving provider agencies by SC.

AMERIGROUP: Transfer requests are to be vetted with the member and made only if the member confirms with AGP directly. The proposed new agency can validate that they have capacity to accept a new member and on what date. At that point, AGP will terminate the prior authorization for the old provider and create a new prior authorization for the new provider and confirm with the member the transfer. AGP does this in an attempt to capture any reportable incidents or quality issues which may be at the heart of the member's decision to make a change.

Providers should follow all other processes under the PCO regulation. This includes maintaining documentation requirements, background checks, checking client eligibility monthly, attendant training requirements, supervisory visits, etc.

Documentation requirements under the D&E Waiver standards are to still be followed for **other** waiver services (**excludes** homemaker and case management). D&E waiver documents such as CIA, MAW letter, ISP, ISD applications were all required documentation of case management agencies as well as other waiver providers. Because the CoLTS MCOs are now responsible for services coordination and are taking on this role, they will be required to maintain any applicable documentation under the new CoLTS "C" Waiver application to CMS. The CoLTS MCOs will include necessary documentation when issuing prior authorizations so that providers can develop plans with consumers, based on consumer need. The state is working on revising the D&E Waiver standards to reflect the new CoLTS "C" Waiver program and changed

services and requirements. Providers should follow the existing D&E Waiver standards to the best of their ability until new CoLTS “C” Waiver standards are issued.

Fee-for-Service PCO: For new consumers (an individual who is not yet in CoLTS), the state has put a process into place to allow individuals to receive temporary personal care services during the enrollment process into the CoLTS program. Consumers will be allocated temporary personal care services for a maximum of 75 days. There are two different ways a consumer can receive temporary personal care services:

- 1.) PCO enrollment: An individual coming in from the PCO enrollment “door” will be assessed by the TPA (currently Lovelace). If the individual meets nursing facility level of care (NF LOC), 20 hours per week of personal care services will be authorized. The consumer will be asked to select a personal care provider using the state’s maintained personal care provider list. The provider selected will receive an authorization from the TPA, should create a plan using the PCSP MAD 058 for 20 hours a week and should bill Medicaid fee-for-services until the consumer is enrolled into CoLTS. After the consumer is enrolled in CoLTS and once the provider has received a new authorization for personal care services from the consumer’s selected CoLTS MCO, the provider should then create a plan using the PCSP MAD 058 based on the newly approved hours and begin billing the consumer’s selected CoLTS MCO.
- 2.) CoLTS “c” Waiver (formerly known as D&E Waiver) allocation: An individual coming in from the waiver “door” will be assessed by their selected case management agency (CMA). The CMA will assist the individual through the eligibility process as usual and request LOC determination from the State’s Utilization Review (UR) contractor (currently BC/BS). If the individual meets NF LOC and the financial eligibility requirements, the CMA will request temporary personal care services based on the CIA score. The consumer will be asked to select a personal care provider (by the CMA) using the state’s maintained personal care provider list. The CMA will then give the personal care provider selected the authorization of services and a copy of the approved plan. Providers should bill Medicaid fee-for-service until the consumer is enrolled into CoLTS and the provider has a new authorization for personal care services from the consumer’s selected CoLTS MCO. Once the provider has received a new authorization for personal care services from the consumer’s selected CoLTS MCO, then the provider should create a plan with the consumer using the PCSP MAD 058 based on those approved hours and begin billing the consumer’s selected CoLTS MCO.

Individuals who are already enrolled in the CoLTS program (i.e., dual eligibles and NF residents) who become eligible for long term care will not be issued a temporary authorization for personal care services. For example: if a healthy dual or nursing home resident receives an allocation for long term care, the MCO will assist the consumer in obtaining a LOC determination and authorize services once the LOC has been issued by the TPA or UR contractor. Providers should not attempt to bill fee-for-service, services for individuals already enrolled into CoLTS, claims will be denied.