2024 LTSS Provider Forum Q&A Session: PERSONAL CARE SERVICES

Answers provided and vetted by DHB 7/22/2024

What percentage of beneficiaries participate in the quarterly beneficiary satisfaction surveys? Are survey results posted with the monthly PCS reporting? There is approximately a 70% participation rate with the Beneficiary Satisfaction Surveys and these surveys are not posted.

Please revisit level 2 review / assessment slide. The second level reviews are the reviews completed by the NC Medicaid nurse consultants on assessments conducted by NCLIFTSS to ensure they are true adverse decisions before notification is sent out to the beneficiary.

"Does the state consider a month of PCS services based on exactly 4 weeks or is it broke out to 4.3? Example: 80 hour per months can either equal 20 hours per week or 18.5" PCS hours are base upon 4.35 week for billing for units.

When is pcs providers expecting a fee increase because in home aides are asking between $15 to $20 The rate was increased to $5.96 per 15 minutes July 1, 2023. There is no further increase or change anticipated at this time.

Who determines that 80 hours a month was the max for PCS? What has to be done to change it from up to 80 hours a month to a set numbers of hours per week like CAP? Because it will be easier for beneficiaries to understand and not think that the agency is not taking their hours. In 2012-2013, a Session Law 2013-306 set PCS requirements and utilization limits. The General Assembly is the only entity to change the PCS mandated requirements and the maximum PCS hours.

Is there any way for providers to adjust the days of need on the QiReport, or do all requests that don't require a change in total hours need to be sent through a 3051 Form? No, providers can not adjust the days of need in Qi Report. A change of status (COS) will need to be submitted to NCLIFTSS.

Will the rate for Personal Care Services be increased or changed. The rate was increased to $5.96 per 15 minutes on 7/1/2023. There is no further increase or change anticipated at this time.

Our pcs clients, services are being denied in NC tracks on day 31 of the 31 day months saying over hours. How do we fix this? A prior approval segment is submitted to NCTracks based on the hours approved for a PCS beneficiary. The prior approval is calculated by the number of units approved and the number of days in the month. When all units are billed, claims billed over the maximum units are cut back to ensure the approved units are not exceeded.

If the member is on the tailored and there assessment is after 7/1 who is going to do the annual assessment? The assigned Tailored Plan will be responsible for completing the assessment.

Will the office be notified that beneficiaries switched to Tailored Plan? Also.... Will the beneficiary have the option to stay standard? How many beneficiaries will this launch effect?

The rate was increased to $5.96 per 15 minutes July 1, 2023. There is no further increase or change anticipated at this time.

Will the agency get a list of those that will be transitioning over to the Tailored Plans and what should be our (agency) next steps? The providers will be notified and can also check NCTracks for confirmation of eligibility.

Is there a specific link or email in the QI Report for submitting 3136 and 3085 forms? These documents can be uploaded on Qi Report's Provider Interface, under " Provider Documents." The individual uploading the documents must have administrator permissions in the Qi Report system.

As far as services for PCS clients, in terms of hours provided, is there an upper weekly limit, or is it okay as long as the plan of care is closely followed or the agency doesn't go over the allotted hours? These hours and days are documented in the service plan and that is what needs to followed as well as have any deviations documented per CCP 3L 6.1.5 (c)n

I missed what was said concerning an additional 50 hours a client may eligible for, can you please elaborate? The 50 additional hours apply to those beneficiaries that meet Session Law Criteria referenced in Clinical Coverage Policy 3L 6.1.2 (d).

How will beneficiary know if they are being transitioned to Tailor Plan? They will receive notification of the transition from NCTracks.

Can EVV have longer hours or staggered hours for their help desk to assist Providers? They close early yet the Providers work late. Can they assist as help desk until 7 pm or 8 pm eastern, Monday-Friday and 8-12 pm on Saturdays to give best help to Providers? The EVV provider adopts the same work hours at NC Medicaid, which are 8 a.m. to 5 p.m. Monday through Friday. After hours, providers can continue to engage with the EVV vendor through their website by submitting questions, requesting a ticket, and accessing interactive videos for support. The EVV vendor is responsive to questions and claims submitted after business hours, which are addressed during their operating hours.

When it comes to supervisor visits , should we use our own personal visit paperwork or use the one provided by NC tracks? Providers may use the own supervisory visits as long as it has all elements of the information required per CCP 3L 7.10 (b).

Do we have to send 3051 to each place or just NCLIFTSS? All DHB 3051 forms are to be faxed to NCLIFTSS at 833-521-2626.

Will the beneficiaries be notified and or trained on the new changes?" The rates will be the same for Tailored Plans and there will be a 90 day grace period during transition period to Tailored Plans. Beneficiaries will be notified if they are transitioned into a Tailored Plan. Providers will also be notified if they have beneficiaries that are being transitioned into a Tailored Plan.

So if eligibility is messed up should providers stop services? To prevent beneficiary harm, providers should not stop services when eligibility is not clearly defined. Instead, the provider should immediately submit a ticket for troubleshooting and quick resolution. Submitting a ticket will assist in determining the beneficiary's Medicaid eligibility and when and if the services need to terminate.

Will the pcs billing process change for those clients with tailored plans? Billing for individuals assigned to Tailored Plan will go through the assigned Tailored Plan.

Can we have a list of all the Tailored Plans agencies? That information is posted on the Medicaid website. Link below. https://medicaid.ncdhhs.gov/tailored-plans

For clarity, the PAs will auto transfer to the Tailored Plans, correct? Yes, all prior authorizations (PAs) for those transitioning will transfer and will be extended until 1/31/2025 to avoid member harm during the transition.

Can Home Health Care Services provide Peer support Services to their Care service for those who are in the Tailored Plan? Providers will need to reach out to the assigned Tailored Plan regarding this inquiry on additional that can be provided concurrently.

What's the best method to sign up for Tailored Plans? Please reach out to the Tailored Plan for the assigned area. https://medicaid.ncdhhs.gov/tailored-plans

What is daily rate methodology? The current rate is $5.96 for 15 minute rate methodology which is $23.84 daily.

Will you change PCS rules for criminal background of aides? There are currently no plans to make a change in these rules.

What is OCPI, how can we tell what these acronyms are for? The Office of Compliance and Program Integrity.

Who at DHB completes the 2nd level reviews for adverse decisions? Can you clarify what the 99.8% approval rate that was referenced on the slide for the adverse decision review means—does it mean 99.8% are deemed to be correct after the review of the IA? The 2nd level reviews are completed by the DHB RN consultants in the PCS unit. The 99.8% percentage rate is the rate at which they have agreed with the adverse decision made by NCLIFTSS.

What is the best process to ensure that new clients are being uploaded to agencies in a timely manner? The reason is, We usually have to wait 2-3 weeks and ask the clients make multiple calls to NCLIFTTS - which cause discouragement and loss of potential clients. The timeline from the date a referral is received to the determination of PCS is 14 business days. If PCS is approved, the selected provider is notified. This process can take up to 2-3 weeks. Having the beneficiary contact NCLIFTSS about their PCS assessment decision status is the best method of confirming approval and the selection of the provider.

We're noticing that since the transition from Liberty, there's a lot of home care hours being dropped from current clients and clients who are paralyzed are being denied services. Is there a difference in process from Liberty to Acentra/Keypro/NCLIFTSS? No, there is no difference in the process. The previous vendor (Liberty) and the current vendor (NCLIFTSS) utilize the same assessment tool, and the scoring of activities of daily living is the same.

Currently mileage is not reimbursed for PCAs and CNAs. Is there a plan to look at reimbursement to help with staffing and retention? There are statewide initiatives to address direct care worker shortages and retention. The recommendations from these initiatives will be

instrumental in building a stronger infrastructure for healthcare providers. The General Assembly is the body that can increase rates to cover expenses such as mileage. These increases would need to be enacted through a budget bill approved by the Governor of North Carolina.

We have clients whose assessment has been expired since 2022. We call and NCLIFTSS keeps saying they will be done. There is currently a backlog. NCLIFTSS is working to get these assessments completed. However, the PAs are being extended to provide continuity of care for the beneficiary and so not to provide and provider abrasion.

"Numerous assessments are past due, what is the time line to get these assessment back on track? What is the provider responsibility for following up on these? Often no one in the office can be reached." There is currently a backlog. NCLIFTSS is working to get these assessments completed. However, the PAs are being extended to provide continuity of care for the beneficiary and so not to provide and provider abrasion**.**

What programs can providers enter to help their clients with, the provider doing their grocery pickup and medical medication and medical supplies. Providers can reach out to their local DSS which may be able to provide them with additional resources to assist the beneficiaries with those services.

Can you bill Medicaid for home care visits? Providers can bill Medicaid for time spent with a Medicaid beneficiary by a personal care assistant (PCA) assisting with activities of daily living (ADLs). PCS does not reimburse payment for the required quarterly supervision visit.

If a client has hours 7 days a week and the client wants to change the hours to 5 days a week can the hours day 6 and 7 be distributed throughout day 1 through 5. If the beneficiary is requesting a change in the number of days it will impact the number of hours. The hours can not be redistributed.

When a client switches service where a new DHB 3051 is required are the old services to stop asap or is there a time frame. And will we be notified in do time so client doesn't have interruptions in service due to insurance switch? When switching from managed care to NC Medicaid Direct. When the Medicaid 3051 (managed care disenrollment) the PCS will automatically pick up on the day of disenrollment (once everything is verified). The agency will be notified via QiRePort. PA's will be given for 3 months until NCLIFTSS can complete an assessment (as is done with the expedited process). There is no interruption in services.

Can Home Care agencies provide services in a nursing home or hospital? No, PCS can not provided in these settings per CCP 3L 4.2.1

Is AmeriHealth and Health Blue represented on stage right now? No, they were not represented on stage.

Will PCS Service providers be able to bill as of July 1st thru NCTracks for the Tailored Plans? Billing for individuals assigned to tailored will go through the assigned Tailored Plan.

Can PCS providers assist the Tailored Plan recipients? PCS providers can assist beneficiaries assigned to Tailored Plans if they are contracted with the assigned Tailored Plan.

Is there an update regarding plans to address outstanding reauthorizations and new participants with pending admissions? It seems like there is a lack of staff in some areas and many client are going months before receiving their initial assessments to get their services started. There is currently a backlog that NCLIFTSS is working through to get these assessments completed; however, the PAs are being extended to provide continuity of care for the beneficiary and so not to provide and provider abrasion.

What is the projected date for the adult care home PCS per diem rate and what is the projected date of the implementation of the Congregate Care Services service definition? The projected date of implementation for CCP 3L-1 which will provide a stand alone policy for Congregate Care will be retroactive to July 1, 2024.

While providing PCS, can transportation in community for daily living needs become a billable service under expansion, innovations etc? We are reviewing what can be done for transportation for PCS but is not included at this time under Policy 3L.

I have had issues getting paid in the past when a client was hospitalized . They received services later in the same day they were discharged. We did not receive payment for that day because the client was discharged from the hospital that same day. The issue is that the employee still had to be paid. Will that be changed in the future? To prevent beneficiary harm, Medicaid permits the reimbursement of a claim when a PCS beneficiary is admitted to a hospital and may have received PCS before the admission or needs PCS services upon discharge. Carefully reviewing the EOB or the reason for the claim denial should assist in resolving the claim issue.

Why would the waiver allow for CAP services to be provided by a family member etc. and not for personal care services, when personal care services are being provided for both and paid for by Medicaid. Is this something that can be changed in the policy for regular Medicaid or voted on for future change? Staff retention is at an all time high. A family member providing beneficiary services is not allowed in PCS per federal guidelines.

What is the state requirement for start of care for individuals needing PCS coming out of the hospital with physicians orders? A DHB 3051 must be completed by the beneficiary's physician and faxed to NC LIFTSS at 833-521-2626.

Why does a PA request have to be uploaded when there is a technical denial after the Medicaid recipient has a scheduled assessment? Each Medicaid beneficiary must be granted due process when requesting a Medicaid service. When an adverse decision is made, the beneficiary is given the right to appeal. A PA is submitted to comply with due process mandates if the decision to deny is overturned.

When will the workgroup resume for the 3L policy changes to separate the 2 programs? These meetings will be rescheduled for mid to late July.

What are the state requirements / hours for Agency skills check yearly? Please see the link below for DHSR for more information on requirements for licensed agencies and required credentials for CNAs, PCAs, etc. https://info.ncdhhs.gov/dhsr/

When clients are expedited, why does it take agencies so long (about a week) before we're able to print out timesheets, independent assessment for PCS, etc? Also what can we do when a clients name comes into QI Report wrong? We have a client who was originally Medicaid Direct, changed to Managed Care & has now changed back to Medicaid Direct, but her name is Misspelled! The information is unable to print until the prior authorizations (PAs) have been generated; and PAs are not generated until the service plan has been completed. If these items are completed and an agency is still able to print the documentation please reach out to VieBridge Support at 888-705-0970. If a clients name is incorrect in QiRePort, they would need to reach out to the local DSS and to have this changed by their Medicaid case worker.

How many beneficiaries receiving PCS are anticipated to be in from an in-home setting (under 3L)? There are approximately 625 beneficiaries receiving services in the in- home setting that will transition to Tailored Plans.

Why is it that Healthy Blue when they send new authorizations for PCS in Carebridge, the units /hours sent are now cumulative , meaning they just add up the units cumulatively with hours from previous authorizations, it's very confusing. Why can't they just put each authorization separately without providers having to start subtracting hours from previous authorizations to figure out the new hours for the new authorizations. NC Medicaid has multiple payers (NC Medicaid Direct and NC Medicaid Managed Care), and each payor source can display approved units in a method that aligns with its utilization management. When these events occur, it is best to contact the health plan directly to confirm that newly approved hours have been approved.