Office of Health Insurance Programs
Division of Long Term Care

Managed Long Term Care Policy 21.06: Changes to Consumer Directed Personal Assistance Program (CDPAP) Regulations

Date of Issuance: December 13, 2021

Effective Date: November 8, 2021

Applicable To: Unless otherwise indicated, this policy applies to all managed care programs, organizations or demonstrations covering personal care and/or consumer directed personal assistance services funded by New York State Medicaid (collectively referred to herein as "MMCOs"). This includes but is not limited to mainstream Medicaid managed care plans, HIV special needs plans (HIV SNP), Health and Recovery Plans (HARP), Medicaid managed long term care partial capitation plans, Medicaid Advantage Plus plans, and Programs of All-Inclusive Care for the Elderly (PACE) plans.

Purpose: This policy provides guidance and instruction to MMCOs regarding regulatory changes impacting Consumer Directed Personal Assistance Program (CDPAP) and Personal Care Services (PCS) that were **effective November 8, 2021**. These changes are the result of various statutory, regulatory and administrative reforms included in the enacted State Fiscal Year 2020-21 New York State Budget and regulatory amendments to 18 NYCRR §§ 505.14 & 505.28 published in the September 8, 2021 New York State Register.

The policy offers guidance and instruction to the MMCOs pertaining to several aspects of the regulatory changes effective November 8, 2021, including:

A. Eliminating the MMCO Requirement to Annually Notify Home Care Recipients about Consumer Directed Personal Assistance Services (CDPAS);
B. Requiring Consumers/Designated Representatives to Work with Only One Fiscal Intermediary (FI) at a Time;
C. Defining Additional Responsibilities of Designated Representatives;
D. Changing Routine Reassessment Timeframe;
E. Ordering Practitioners for Personal Care (PCS) and Consumer Directed Personal Assistance (CDPAS) Services;
F. Codifying Supervision and Cueing; and
G. Updates to the Requirements for the Continuation, Denial, Reduction or Discontinuation of Services.

To conform with changes to the CDPAP as outlined in A-C, the Department has also revised the agreement template between the MMCO and the consumer/designated representative.

NOTE: This policy does not implement any aspects of the Independent Assessment process, nor changes to the minimum eligibility criteria. 18 NYCRR §§ 505.14(b)(8) & 505.28(m) allow the Department to permit the current assessment process to continue until such time as the Independent Assessor has been implemented.

Program Implications and Required Actions

A. Elimination of the MMCO requirement to annually notify home care recipients about Consumer Directed Personal Assistance Services (CDPAS)

MMCOs are currently required to annually notify members who are receiving personal care, long term home health care program, AIDS home care program or private duty nursing services of the availability of Consumer Directed Personal Assistance Services (CDPAS). MMCOs can direct individuals to the Department's website or have them reach out to their FI for information regarding CDPAS. The Department is no longer requiring MMCOs to notify members annually of the availability of CDPAS.

The model contract sections repealed by this change are:

1. Mainstream/Family Health Plus/HIV SNP/HARP:
    a. Section 10, Item 10.36(b) and
    b. Appendix S Item 3: Care Management for LTSS (b)(I)(G).
2. MLTC Partial Capitation:
    a. Article V, Section K, #2 and
    b. Article V, Section K, #3.
3. Medicaid Advantage Plus (MAP):
    a. Section 10, #10.13(d) and
    b. Section 10, #10.18(b)

While MMCOs are no longer obligated to educate recipients about CDPAS, it is expected that if a recipient of personal care, long term home health care program, AIDS home care program or private duty nursing services does inquire about CDPAS, the MMCO will inform them about the program, give them the opportunity to apply, and inform them of the FIs in the MMCO's network. In addition, if during the development of a person-centered care plan it appears that CDPAS may address some or all the individual's personal care needs, the MMCO should provide information about the program to the member.

B. Requiring consumers/designated representatives to work with only one FI at a time

18 NYCRR §§ 505.28(e)(1)(v) & 505.28 (h)(3) prohibit consumers or their designated representative from working with more than one FI at a time. While a consumer can still hire as many personal assistants (PAs) as may be necessary under their plan of care, those PAs will have to use the one FI with which the consumer, or their designated representative, has chosen to work.

Should an MMCO become aware that a consumer or their designated representative is working with more than one FI, either on their own or through an FI that alerts the MMCO, the MMCO must work with the consumer or their designated representative to reduce the number of FIs to one. The FI they choose to work with, however, remains the consumer's/designated representative's choice.

As of the issuance date of this policy, the MMCO has 60 days to contact all consumers for whom they have authorized CDPAS under more than one FI. Going forward, the MMCO has 30 days to contact a consumer if they become aware they are working with more than one FI. The MMCO must use the template included as Template 1 to communicate with each consumer identified as having more than one FI.

From the point of contact, the consumer has 60 days to choose one FI and have all their personal assistants onboarded to that one FI. The MMCO must close all other authorizations.

If a consumer does not choose an FI within the allowed 60-day timeframe, the MMCO is required to choose one of the FI's the consumer is working with to continue and inform the consumer of this choice in writing using the template included as Template 2. The MMCO must choose one of the FIs that the consumer is currently working with, and it should be, where possible, the FI that would cause the least disruption to the consumer's schedule. For example, if a consumer has four personal assistants and three of those are working for one FI while the fourth works for a second FI, the MMCO should choose the FI that is making payment to the three FIs.

The MMCO will only provide authorization to the one FI that either the consumer has chosen or the MMCO has chosen for the consumer.

This requirement does not constitute a discontinuation, suspension, reduction, or restriction of CDPAS and, therefore, does not give rise to Fair Hearing rights. However, the written notices from the MMCO should provide appropriate contact information for the MMCO so that the consumer or designated representative may contact them with any relevant questions or complaints. There are no exceptions to this requirement.

This requirement only applies to the consumer/designated representative. Personal assistants may work with multiple FIs if they are working for multiple consumers who have each chosen their own singular FI.

Please note, the requirement for a CDPAP consumer to have only one FI pertains only to the Department of Health's CDPAP and not fiscal intermediary services or programs at other agencies, e.g., OPWDD. A consumer may work with an FI at another agency in addition to the one FI for the Department of Health CDPAP.

C. Additional Designated Representative Responsibilities

18 NYCRR § 505.28(h)(2) has been added to require Designated Representatives (DR) to acknowledge in the consumer agreements with the MMCO and FI that they will:

- Make themselves available to ensure the consumer responsibilities are carried out without delay; and
- For non self-directing consumers, make themselves available and be present with the consumer for any scheduled assessment or visit by the independent assessor, examining medical professional or MMCO.

D. Timeframes for PCS and CDPAS Routine Reassessments

18 NYCRR §§ 505.14(b)(4)(vii) & 505.28(e)(5) have expanded the timeframe for routine reassessments from six (6) to twelve (12) months, effective November 8, 2021. On and after November 8, 2021, any individual assessed through the Community Health Assessment (CHA) in the UAS-NY for PCS and/or CDPAS will have a routine reassessment date in the UAS-NY calculated for 12 months from the date the last assessment was conducted.

Individuals who were last assessed before November 8, 2021 should still receive their next assessment within six months of the prior assessment. For example, an individual who was assessed on September 5, 2021 should have their next assessment on or before March 5, 2022. Once an individual receives an assessment after November 8, 2021, their next assessment should be scheduled within the next 12 months.

Note that the Department has not substantively amended the requirement to align the duration of service authorization with the assessed needs of the individual. This requirement is retained, although the duration of authorization may be extended up to 12 months based on the results of the assessment. This means it remains the responsibility of the MMCO care manager to consider the general health and circumstances of the individual and seek more frequent non-routine reassessments, if necessary, to reasonably maintain their health and safety in the community, as well as whenever there is a change in condition that may affect the amount, duration, and scope of services, or upon an individual's request for an assessment.

Additionally, other programs and services that address long term care needs require more frequent reassessment, including but not limited to:

- Programs for All-inclusive Care of the Elderly (PACE) – at least every six months
- Assisted Living Programs (ALP) – at least every six months
- Adult Day Health Centers (ADHC) – at least every six months

This policy does not affect the MMCO's care management responsibilities. Care management requirements have not changed.

E. Ordering Practitioners for Personal Care and Consumer Directed Personal Assistance Services

18 NYCRR §§ 505.14(b)(2)(ii)(g) & 505.28(d)(2)(vii) expand the titles of practitioners now able to sign the DOH-4359 and HCSP-M11Q forms to include the following, as defined in State Education Law:

- Medical Doctor (MD)
- Doctor of Osteopathy (DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Specialist Assistant

The practitioners listed above are able to complete the medical exam and sign the order forms without an MD or DO co-signing.

All other aspects of ordering for PCS and CDPAS remain in place until the announced implementation of the Independent Assessor, which has not yet occurred.

F. Codifying Supervision and Cueing

18 NYCRR § 505.14(a)(5)(iii) codifies supervision and cueing as forms of assistance with PCS. The Department had most recently addressed supervision and cueing in GIS 03 MA/003 which outlines that supervision and cueing are forms of assistance with personal care functions (Level 2 services).

This policy supersedes GIS 03 MA/003 in that it expands allowable supervision and cueing to include assistance with Nutritional and Environmental support functions (Level 1 services), as well.

However, consistent with GIS 03 MA/003, supervision and cueing cannot be authorized by the MMCO or reimbursed unless provided as a means of assistance with a recognized Level 1 or 2 service. Safety monitoring is not a recognized state plan service. For instance, someone may be authorized for four hours a week of assistance with shopping, meal preparation and laundry and these tasks may be provided through hands-on assistance, supervision or cueing, but the individual may not be authorized for supervision and cueing that is not associated with the authorization for shopping, meal preparation and/or laundry.

For example, the aide may do the shopping or accompany the individual to the market to ensure that they purchase adequate and appropriate food. The aide may supervise meal preparation to make sure the individual practices safe food handling, turns off appliances and puts everything away. In addition, the aide may provide cues to ensure that the individual properly completes their laundry (placing the sheets in the washer, putting them in the dryer, bringing them to the bedroom so the individual can make their bed later). However, the aide may not remain in the home to make sure the individual doesn't wander or turn the stove on inappropriately after the cooking task is completed.

NOTE: For those who only need Nutritional and Environmental supports, services remain capped at 8 hours per week. By extension, this service limit applies to the authorization of supervision and cueing as well.

G. Updates to the Requirements for the Continuation, Denial, Reduction or Discontinuation of Services

1. 18 NYCRR §§ 505.14(b)(1)(viii)(c)(1) & 505.28(i)(4)(i) now specify that the MMCO must identify in the Notice and Plan of Care, for actions based on Medical Necessity, the factors that demonstrate why services are not, or are no longer, medically necessary.

   The MMCO must include a clinical rationale that:
   - Shows a review of the individual's specific clinical data and medical condition
   - If applicable, includes the basis on which the individual's needs do not meet specific benefit coverage criteria and
   - Is sufficiently clear and understandable to enable review of the action on appeal.

2. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(2) & (3), & 505.28(i)(4)(ii) & (ii) have been modified to update and add examples of already appropriate reasons and notice language for use when denying or reducing services.

As a reminder, the lists included in the regulations are NOT new reasons, nor are the lists exhaustive. Rather, the lists are illustrative and provide examples of reasons that the Department considers as independently permissible. Other reasons that are not on the list *may* apply, such as additional statutory or regulatory requirements for the provision of services. The list of reasons is included to assist/guide the MMCO toward permissible reasons for denying or reducing services.

a. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(2)(i), (3)(i) & 505.28(i)(4)(ii)(a), (iii)(a) have updated the health and safety rationale to align with previous guidance. The update has included the term "reasonably". When denying or reducing services, the MMCO must determine that the individual's health and safety cannot be reasonably assured with the provision of PCS or CDPAS.

   Authorization of services does not require the MMCO to eliminate all doubt as to whether PCS or CDPAS, in conjunction with other formal or informal services and supports, will maintain the individual's health and safety.

b. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(2)(vi), (3)(iv) & 505.28(i)(4)(ii)(e), (iii)(d) have been revised to update the rationale for denying or reducing services when the use of technology or devices may meet <u>some or all</u> the identified needs.

   Updates also include that applicable technologies incorporate the use of telehealth services or assistive devices. Some examples include telemonitoring, assistive devices such as a microwave to eliminate the need to stand at a stove to prepare home delivered meals, medication dispensers or pill pak, provided:
   - the service or device is readily available to the individual, and
   - the MMCO documents that the device reduces the individual's service needs, e.g., by indicating in the notice and plan of care which Level 1 or Level 2 task(s) the technology is being used to address.

   It should be noted that there is a difference in wording between (2)(vi) and (3)(iv). The additional requirement added to (2)(vi) regarding availability was made in response to public comments received and should be applied to both PCS and CDPAS, and to reductions as well as initial denials.

c. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(2)(vii) & (3)(v) update the rationale for denying or reducing services for residents of facilities where the facility is responsible for providing care.

   In using this rationale, the MMCO should have determined, and must indicate in the notice, that either:
   - the individual is not seeking to transition to a less restrictive setting, or
   - the individual's health and safety cannot be reasonably assured in a less restrictive setting.

   The Department notes a drafting error which occurred in the notice of adoption where that the equivalent rationale at 18 NYCRR § 505.28(i)(4)(ii)(f)

was removed. Despite this, the Department views the rationales regarding residents of facilities as being applicable to both PCS and CDPAS.

d. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(2)(ix) and (3)(i), & 505.28(i)(4)(ii)(h) & (iii)(a) have been added to instruct the MMCO that voluntary informal supports can be a rationale for denying or reducing services, where the available informal supports, or other supports or services, can meet the individual's needs.

   When using this rationale, the MMCO must document the alternative services (e.g., informal supports) and what needs in the plan of care the alternative services meet.

   These provisions are based on existing provisions that prohibit the authorization of services when voluntary assistance, other forms or supports, or adaptive or specialized equipment are available, cost-effective and meet the consumer's needs.

e. 18 NYCRR §§ 505.14(b)(4)(viii)(c)(3)(vii) & 505.28(i)(4)(iii)(h) have been added to allow that an MMCO may determine to reduce services based on its assessment of medical necessity following an applicable continuity of care period.

   The MMCO must support its determination based on medical necessity, including adherence to 10 NYCRR §§ 505.14(b)(1)(viii)(c)(1) & 505.28(i)(4)(i). That means the notice must contain the clinical rationale, including any applicable coverage criteria, as related to the individual's specific clinical condition and it must be sufficiently clear to enable judicial review.

   In these cases, the MMCO is supporting its own initial determination of services, and a reduction or termination of services for the member does not require evidence of a change in condition.

   Applicable continuity of care periods include but are not limited to those defined in PHL 4403-f(y)(g)(i), the 1115 waiver and MLTC Policy 17.02. They may also include continuity of care periods imposed by the Department as a condition of a transaction or by court order. Aid continuing, which is a procedural enrollee right available only after certain, separate plan actions, would generally not constitute a continuity of care period for the purposes of this rationale.

Updates to the CDPAS Consumer Agreement

Individuals participating in CDPAP are required to sign the "Consumer Directed Personal Assistance Program Agreement Between the Consumer/Designated Representative and the Health Plan" (the Consumer Agreement or Agreement). This Agreement outlines the responsibilities of the consumer, designated representative and MMCO. By signing this agreement, all parties acknowledge and agree to their responsibilities under the CDPAP.

To effectuate the changes to rules and regulations, the Department has updated the Agreement template that must be used among consumers, designated representatives (if applicable), and the MMCO. The Department updated this Agreement on December 10, 2021 and it replaces, in whole, any agreement template the Department issued previously. The new Agreement applies to consumers who are currently authorized for services as well as for new authorizations.

A revised version of the CDPAP Consumer Agreement has been included in Attachment 1 and is also posted to the Department's website here, and includes the following updates:

- Removes MMCO responsibility to notify members about CDPAS;
- Adds MMCO responsibility to only authorize CDPAS provided through one FI
- Adds or revises consumer responsibilities to include:
    - Working with only one FI; and
    - Ensuring PAs adhere to Electronic Visit Verification (EVV) requirements as outlined in the Department's EVV Program Guidelines and Requirements; and
- Adds specific Designated Representative responsibilities section as outlined in Section C. above.

A new Consumer Agreement must be signed when CDPAS is authorized, when a change is required (such as having to appoint a new or different designated representative) and on an annual basis. The MMCO will provide the consumer and/or designated representative a copy of the signed Agreement as well as retaining a copy in the consumer's file.

The MMCO is required to use the revised Consumer Agreement, as provided in Attachment 1, when a new Consumer Agreement is needed as outlined above; it is not required to be updated outside that cadence. However, the MMCO, consumer and designated representative are required to fulfill all responsibilities as outlined in 18 NYCRR §§ 505.28(e), (h) & (i), which include the revisions as described above and ensures statewide programmatic consistency.

MANAGED LONG TERM CARE POLICY 21.06

ATTACHMENT 1

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM AGREEMENT BETWEEN THE CONSUMER/DESIGNATED REPRESENTATIVE AND THE HEALTH PLAN

CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM AGREEMENT BETWEEN THE CONSUMER/DESIGNATED REPRESENTATIVE AND THE HEALTH PLAN

Consumer Name: _____

Designated Representative Name (if applicable): _____

Health Plan Name:_____

I. CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM (CDPAP) AGREEMENT

The Consumer Directed Personal Assistance Program (the "Program") is a program for Medicaid recipients ("Consumers") who need home care services, including help with personal care and certain home health and skilled nursing services. The Program gives Consumers more flexibility and freedom of choice by letting them direct their own care, including choosing their own personal assistants in accordance with their Health Plan's authorization.

To participate in the Program, Consumers must be able to direct their own care and understand and fulfill the Consumer's responsibilities within the Program or have a Designated Representative that will do this for them. The Consumer or Designated Representative must also understand the roles and responsibilities of the Health Plan and the Fiscal Intermediaries under the Program.

As used throughout this agreement the term "Consumer" also includes the Consumer's Designated Representative when applicable, unless otherwise specified. As used throughout this agreement the terms "I" and "my" will refer to the Consumer or alternatively to the Consumer's Designated Representative when applicable and depending on context.

This agreement outlines the roles and responsibilities of the Consumer and the Health Plan under the Program. The Consumer must enter into this agreement to acknowledge that they understand the roles and responsibilities and to participate in the Program. The Consumer must also enter into a separate agreement with their chosen Fiscal Intermediary (FI), which will outline the roles and responsibilities of the Consumer and FI.

II. <u>RESPONSIBILITIES OF THE CONSUMER/DESIGNATED REPRESENTATIVE:</u>

As a Consumer participating in the Program, I will:

1. Read and understand this agreement and the roles and responsibilities of the Health Plan, FI, and Consumer under the Program.

2. Only work with one FI. I understand that I can change my FI at any time, but I will work with only one at a time. If I am working with more than one FI, I must choose just one FI to continue working with.

3. Manage my plan of care.

4. Be responsible for recruiting, hiring, training, supervising, and scheduling a sufficient number of qualified individuals of my choosing to serve as my personal assistant(s) in accordance with my Health Plan's authorization.

5. Maintain a back-up plan for substitute coverage when a personal assistant is temporarily unavailable for any reason.

6. Maintain an appropriate home environment.

7. Review the plan of care with each personal assistant outlining their responsibilities.

8. Ensure my personal assistant(s) safely and competently performs only the tasks identified in the plan of care during authorized hours.

9. Comply with labor laws, providing equal employment opportunities as specified in the Consumer's agreement with the CDPAS FI.

10. Inform the Health Plan and FI within 5 business days of any change in status or condition, including but not limited to hospitalizations, address and telephone number changes, and vacations.

11. Terminate a personal assistant's employment, if necessary.

12. Notify the FI of any changes in the employment status of a personal assistant.

13. Ensure my personal assistant's required documents are submitted to the CDPAP FI including annual worker health assessments and required employment documents.

14. Ensure my personal assistant(s) adhere to EVV requirements, including those outlined by the EVV Program Guidelines and Requirements.

15. Attest to the accuracy of the hours my personal assistant(s) worked either through the EVV data system or by signing the personal assistant's time sheet.

16. Distribute paychecks to each personal assistant, if applicable.

17. Comply with Program eligibility requirements including participating, as needed, in the required assessment and reassessment processes.

18. Report and return to the health plan any overpayment or inappropriate payments from the Medicaid program made to my personal assistant(s).

III. ADDITIONAL RESPONSIBILITIES OF THE DESIGNATED REPRESENTATIVE ONLY:

In addition to responsibilities listed above that I, as Designated Representative, must perform on behalf of the Consumer, I will:

1. Make myself available to ensure the consumer responsibilities are carried out without delay.

2. Be available and present for any scheduled assessment or visit by the independent assessor, examining medical professional or health plan when the member is not self-directing.

IV. RESPONSIBILITIES OF THE HEALTH PLAN:

The health plan must provide the Consumer with written educational materials outlining the roles and responsibilities of the Consumer to ensure they are making an educated, informed choice to receive Program services and will:

1. Determine if the Consumer (not including the Designated Representative) is eligible for the Program and whether home care or personal care services should be authorized.

2. Determine if the Consumer is able and willing to assume all responsibilities associated with participating in the CDPAP or has a Designated Representative able and willing to act on the Consumer's behalf.

3. Discuss and document that the Consumer's or Designated Representative's plan to assure adequate supports are available to meet the Consumer's needs.

4. Develop a patient centered plan of care with the Consumer or Designated Representative, outlining the tasks to be completed by the personal assistant.

5. Maintain a copy of the plan of care in the Consumer's file and give a copy to the both the Consumer and Designated Representative.

6. Authorize the type/amount of services and number of hours required.

7. Only authorize Program services provided through one FI and work with the Consumer or Designated Representative to select just one FI should the health plan become aware that services are being provided by more than one FI.

8. Evaluate on an ongoing basis whether the Consumer requires personal care, home health care, or some other level of service.

9. Notify the Consumer and Designated Representative that Program services are being decreased or discontinued if the health plan determines such services are no longer appropriate and, if applicable, refer the Consumer to other appropriate programs.

10. Provide the Consumer and Designated Representative with the appropriate fair hearing notice.

ALL PARTIES ACCEPT THE ROLES AND RESPONSIBILITIES TO PARTICIPATE IN THE CDPAP AS EXPLAINED ABOVE. FULFILLING THE CONSUMER'S ROLES AND RESPONSIBILITIES IS A REQUIREMENT OF PARTICIPATION IN THE PROGRAM. FAILURE TO FULFILL THE CONSUMER'S ROLES AND RESPONSIBILITIES MAY RESULT IN DISCONTINUANCE OF PROGRAM SERVICES.

Signatures

_____ _____
Consumer Date

_____ _____
Designated Representative (If applicable) Date

_____ _____
Health Plan Representative Date

TEMPLATE 1

Click here to enter date

Click here to enter LDSS/MCO name
Click here to enter LDSS/MCO street address
Click here to enter LDSS/MCO city, state zip

Dear Click here to enter Consumer's name,

This letter is to tell you of a change to the Consumer Directed Personal Assistance Program (CDPAP). All CDPAP consumers can now only work with one (1) fiscal intermediary (FI) at a time. Your FI processes your personal assistant's wages and benefits and maintains their records. You must still manage your plan of care and hire enough personal assistants to cover your authorized hours, but you must do this using only one FI for all your CDPAP hours.

Click here to enter LDSS/MCO name records show you are currently using more than one FI. Please let us know which current FI you want to continue to work with so we can help with the transition process. Or, if you prefer, you can select an entirely different FI from the attached list.

Within 60 days of the date on this letter you need to let us know your choice of FI by contacting Click here to enter name, email, telephone, TTY**.**

Once you have told us which FI you picked, you also need to do the following within 15 days after that:

- ☐ Provide your affected personal assistants the name and contact information of the FI you picked.
- ☐ Tell your affected personal assistants they will need to provide Attachment 2, Consent to Transfer Necessary Personal Assistant Medical Documentation, to their current FI to transfer their health status records to the FI you picked.
- ☐ Tell your affected personal assistants they may need to have new employment forms (I-9, W-4, IT-2104) completed by you or the new single FI.
- ☐ Give permission (consent) to the FI(s) not picked to release and move your service authorization records to the single FI. You can use Attachment 3, Consent to Transfer Consumer Service Authorization Records, to have your records moved.

FIs should be able to transfer records within five (5) business days of receiving written consent.

TEMPLATE 1

We will work closely with you to move your affected personal assistants to the one FI you picked. If you have any questions concerning this letter, please contact Click here to enter name, email, telephone, TTY.

Sincerely,

Click here to enter LDSS/MCO name

Attachments

1. List of FIs and their contact information
2. Consent to Transfer Necessary Personal Assistant Medical Documentation
3. Consent to Transfer Consumer Service Authorization Records

TEMPLATE 2

Click here to enter date

Click here to enter LDSS/MCO name
Click here to enter LDSS/MCO street address
Click here to enter LDSS/MCO city, state zip

Dear Click here to enter Consumer's name,

Dear Click here to enter Consumer's name,

On Click here to enter date we sent a letter to tell you about a change to the Consumer Directed Personal Assistance Program (CDPAP). After November 8, 2021 all CDPAP consumers may only work with one (1) fiscal intermediary (FI) at a time. In the letter, we asked you to pick a single FI within 60 days.

Click here to enter LDSS/MCO name records show you did not respond to the letter and are still using more than one FI. Since you did not pick a single FI to continue working with, Click here to enter LDSS/MCO name has picked one for you.

The single FI that will continue to pay your personal assistants and provide FI services to you is Click here to enter FI name.

This change will go into effect on Click here to enter date. If you want to pick a different FI, please contact us **as soon as possible** to avoid any disruption to your services. You can contact us at Click here to enter name, email, telephone, TTY.

To make sure there is no delay with your personal assistants being paid, it is important that you do the following:

- ☐ Provide your affected personal assistants the name and contact information of the single FI.
- ☐ Tell your affected personal assistants they will need to provide Attachment 2, Consent to Transfer Necessary Personal Assistant Medical Documentation, to their current FI to transfer their health status records to the new single FI.
- ☐ Tell your affected personal assistants they may need to have new employment forms (I-9, W-4, IT-2104) completed by you or the new single FI.
- ☐ Give permission (consent) to the FI(s) not picked to release and move your service authorization records to the single FI. You can use Attachment 3, Consent to Transfer Consumer Service Authorization Records, to have your records moved.

TEMPLATE 2

FIs should be able to transfer records within five (5) business days of receiving written consent.

We will work closely with you to move your affected PA(s) to the single FI.

If you have any questions concerning this letter, please contact Click here to enter name, email, telephone, TTY.

Sincerely,

Click here to enter LDSS/MCO name

Attachments

1. List of FIs and their contact information
2. Consent to Transfer Necessary Personal Assistant Medical Documentation
3. Consent to Transfer Consumer Service Authorization Records