GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11-14

Officer of the Director

TO: **Home Health Agencies Enrolled in the District of Columbia Medicaid Program**

FROM: **Linda Elam, PhD, MPH**
Deputy Director, Medicaid

DATE: **June 14, 2011**

SUBJECT: **Effective July 1, 2011: Inter-Agency Transfer Form for Medicaid Personal Care Aide (PCA) State Plan Services**

As part of the Personal Care Aide (PCA) benefit provided by the District of Columbia (DC) Medicaid program, the Department of Health Care Finance (DHCF) is committed to working with providers to ensure a smooth transition of services whenever a Medicaid beneficiary requests to be transferred to another home health agency (HHA). When a transfer is requested by a beneficiary, the home health provider agency must respect the beneficiary's choice and facilitate the transfer to another home health provider agency.

DC Municipal Regulations (DCMR) for the Medicaid program in section 5002.10 of Title 29, requires that:

"If the patient seeks to change providers, the Provider shall assist the patient in selecting a new provider and cannot abandon the patient until the transfer has been successfully completed."

This transmittal establishes policies and procedures for the transfer of services from one home health provider agency to another home health provider agency.

Discharging HHA Responsibilities

The provider agency must begin to coordinate the inter-agency transfer process within forty-eight (48) hours of notification by the beneficiary of his/her desire to transfer.

The discharging home health provider agency must complete the following two documents:

1. A Discharge Summary form; and
2. An Inter-Agency Transfer form (Attached).

The Discharge Summary form is agency-specific (i.e. created by the home health provider agency). It provides a summary of the beneficiary's health status and needs for skilled nursing, home health aide, and/or personal care aide services.

The Inter-Agency Transfer form must include details about the duration (i.e. hours) and frequency (i.e. number of days per week) of PCA services the discharging home health provider agency has been providing to the beneficiary, as well as the total number of hours of PCA services provided to the beneficiary on the last date of service.

The discharging home health provider agency must also provide a copy of the physician's or nurse practitioner's order for services to the receiving home health provider agency. This form verifies that a physician or a nurse practitioner ordered the PCA services.

Receiving HHA Responsibilities

The receiving home health provider agency may only conduct the initial assessment after receiving a completed Discharge Summary Form, completed Inter-Agency Transfer Form and a copy of the physician's or nurse practitioner's order for services from the discharging home health provider agency. The receiving home health provider agency must sign the Inter-Agency Transfer Form and send a copy of it to the discharging home health provider agency **within twenty-four (24) hours of its receipt** to confirm acceptance of the new case.

If the PCA services to be provided by the receiving agency will be in excess of 1,040 hours of service to the beneficiary for the present calendar year, the receiving home health provider agency **must** request an authorization from DHCF prior to delivering any PCA services and in order to be paid for PCA services. These requests must be submitted through the web portal (**www.dc-medicaid.com**). A **complete** request for prior authorization of extended PCA services includes the following forms:

- Request for Extended State Plan Personal Care Aide (PCA) Services;
- Plan of Care;
- Inter-Agency Transfer Form; and
- A copy of the Prescription Form For Medicaid Personal Care Aide Services (applicable for beneficiaries first seen by the HHA after June 30, 2011)

Coordination between Discharging and Receiving Agency

The discharging home health provider agency and the receiving home health provider agency are responsible for coordinating the submission of all paperwork necessary to complete an inter-agency transfer. **Provider agencies must work together to transfer services in a timely manner and to prevent any gap in service. All aspects of the transfer, including the last and first day of services, must be coordinated between and mutually agreed upon by the two agencies. Both agencies must sign the Inter-Agency Transfer Form attesting to their agreement to the transfer.**

For questions about this policy, please contact Pamela Hodge, Management Analyst, at pamela.hodge@dc.gov or (202) 724-4282 or Program Specialist, Celestine Lara at celestine.lara@dc.gov or (202) 442-5912, both in DHCF's Division of Long-Term Care.

Attachment:
Medicaid State Plan Personal Care Aide (PCA) Services Inter-Agency Transfer Form

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE
DIVISION OF LONG-TERM CARE

Medicaid State Plan Personal Care Aide (PCA) Services
Inter-Agency Transfer Form

Please print clearly and be sure to complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Name of Medicaid Beneficiary: _____

Address: _____

Phone: (____) ____-_____ Date of Birth: ____/____/_____

Medicaid ID: _____

Name of Discharging Home Health Agency: _____

Last day PCA services will be provided: ____/____/_____

Number of PCA hours beneficiary receives per day: _____

Number of days per week PCA services provided: _____

As of ____/____/_____, the total number of hours of Medicaid state plan PCA services provided during
Date of Discharge
the current calendar year will be _____ hours.
List # PCA Hours Received

Reason for Transfer: _____

_____

Name of Receiving Home Health Agency: _____

Receiving agency start-of-care date: ____/____/_____

All aspects of the transfer, including last and first date of services, should be coordinated between and mutually agreed upon by the discharging and receiving agencies.

Discharging Home Health Agency:
Name of Director of Nursing or Designee (please print): _____

Director of Nursing or Designee Signature: _____

Date: ____/____/_____

Receiving Home Health Agency:
Name of Director of Nursing or Designee (please print): _____

Director of Nursing or Designee Signature: _____

Date: ____/____/_____