

## **OPWDD Guidance Documents with Payment Standards**

This guidance document contains payment standards, with all payment standards shaded in grey. Any requirement in this guidance document which is not shaded in grey is a program standard or an explanation, illumination or illustration to aid auditors in interpreting the documents. Please note that there may be instances where materials may be partially shaded in a sentence, paragraph or beneath a header. It is OPWDD's intent that only those words that are shaded shall be considered part of a payment standard and any other words within a sentence or paragraph or below a header that are not shaded should be construed to be a program standard or an explanation, illumination or illustration to aid auditors in interpreting the document.

## CHAPTER 2

## THE MSC SERVICE COORDINATOR

### CHAPTER INTRODUCTION

This Chapter of the manual presents an overview of the qualifications, training requirements, and the roles and responsibilities of the MSC service coordinator. In this Chapter, we will examine the service coordinator's activities, many of which directly relate to the creation and maintenance of the service coordination documents in the individual's Service Coordination Record (Chapter Four).

### CASELOAD REQUIREMENTS

For service coordinators **who do not serve members of the Willowbrook** class, the **maximum** caseload for an MSC service coordinator is 30 people. There is, however, a weighting factor of 1.2 for people who live with family, or in a non-certified setting with others or alone.

- When all the people on a service coordinator's caseload live in certified residences the maximum number of people that can be served is 30.
- When all the people on a service coordinator's caseload live with family, or in a non-certified setting with others or alone, the maximum number of people who can be served is 25 ( $25 \times 1.2 = 30$ ).
- When a service coordinator's caseload is "mixed" (i.e., some individuals living in certified residences and some living with family, or residing in a non-certified setting with others or alone), the maximum number of people that can be served falls between 25 and 30.

For example, a service coordinator provides MSC for 10 people who live with family or in a non-certified setting with others or alone. These 10 people are counted as "12" ( $1.2 \times 10 = 12$ ). This service coordinator can serve no more than 18 additional individuals living in a certified residential setting in addition to the 10 people who live with family or in a non-certified setting with others or alone. Thus the service coordinator will serve 28 people ( $10 + 18$ ), but the caseload will be weighted at 30 ( $12 + 18$ ).

- Staff who are **not** working full time should have their caseload size adjusted proportionately, e.g., a staff person who works half time should have no more than half the maximum caseload size (for a service coordinator who works half time, the maximum caseload would be 15 if all individuals on the service coordinator's caseload live in a certified residential setting).
- **When an MSC service coordinator serves even one member of the Willowbrook class, his or her maximum workload is 20 units. See text box for additional information on calculating the Willowbrook workload.**

When calculating Willowbrook workload, the following rules apply:

- OMRDD is obligated to provide service coordination at the equivalent of 1:20 for class members.
- A staff person who works as a full-time service coordinator can carry 20 work units. Staff can be full-time employees, but work only part-time as a service coordinator. In such instances, work units are adjusted appropriately. For example, a staff person working half-time as a service coordinator may carry 10 work units; a staff person working quarter-time may carry 5 work units.
- Individuals living in VOICFs, though not MSC eligible, count as .5 work unit, with the understanding that matching case management services are provided within the residence. People living in any residential setting other than a VOICF are considered to be one work unit. This includes those living in IRAs, SOICFs, community residences, Family Care, and in uncertified settings.
- The MSC weighing factor of 1.2 for people who live with family or in a non-certified setting with others or alone does NOT apply when calculating Willowbrook workload.
- Each person receiving Plan of Care Support Services, whether or not the person is a class member, counts as (1) one work unit.

#### CONFLICT OF INTEREST

To avoid a potential conflict of interest and to promote the independence of the service coordinator, staff providing direct services to a person cannot also serve as that person's MSC service coordinator. This includes residence managers, clinicians (e.g., psychologists, nurses), habilitation specialists, Family Care home liaisons and direct support staff.



## Policy & Enterprise Solutions

Gary Lind, Deputy Commissioner

44 Holland Avenue  
Albany, NY 12229-0001

TEL: 518-473-9697  
FAX: 518-473-0054  
TTY: 866-933-4889

omr.state.ny.us

### MEMORANDUM

To: DDSO Directors

From: Gary Lind 

Subject: MSC Contract – Letter of Agreement to temporarily increase caseload size

Date: May 17, 2010

**Background:**

The attached information outlines implementation directions to effectuate a temporary optional increase to the Medicaid Service Coordination (MSC) caseload size for voluntary MSC vendors and DDSOs. This is based on discussion with providers and others concerning the anticipated reductions to MSC vendor revenue beginning October 1, 2010.

During this interim period, while OMRDD works through MSC redesign changes that will take effect after October 2010, MSC vendors will have the option of a **temporary** increase to the MSC caseload requirements. This will enable MSC vendors to more effectively manage their service coordination workforce and attrition during this period until the details and related implications of the MSC redesign are known on a provider specific level.

The optional increase to caseload size will also be available to DDSOs at their discretion under certain circumstances as outlined below.

**Implementation of Temporary Caseload Increase for Voluntary MSC Vendors:**

Attached to this memorandum is a copy of the MSC Letter of Agreement which will amend the current MSC Vendor Contract to increase the caseload size when fully signed and executed.

The Letter of Agreement once signed by both the DDSO and the vendor, will temporarily increase the MSC caseload requirements to one service coordinator to no more than 40 units (1:40) on an interim basis until the MSC program redesign goes into effect on October 1, 2010 with the new requirements. Our expectation is that the optional increase in caseload size will be used when there is natural attrition. MSC vendors are still obligated to deliver the quality of the service within the existing program model and to adhere to all other requirements in the MSC Vendor Manual and Vendor Agreement.

Two copies of the Letter of Agreement must be sent (by mail or e-mail) to each MSC vendor in your DDSO's catchment area. The Letter of Agreement must be signed by all MSC vendors in your district who wish to temporarily increase their MSC caseload sizes and returned to you by June 30, 2010.

**Implementation of Temporary Caseload Increase for MSC Provided by DDSO Staff:**

The optional temporary increase in the caseload size for MSC provided by DDSO staff is available at the discretion of each DDSO Director in order to manage the service coordination workforce and attrition in each individual district. It is OMRDD's expectation that DDSOs will judiciously utilize the increase in caseload size only when necessary to address the attrition of service coordinators and not to manage/balance workforce issues in other areas of the DDSO.

**Caseload Size Change Applicable to Voluntary MSC Vendors and MSC Provided by DDSOs**

- Effective June 1, 2010, the MSC caseload requirement is now one service coordinator to no more than 40 units (1:40) (MSC vendors must have a fully executed Letter of Agreement prior to June 30, 2010).

The following caseload weighting provisions remain unchanged:

- Individuals living with family, with others in an uncertified setting, or alone in an uncertified setting have a weight of 1.2
- Individuals living in Supportive Community Residences (CRs) or in Supportive Individualized Residential Alternatives (IRAs) and in Family Care (FC) homes have a weight of 1
- Individuals living in Supervised CRs and Supervised IRAs have a weight of .85
- Exception: Consistent with Willowbrook court-ordered requirements, a service coordinator who serves at least one or more Willowbrook class members can have a caseload of no more than 20 individuals (1:20) ratio, regardless of where the individuals live. The .85 and 1.2 work standards do not apply when calculating Willowbrook compliance; court-ordered work standards include 1 work unit for individuals in any non-VOICF setting, i.e., VOIRA, SOIRA, SOICF, FC, nursing home, independent living, etc. and .5 work unit ONLY for individuals living in VOICFs with the understanding that matching case management is provided within the residence.

The caseload requirements cited above supersede the caseload requirements detailed in the MSC Vendor Manual and/or any other references to caseload size pertaining to the MSC program. It is the responsibility of the MSC vendor and the DDSO (for MSC provided by DDSO staff) to produce the Letter of Agreement upon audit/program review.

Please contact Carol Kriss, of my staff, if you should have any questions regarding this process. Carol may be reached at by phone at (518) 474-5647, or e-mail: [carol.kriss@omr.state.ny.us](mailto:carol.kriss@omr.state.ny.us).

Thank you.

**Attachment**

cc: Jill Gentile  
Jim Whitehead  
Jim Moran  
Sheila McBain  
Maryellen Moeser  
Carol Kriss

## REQUIRED EXPERIENCE, EDUCATION, AND TRAINING

MSC service coordinators must meet **all** of the following minimum educational, experiential, and training requirements:

### Minimum Educational Level

Associate's degree in a health or human service field, or an RN,

(Please note that a candidate for a bachelor's degree may meet this educational requirement by providing a letter from his or her college verifying that the candidate has completed course work equivalent to an Associate's degree both in total number of credits received and number of credits earned in a health or human service field.)

### Minimum Experiential Level

One year experience working with people with a developmental disability, or

One year experience as a service coordinator with any population.

(Please note: The minimum experiential level requirement does not have to be met if the person has a master's degree in a health or human service field.)

Documentation that the service coordinator meets the minimum educational and experiential requirements must be retained for OMRDD review.

### Minimum Training Level

Attendance at an OMRDD-approved Core service coordination training program within three months of assuming MSC responsibilities, unless the person can produce a certificate verifying past attendance at a Core training.

A copy of the service coordinator's Core certificate must be kept on file and be available for OMRDD review.



- Name of the person's advocate or statement that the person is self-advocating

## SECTION 2 - WRITTEN EVALUATIONS



This section of the Service Coordination Record contains written, professional evaluations regarding the person.

- Clinical assessments and recommendations, service provider reports, and medical information
- The ICF/MR final summary and post discharge plan for people enrolled in the HCBS Waiver who moved directly from an ICF/MR to Waiver enrollment
- Other service plans for non-HCBS Waiver services (e.g., day treatment plans)

## SECTION 3 THE INDIVIDUALIZED SERVICE PLAN WITH ATTACHMENTS



The Basic Agreement portion of the Service Coordination Agreement does not have to be attached to the ISP. A copy of the Basic Agreement should be given to the person, family/advocate, and a copy should be placed in the first section of the Service Coordination Record.

This section of the Service Coordination Record contains the Individualized Service Plan (ISP) with appropriate attachments. The attachments include:

- For Waiver enrollees, Waiver habilitation plans (IRA and CR residential habilitation, day habilitation, pre-vocational, and supported employment plans)
- The Individual Plan for Protective Oversight if the person lives in an IRA
- Service Coordination Activity Plan.

## CONTENTS OF THE ISP

The ISP is a personal plan written by the MSC service coordinator. It describes the person, identifies the person's valued outcomes and aspirations, and details the supports and services to achieve them. The ISP should also identify any significant conditions, needs, or problem areas (e.g., medical or behavioral) that may impede the person's attainment of his or her valued outcomes. It communicates information and expectations and clearly establishes service provider accountability. The ISP is used to coordinate services and supports in order to prevent

duplication of services. The ISP documents the person's choice of activities, supports, services, and providers. It identifies the funding source for all services including those funded through the HCBS Waiver.

For all funded services and supports, (i.e., Medicaid State Plan Services, federal, state and county funded resources, HCBS Waiver services and other services, including 100% OMRDD funded services), the ISP must document the:

- **Name of Provider or Agency** (e.g., Southern DDSO, York County ARC, Wells Day Treatment Program)
- **Type of provider or type of service** (e.g., physician, educational service, MSC)
- **Person's valued outcome or reason for receiving the support or service**
- **Frequency of the support or service.** How often (e.g., weekly, monthly, as needed). The frequency of an HCBS Waiver service must correspond to the unit of service. For example, the unit of service for waiver supported employment is monthly, therefore, the frequency of service should be listed as monthly on the ISP.
- **Duration of the support or service.** For how long (e.g., one year, on-going).
- **Effective date.** This is the date the current provider began providing the service. A service provider's (e.g., IRA Res Hab provider) billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP.

**HCBS Waiver services are not eligible for payment unless the Name of the Provider, Type of Service, Frequency, Duration, and Service Effective Date are accurately described in the ISP.**

The ISP must include safeguards needed by the person to keep the person safe from harm and actions to be taken should the health or safety of the person be at risk. These safeguards are individualized and specific to the person. Fire safety at home is a required safeguard that **must** be discussed and included in the person's ISP.

## COORDINATION OF THE ISP WITH THE ATTACHED HABILITATION PLANS



**The ISP, which is written by the service coordinator, identifies all supports and services the individual receives.** If the individual is enrolled in the HCBS Waiver, his or her ISP must have all Waiver habilitation plans attached for any IRA or CR residential habilitation, Waiver day habilitation, prevocational or supported employment habilitation services that he or she receives.

**The waiver habilitation provider writes the habilitation plan.** The plan describes the habilitation activities that will be put in place to pursue the valued outcomes as described in the person's ISP. **The ISP's description of the Waiver service (i.e., the Name of Provider, Type of Service, Frequency, Duration and Effective Date) must be consistent with the description of the service in the habilitation plan.**

The service coordinator and habilitation provider should carefully review each habilitation plan to be certain that the ISP corresponds with details of the habilitation plan and the actual provision of the waiver service. The waiver provider's billing will be jeopardized if the ISP does not accurately reflect waiver service provision (Name of Provider, Frequency, Duration and Effective Date). For example, the Waiver provider's billing for day habilitation will be in jeopardy if day habilitation began on June 1, 2002 and the ISP indicates an effective date of July 1, 2002.

## THE ISP: TIMEFRAME FOR COMPLETING THE INITIAL ISP



An ISP is required for all people enrolled in MSC or the HCBS Waiver. The ISP must be completed within 60 days of the HCBS enrollment date or within 60 days of the MSC enrollment date, whichever is earlier.

## ISP DISTRIBUTION REQUIREMENTS



The service coordinator distributes the ISP, with attachments, to the:

- Consumer

any revised habilitation plans to the consumer, advocate and major service providers.

If the 45-day time frame cannot be met because of delays in obtaining the necessary signatures, the service coordinator can send copies of the ISP to all parties without signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the consumer's Service Coordination Record.

When the ISP review is **not a face-to-face meeting**, the service coordinator must inform the Waiver habilitation staff of the "official" six-month review date, since the service coordinator must receive any revised habilitation plan within 30 days of that ISP review date. Both the service coordinator and the habilitation provider should document the six-month review date in their respective monthly notes.

The service coordinator has 45 days from the official six-month review date to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate and major service providers.

If the 45-day time frame cannot be met because of delays in obtaining the necessary signatures, the MSC service coordinator can send copies of the ISP to all parties without signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's Service Coordination Record.

## THE SERVICE COORDINATION AGREEMENT

All people enrolled in MSC must have a signed, written **Service Coordination Agreement** (both sections – the Basic Agreement **MSC5-SCA**, and the Activity Plan **MSC5-SCA Plan**) (Appendix One).

The Basic Agreement describes the responsibilities of the MSC service coordinator, the MSC vendor and the person receiving MSC. **The Basic Agreement does not have to be attached to the ISP.** A copy of the Basic Agreement should be given to the person or family/advocate, and a copy must be placed in Section 1 of the person's Service Coordination Record.

The Activity Plan describes the short-term service coordination

**clinical practice** and the agency's **monthly billing** for the service.

Since the service coordinator's notes are audited based on a monthly unit of service, specific elements must be included in the notes recorded during any given calendar month. A description of these required elements follows.

## CONTENTS OF THE SERVICE COORDINATION NOTES

Service Coordinators are encouraged to document the results of meetings and services **as soon as possible** after the activity or meeting has occurred. However, the monthly face-to-face service meeting must be documented contemporaneously.



Service coordination notes record MSC services and activities provided by the service coordinator, including the monthly face-to-face service meetings and other contacts with or made on behalf of the individual.

The service coordination notes must also track relevant information about the person's life in order to allow the service coordinator to maintain a written record of major events, changes, issues, and progress, and thereby provide person centered services. Though the content of the notes may vary depending on each person's ISP and personal situation, the notes must contain the same minimum elements. **These minimum elements subject to review by OMRDD, other state agencies, and federal reviewers are:**

- The person's name.
- A specific notation documenting the required monthly face-to-face service meeting. **In accordance with federal and Medicaid requirements, this notation must be made contemporaneously with the monthly face-to-face service meeting.** This notation must include the name of the individual, the date of the face-to-face service meeting and the location of the meeting (e.g., in the person's home, day program or community location). **This notation must be signed and dated by the service coordinator and must include the service coordinator's title.** This notation can also serve as the documentation of the required quarterly in-home visit.
- The date(s) and a brief description of the service coordination activities provided during the month by the service coordinator. (Services are to be individualized based on the person's ISP)
- Information about the person's satisfaction/dissatisfaction with

the supports and services in his or her ISP. Any follow-up activities taken by the service coordinator to address any concerns that the person may have about his or her supports and services must also be noted.

- Significant changes or events in the person's life. This might include changes in valued outcomes, employment, home, personal relationships, health, and other person centered information. **If no changes or events occurred during the month, then this must be noted.**
- Any concerns regarding the health and safety of the person and person's environment and actions taken by the service coordinator to correct the situations. **If there were no concerns about the person's health or safety during the month, then this must be noted.**
- At least every six months, a written statement that the ISP and the Service Coordination Agreement were reviewed, even if no updates were necessary.
- Documentation to substantiate any transitional payments (Chapter Six).
- The service coordinator's name, signature, title, and the date the note was written.

It is important for service coordinators to understand that they may comply with the requirement for service coordination notes, other than the contemporaneously documented monthly face-to-face service meeting, using either of two methods:

One method is to create a "monthly summary" based on the informal notes that a service coordinator may keep in the process of delivering services to a person. Such a monthly summary must contain all the required elements noted above.

A second method is for the service coordinator to maintain **legible ongoing notes** during the normal course of delivering services, as is typical of good clinical practice. At the end of each calendar month, these notes should be reviewed to see if they contain all the required elements identified above. So long as they are legible and make reference to each of the required areas of content, such ongoing notes are sufficient to meet the standard. There is no requirement to do a separate monthly summary.

Irrespective of the method used, the service coordinator must

**contemporaneously document the monthly face-to-face service meeting** (See Page 12 for details). Documentation of the required monthly face-to-face service meeting may be maintained on a **separate meeting log**, as long as such a log is kept in the Service Coordination Note section of the Service Coordination Record.

#### TIMEFRAME FOR COMPLETING THE ELEMENTS OF THE SERVICE COORDINATION NOTE



**Service coordination notes** containing all the elements specified above must be completed **by the fifteenth of the month following the month of service**. The service coordinator must, however, make a contemporaneous notation of the required monthly face-to-face service meeting.

#### DOCUMENT RETENTION AND REVIEW



The notes must be retained in the person's Service Coordination Record for Division of Quality Assurance Review. Service Coordination notes are required as "back-up" for the MSC vendor's monthly billing. Service coordination notes are subject to review by OMRDD, other state review entities and the federal government. Note that auditors may examine vendor MSC claims made for six years prior to the audit.

## CHAPTER 5

# FACE-TO-FACE SERVICE MEETINGS & THE SERVICE COORDINATION OBSERVATION REPORT

### CHAPTER INTRODUCTION

This chapter discusses face-to-face service meetings, and the Service Coordination Observation Report (MSC7-SCOR).



MSC services are reimbursed as a monthly unit of service. A vendor's monthly billing must be substantiated by contemporaneous documentation of a face-to-face service meeting with the person. If a person is away (e.g., on vacation and no face-to-face service meeting takes place) the MSC vendor cannot bill for MSC for those months. Documentation of the monthly face-to-face service meeting is subject to review by OMRDD, other state agencies and federal reviewers.

### FACE-TO-FACE SERVICE MEETINGS



A service coordinator must conduct at least one face-to-face service meeting with every person on his or her caseload during **each calendar month**. The monthly face-to-face service meeting:

- Enhances the development of the relationship between the service coordinator and the person.
- Enables the service coordinator and the person, family, and others to discuss various aspects of the person's ISP, such as: Is the person satisfied with the quality, frequency, and types of services being received? Are there any changes the person wants made to his or her plan?
- Acts as a quality check. The service coordinator has the opportunity to observe the person and his or her home environment to identify potential health and safety problems.

The results of the monthly face-to-face service meeting(s) with the consumer must be contemporaneously documented as part of the **service coordination notes** (Chapter Four). These notes provide the required backup for the MSC vendor's monthly billing. The agreed upon frequency of face-to-face service meetings

**Limited Changes to MSC for  
Supervised Individualized Residential Alternatives  
And Supervised Community Residences ONLY  
Effective October 1, 2009**

- Effective October 1, 2009, OMRDD amended the reimbursement level for Medicaid Service Coordination (MSC) for individuals residing in Supervised Individual Residential Alternatives (IRAs) to be consistent with those who reside in Supervised Community Residences (CRs). This change is effective as of the October 2009 service month (billing date of service 11/1/09). The revised billing chart is in Appendix One of this manual.
- As part of this cost savings effort, effective October 1, 2009, OMRDD implemented the following changes to the MSC program for individuals residing in Supervised IRAs and Supervised CRs to maintain quality and provide mandate relief by streamlining some requirements.

Note: MSC for Willowbrook Class members is not affected by any of the changes presented in this document. All current requirements for service coordination/case management to members of the Willowbrook class, whatever their living arrangement, will continue to be met.

**Limited Changes**

The following changes are not intended to alter the purpose of Medicaid Service Coordination (MSC). The following components continue to be the Key elements of MSC: assessment; development of a specific care plan; referral and related activities to help an individual obtain needed services; monitoring and follow up activities.

The following changes to MSC for Individuals Residing in Supervised IRAs and Supervised CRs that affect language in the Preface, Chapters Two, Four and Five of this manual, are:

- **The Required Face-to-face Service Meeting; Monitoring and Follow-up:  
(Chapters Four, Five)**
  - As of October 1, 2009, the requirement of a monthly face-to-face meeting is reduced to a bi-monthly (occurring every two months) face-to-face service meeting with the individual unless the person's health, safety and/or needs indicate the necessity for a monthly face-to-face service meeting. All requirements for the monthly face-to-face service meeting remain the same.
  - During the months when there is not a face-to-face contact with the individual, the service coordinator continues to perform monitoring and follow-up activities. These include direct contact with the person or with other qualified parties and additional communication by phone, e-mail, letter, in meetings, etc for purposes that are consistent with service coordination. These activities, if appropriately documented, are considered allowable activities to justify billing for MSC. For specifics, see insert before Chapter 6 of this manual.
- **Home Visit and SCOR Report:  
(Chapter Five)**
  - The requirement for home visits is reduced to one visit in every four month period, i.e., a minimum of three home visits annually, unless otherwise determined by the person and service coordinator or more frequent visits are required or requested.
  - The Service Coordination Observation Record (SCOR) is completed only when there is an issue to report. The monthly MSC notes must include documentation that the home visit occurred in the month and that there were no SCOR-reportable issues observed.

Medicaid Service Coordination  
 Billing Changes  
 Effective October 1, 2009  
 (Billing Date of Service 11/1/2009)

Service Month September 2009 and Prior				Service Month October 2009 and After			
Level of Service (LOS)	Rate Code	Locator Code	Payment Level for Individuals living in -	Level of Service (LOS)	Rate Code	Locator Code	Payment level for Individuals living in -
Basic	5211	03	Supervised CRs	Basic	5211	03	Supervised CRs and <b>Supervised IRAs</b>
Intermediate	5212	03	Supportive CRs, Supportive IRAs and <b>Supervised IRAs</b>	Intermediate	5212	03	Supportive CRs and Supportive IRAs
Transition * – Basic	5211	04	Supervised CRs	Transition * – Basic	5211	04	Supervised CRs and <b>Supervised IRAs</b>
Transition * – Intermediate	5212	04	Supportive CRs, Supportive IRAs and <b>Supervised IRAs</b>	Transition * – Intermediate	5212	04	Supportive CRs and Supportive IRAs

The chart above does not apply to Willowbrook individuals.

\* Transition billing is limited to two months in accordance with the MSC Vendor Manual.

Examples of Transition Billing and the October 2009 Change:

For individuals who move into a Supervised IRA during **August 2009**, the Service Months of September 2009 and October 2009 may be billed at the Transition Level. For September 2009, billed date 10/1/2009, Transition-Intermediate would be billed. For October 2009, billed date 11/1/2009, Transition-Basic would be billed.

For individuals new to MSC in **September 2009**, or who are receiving Adult Services for the first time in **September 2009**, and who reside in a Supervised IRA, the Service Months of September 2009 and October 2009 may be billed at the Transition Level. For September 2009, billed date 10/1/2009, Transition-Intermediate would be billed. For October 2009, billed date 11/1/2009, Transition-Basic would be billed.

**Change to the MSC Minimum Billing Standard for  
Supervised Individualized Residential Alternatives and  
Supervised Community Residences ONLY  
Effective October 1, 2009**

Effective October 1, 2009, OMRDD implemented the following change to the minimum billing standard for the Medicaid Service Coordination (MSC) program. This change applies only to individuals residing in Supervised IRAs and Supervised CRs who are not Willowbrook Class members. The current MSC documentation and billing standards (as outlined in the MSC Vendor Manual, Chapters Four and Five) remain in effect for individuals residing in all other residential settings and for Willowbrook class members. This change does not alter the overall responsibilities of MSC vendors and service coordinators. Service coordinators remain accountable for all of their current responsibilities in accordance with the MSC Vendor Manual.

**Change to the Minimum Billing Standard for MSC  
(Chapter Five)**

Effective with the October 2009 service month (billing date of service 11/1/09), OMRDD will allow a provider to bill for a calendar month of MSC services for individuals residing in supervised settings during a month when a face-to-face service meeting does not occur if the following conditions are met:

- The MSC has direct contact with the person or a qualified contact;  
AND
- MSC activities were delivered and documented during the month in accordance with the MSC Vendor Manual and the guidance in this document;  
AND
- A face-to-face service meeting is conducted during the previous month.

***Example:*** If the service coordinator has a face-to-face service meeting with the individual during the calendar month of October 2009, the service coordinator and individual may opt to forego the face-to-face service meeting for November 2009.\* In December 2009, there must be a face-to-face service to meet the billing standard.

***\*Important Note:*** *The decision to forego a face-to-face service must be a mutual decision agreed upon by the service coordinator and the individual and/or others as necessary. This decision must be based on the individual's needs and the service coordinator's knowledge of the health and safety of the individual and documented in the service coordination notes on a monthly basis.*

## **Required Documentation to Substantiate Billing (Chapter Four and Five)**

All requirements for monthly contact remain in place.

- During a month when a face-to-face meeting does occur, the MSC monthly notes that are used to substantiate billing must clearly include a **contemporaneous note**. This notation must include the name of the individual, the date of the face-to-face meeting and the location of the meeting (e.g. in the person's home, day program or community location). It must be signed and dated by the service coordinator and include the service coordinator's title.
- During a month when a face-to-face meeting does not occur, the MSC monthly notes that are used to substantiate billing must clearly include a **contemporaneous note** documenting the contact with the person and/or other qualified individuals. All contemporaneous notes must include the date of the contact, the full name of the person who was contacted, the relationship to the individual (e.g., Residence Manager, parent, Day Habilitation provider, teacher), and a summary of the purpose for the contact and any follow up actions or outcomes as appropriate. As with all monthly notes, It must be signed and dated by the service coordinator and include the service coordinator's title.

The MSC monthly notes must include all the minimum elements outlined in Chapter Four of the MSC Vendor Manual.

### **Qualified Contacts**

Contacts used to substantiate billing must be directly related to services listed in the individual's ISP and/or for monitoring and follow-up purposes including: identifying the individual's needs and care; helping the individual access services; identifying needs and supports to assist the individual in obtaining and maintaining services; obtaining useful feedback; and obtaining information on changes in the individual's needs.

**This change in the minimum billing standard for individuals residing in Supervised IRAs and Supervised CRs does not alter any other documentation and billing standards or policy guidelines that are in effect and applicable to MSC including the established rules for billing for MSC services when an individual is hospitalized.**

**This document serves as the official notice of this change and has the force and effect of the MSC Vendor Manual.**

**Copies of the revised Basic Agreement (MSC 5-SCBA), a new Basic Agreement (MSC 5-SUPR-SCBA), and the revised SCOR with revised instructions are in the appendix of this manual.**

For questions or further information, please contact Carol Kriss, MSC Statewide Coordinator at [Carol.Kriss@omr.state.ny.us](mailto:Carol.Kriss@omr.state.ny.us) or (518) 474-5647.

MSC vendors operating in New York City have one contract for all MSC services provided with New York City DDSOs. The MSC vendor is authorized to only bill MMIS for the people authorized by each New York City DDSO with which the MSC vendor subcontracts. There will be a unique **vendor opportunity level** established by each New York City DDSO with which the MSC vendor is a subcontractor. NYCRO will manage the MSC contract process and each New York City DDSO will manage the consumer enrollment in TABS for the individuals living in its catchment area.

**Consumer Registration in TABS**

The DDSO registers all MSC consumers in TABS with their MSC vendor. Individuals served by State service coordinators (i.e., DDSO staff) are registered in TABS with the appropriate DDSO.

The Medicaid billing system, MMIS, only pays a vendor for a person’s MSC services if the consumer is registered with that vendor in TABS. Procedures for MSC consumer enrollment are discussed in Chapter Seven. Billing procedures are described in Chapter Twelve.

**MSC CONTRACT PAYMENT STRUCTURE**

MSC has a monthly unit of service and the contract payment level to the vendor is based on the type of residential setting in which the person lives. There is a higher payment level for service coordination provided to Willowbrook class members. There are four levels of payment:

<u>Payment Level</u>	<u>Person’s Living Arrangement</u>
Basic	Supervised Community Residences (CRs)
Intermediate	All Individualized Residential Alternatives (IRAs) & Supportive CRs
Enhanced	Living with family, in Family Care or in a non-certified setting with Others or Alone
Willowbrook	All Willowbrook Class members eligible for MSC, regardless of living arrangement

## TRANSITION PAYMENTS

An MSC vendor is also eligible to receive a special, higher level of payment for the provision of MSC to people "in transition" (Chapter Twelve). In recognition of the additional service coordination workload, the vendor may bill the transition payment level (in lieu of the regular monthly payment levels) for two months **following the person's move to a more independent residential environment, from his or her family home to a certified residential setting, or to a new service environment.** A person will be considered to be "in transition" when one of the following is true:

- The person is new to service coordination, that is, the individual has never received any type of OMRDD Medicaid service coordination (i.e., CMCM, HCBS Waiver Service Coordination or Medicaid Service Coordination (MSC))--(bill at the transition level for the first two months of MSC service delivery).
- The person moves from an ICF to an IRA, Community Residence or Family Care home (bill at the transition level for the first two months **following** the person's move to the IRA, CR, or Family Care home).
- The person moves from a Family Care Home, Supervised CR or IRA with 24 hour staffing to a Supportive CR or an IRA with less than 24 hour staffing (bill at the transition level for the first two months **following** the person's move to the Supportive CR or IRA with less than 24 hour staffing).
- The person moves from an OMRDD-certified residence or his or her family home to an independent living situation (bill at the transition level for the first two months **following** the person's move to an independent setting).
- The person moves from his or her family home to a certified residential setting (bill at the transition level for the first two months **following** the move to the certified residence).
- The person transitions out of school and begins receiving adult services (bill at the transition level for the first two months the person receives adult services).

The transition payment is double the “non-transition” MSC monthly payment, based upon the person’s residential setting **after the transition** and can only be used **after** the person has moved to the new residential or service environment. For example, if a person moves from a supervised CR to a supportive CR in April, the vendor is eligible to bill at the transition level for May and June service months. In this case the transition payment level would equal two times the “intermediate” MSC monthly payment level.



The service coordination notes must document that the person meets one of the above criteria to support the vendor’s transition billing. As part of its review of MSC services, OMRDD Quality Assurance will examine the vendor’s appropriate use of the transition payment level.

#### CONTRACT COMPLIANCE REVIEW

OMRDD will monitor a vendor’s compliance with requirements specified in the contract and in this manual. This monitoring will include but not be limited to reviews of: service coordinator and service coordination supervisor qualifications and training, caseload size, and safeguards against staff conflicts of interest as discussed in Chapters Two and Three.