

Office For People With Developmental Disabilities

MSC Supervisors Video Conference
September 15, 2010

**Medicaid Service Coordination
Restructuring**

Effective October 1, 2010

Updated 9-16-10

Topics

- Recap of the Key Changes to the MSC Program
- Unit Management Overview Recap
- MSC Billing Standards ADM and Monthly Note
- Revised ISP and Process Changes
- New Service Coordination Agreement
- Questions
- Federal OIG audit of HCBS Waiver services

All materials distributed are still considered preliminary and subject to change based on final review and discussion with external oversight entities.

What is not changing:

- MSC Requirements for Willowbrook Class Members
- The scope and functions of MSC under TCM
- Eligibility criteria to receive MSC pursuant to OPWDD regs
- Qualifications of service coordinators and supervisors
- Delivery of MSC services by voluntary not-for-profit providers under a contract with OPWDD (contracts will be revised)
- Outcomes and expectations for MSC including informed choice, and individualized and person-centered service provision

What is changing:

- Face-to-Face Service Meetings minimum requirement
- In-Home Visits Minimum Requirement and elimination of SCOR Report (except for Willowbrook class members)
- Maximum Caseload Size
- MSC Minimum Training Requirements
- ISP Streamlining
- Service Coordination Agreement
- Documentation Requirements for Billing and Monthly Note Format

Note: Except for form changes, all Willowbrook requirements remain the same.

Face-to-Face Service Meetings

- Face-to-face service meetings are important to establish relationship, assess health/safety, etc.
- Not everyone needs a face-to-face service meeting on a monthly basis
- Effective 10/1/10, a minimum of 3 face-to-face service meetings are required annually; one of these meetings can be the required annual face-to-face ISP meeting*
- Face-to-face service meetings are based on individualized needs and circumstances (e.g., if the person cannot communicate their needs effectively over the phone)
- Providers should work with individuals and others to understand when a face-to-face service meeting is appropriate

*Note: For Willowbrook class members, a monthly face-to-face service meeting will continue to be required in order to bill for MSC.

In-Home Visits

- Effective 10/1/10 at least one in-home visit is required annually for all MSC participants*
- Professional judgment and individualized assessment used to determine additional frequency of in-home visits
- Elimination of SCOR requirement*—still required to report any safety issues identified in the person's home

*For Willowbrook class members, a quarterly in-home visit continues to be required and a SCOR must be filed two (2) times in the year.

Maximum Caseload Size

- Effective 10/1/10, **maximum** caseload is 40 units:
Supervised (24 hr. staffed) IRAS/CRs = .8
Family Care, Supportive settings, own home/apartment or living with family members = 1
- OPWDD is not mandating this caseload size—it is a maximum caseload size.
- Willowbrook remains the same = 1:20 ratio (Willowbrook weighting is 1 for everyone except VOICF which is .5). PCSS counts as 1 unit.
- PCSS is not counted in caseload if service coordinator does not serve Willowbrook class members.

MSC Training Requirements

- Completion of the Core training for new service coordinators will be six (6) months from the date of assuming MSC responsibilities
- Service Coordinators and supervisors with three (3) years of experience (who do not serve Willowbrook class members) will need to complete a minimum of 10 hours of professional development in their training year
- Specialized training on Informed Choice being developed

MSC Fee Changes Effective October 1, 2010

Cost & Revenue Solutions

Extensive analysis of the following five areas was completed in order to calculate a state wide fee methodology for Medicaid Service Coordination:

- Billing history
- Billing patterns
- Agency specific case mix
- Living arrangements of individuals
- Enrollments

Unit Allocation Based on the 6 – 10 – 12 Methodology

- Non- Willowbrook individuals living in Supervised IRA and CR's were allocated 6 billable units per year.
- Non – Willowbrook individuals living in Supportive IRA's and CR's were allocated 10 billable units per year.
- All other individuals including Willowbrook were allocated 12 billable units per year.

Unit Allocation Methodology

- Providers have the flexibility to manage their pool of MSC units in any manner they see necessary to meet the needs of each MSC participant served.

Unit Allocation Methodology

- Districts were allocated total unit and dollar resources.
- The allocations were based on:

Any individual who had at least one paid claim during the past 12 months.

AND

Any Individual newly enrolled in MSC between 7/1/09-7/31/10, whether they had a paid claim or not.

Medicaid Service Coordination

Effective October 1, 2010

- \$252.98* is the fee to be paid for Medicaid Service Coordination being provided to all non-Willowbrook Class Members, regardless of residential setting.
- \$345.18* is the fee to be paid for Medicaid Service Coordination being provided to all Willowbrook Class Members, regardless of residential setting.

* Includes HCA VI and trend of 2.08%

Medicaid Service Coordination Transitional Fees

Effective October 1, 2010
(new transition rules apply)

- \$758.94* is the fee to be paid for Medicaid Service Coordination being provided to all non-Willowbrook Class Members, regardless of residential setting.
- \$1,035.54* is the fee to be paid for Medicaid Service Coordination being provided to all Willowbrook Class Members, regardless of residential setting.

* Includes HCA VI and Trend of 2.08

Portability

- Guidance on portability of resources will be provided prior to October 1, 2010

Next Steps

- Central Office will run reports to monitor unit utilization.
- Reports will be provided to each District on a quarterly basis.
- Initial allocations will be refreshed in April 2011 for any individual enrolled between 7/31/10 – 9/30/10.

Questions Regarding Allocations

- **Questions** regarding MSC allocations should be directed to the MSC Coordinator in your district.

Medicaid Service Coordination Documentation Requirements for Billing Effective October 1, 2010

Medicaid Standards

What is not changing:

- Individuals must be prior authorized by the DDSO or Service Delivery and Development Region
- Individuals enrolled in the HCBS Waiver must have an Individualized Service Plan
- The unit of Service continues to be a month.

Billing Standards vs. Quality

- Billing Standard : Minimum Activity to bill
- Quality Standard: Higher level to document the provision of quality services
- MSC ADM

Billing Standard

- To bill for a month of service, the service coordinator must deliver and document a certain number of activities from the following lists:
 - List A: When a service coordinator delivers and documents an activity from this list, only one activity is necessary to meet the billing minimum
 - List B: When a service coordinator delivers and documents an activity from this list, two activities are necessary to meet the billing minimum

List A

- Face-to-face service meeting with individual
- Semi-annual ISP review
- Annual ISP meeting with the service coordinator, individual, parent/advocate (if appropriate), and major service providers
- Updates (addendum) to the ISP
- Completion of the ICF/MR level of care eligibility determination

For activities from List A, only one is necessary to meet the billing minimum.

List B

- Non-face-to-face contacts with the individual (e.g. phone calls)
- Direct contact with other agencies to maintain benefits eligibility or to obtain referrals for services that might be appropriate for the individual. This can include:
 - Phone call or personal contact
 - Email exchange
 - Letter/Correspondence exchange

For activities from List B, two activities are required to meet the billing minimum.

List B Continued

- Direct contact with a qualified contact during which the service coordinator gathers information to assess or to monitor the status of the individual. This can include:
 - Phone call or personal contact
 - Email exchange
 - Letter/correspondence exchange

For activities from List B, two are necessary to meet the billing minimum.

Definition of a Qualified Contact

- Someone directly related to the identification of the individual's needs and care and who can help the Service coordinator with the assessment, care plan development, referral, monitoring, and follow-up activities for the individual.

Examples include family members, medical providers, social workers, educators, and service providers.

Activities

- Activities must have a purpose and outcome
- Activities serve to develop, monitor, or implement the valued outcomes in the person's ISP.
- When activities from list B are delivered, documentation must demonstrate that the purpose of the activity is related to referral/linkage, or monitoring to ensure that the ISP is implemented and addresses the needs of the person.

Willowbrook Class

- To bill for a month of service for a member of the Willowbrook Class, service coordinators must continue to deliver and document a minimum of one face-to-face service meeting per month.

Billing Standard Continued

■ Hospitalization:

- Activities from the lists above that are conducted during an individual's first 30 days in the hospital can be counted toward the billing requirement.
- After the first 30 days of hospitalization, these activities can no longer be counted toward the billing requirement.

Billing Standard Continued

- Transition Payments are allowable when
 - the individual is new to service coordination, i.e. he/she has never received any type of service coordination/case management service through OPWDD
 - the individual moves from an OPWDD certified Supervised or Supportive Individualized Residential Alternative or Community Residence to an independent uncertified living situation
- The service coordinator must document in the individual's record or maintain documentation that substantiates the eligibility for a transition payment.

Service Coordinator Training

- Evidence that the service coordinator attended basic (i.e., core) training or received instruction using an approved OPWDD curriculum.

- Evidence may include, but is not limited to:
 - a training certificate
 - an attestation from OPWDD that the service coordinator attended training.

Service Documentation Requirements

- Individualized Service Plan (ISP)
- Level of Care Eligibility Determination
- Evidence that a Service Coordination Agreement was completed
- Evidence of an ISP review
- Monthly Service Note

Service Documentation Requirements

- A copy of the individual's ISP that includes identification of the service provided
 - Identify the service as Medicaid Service Coordination
 - Identify your agency as the provider of MSC
- An individual's first ISP must be written and signed by the service coordinator within 60 days of the HCBS Waiver enrollment date or of the MSC enrollment date, whichever comes first.

Service Documentation Requirements

- A copy of the individual's annual Level of Care redetermination,
 - For individuals enrolled in the HCBS waiver.
 - Must have been completed within 365 days prior to the date of the claim

Service Documentation Requirements

- Evidence that a Service Coordination Agreement was executed.

- Evidence may include
 - a copy of the Service Coordination Agreement
 - a monthly service note indicating the agreement was reviewed.

Service Documentation Requirements

- Evidence that the person's ISP has been reviewed within 365 days prior to the date of the claim.
- Evidence of a review may include,
 - a review sign-in sheet,
 - a monthly service note indicating that the ISP was updated or revised
 - an ISP addendum
 - a revised ISP
 - a review section on the ISP with a date and the service coordinator's initials.

Service Documentation Requirements

- Evidence of an ISP review needs to have these elements:
 - The individual's name
 - Name of the vendor providing MSC
 - The name, signature and title of a service coordinator or a supervisor who conducted the review. Initials are permitted if a "key" is provided, which identifies the title, signature and full name associated with the staff initials
 - The date of the review
 - Description of any changes made to the ISP. If no changes were made, note this.

Monthly Service Note Elements

- The individual's name
- Identification of the service provided (e.g. Medicaid Service Coordination)
- Identification of the agency providing MSC
- The month and year that the MSC service was provided

Monthly Service Note Elements

Continued...

- A description of the activity(s) provided by the service coordinator
 - If the activity involves a face-to-face service meeting with the individual or involves contact with a qualified contact then the purpose and outcome of the contact must be included.
 - For a face-to-face meeting, the location of the service must be included
 - For contacts with a qualified contact, the identity of the qualified contact and the relationship to the person should be included

Monthly Service Note Elements

Continued...

- A monthly summary that includes the person's satisfaction with services along with any follow-up taken, changes in the person's life, and any issues or concerns identified over the month regarding the person's health and safety.

Monthly Service Note Elements

Continued...

- The full name, title and signature of the MSC Service coordinator delivering the service. Initials are permitted if a “key” is provided, which identifies the title, signature and full name associated with the staff initials.
- The date the note was written (i.e. the signature date) which must include the day, the month, and the year.

Formats and Examples

- Agencies must use all of the elements in the OPWDD developed Note Format
- Agencies may not remove any elements, but may add additional elements or convert the note into an electronic format.
- Please see your handouts for examples of service documentation.

Other Requirements

- Each MSC service provider must have a current contract with OPWDD to provide MSC services
- Every service coordinator and service coordination supervisor must meet minimum qualifications
- A service coordinator's maximum caseload cannot be exceeded.

Retention & Contemporaneous

- Documentation must be completed contemporaneously.
- The monthly service note, including a monthly summary, must be completed by the 15th day of the month following the service month.
- Service Documentation must be retained for a period of at least six years from the date the service was delivered or from the date the service was billed, whichever is later.

Revised Individualized Service Plan (ISP) and Process Changes

Changes to the Individualized Services Plan (ISP)

- Format
- Review and Distribution Time Frames
- Instructions

ISP Changes - Format

- The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written.
- “ISP Date” is the date the ISP was reviewed and does not change unless the ISP is rewritten.
- Check boxes to indicate whether the ISP review was “Face to Face”

ISP Changes - Format

- Valued Outcomes will now be listed in section one (narrative) of the ISP **only**. It is no longer required to state the VO under the listing of each service.
- For **Non-Waiver** services: no longer required to list the *frequency, effective date, duration, and valued outcome* of the service.

Required only: *Name of Provider and Type of Service.*

ISP Changes - Format

- Long Term Clinic services: no longer listed in separate section and will now be listed under State Plan Services.
 - Indicate Type of clinic (Article 16, 28,31) and specific service being provided (e.g. Physical Therapy).
 - Location of clinic service is no longer required.

- No longer required to list all clinical services that are provided as part of a waiver service (e.g. psychology services included in residential habilitation).

ISP Changes - Format

- Order of signature lines changed so that the Service Coordinator's signature is first.
 - Service Coordinator should sign the ISP as soon as it is written and within 45 days of the review.

- *Name of Provider* and *Date Sent* is no longer a required element of the ISP format
 - Must still document distribution information but provider can determine how this is done.

- **ISP Addendums** - Only the Service Coordinator's signature is required on ISP Addendums.
 - Must document that the change was discussed with and approved by the individual and/or advocate

ISP Changes – Review and Distribution

- **ISP Distribution time frame is increased from 45 to 60 days from the date of the review.**
 - The ISP is written and signed by the Service Coordinator within 45 days of the review.
 - Habilitation Providers have 30 days to send the revised habilitation plan to the Service Coordinator and are responsible for their own distribution if this time frame is not met.

ISP Changes – Review and Distribution

- **ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual, advocate (as appropriate) and major service providers. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365th day occurs.**

For example, a face-to-face ISP review meeting is held on March 15, 2010. The semi-annual review is held sometime in the month of September, 2010. The next face-to-face review meeting must be held no later than March 31, 2011.

ISP Changes – Review and Distribution

- It is recommended that an ISP review take place every 6 months.
- For **Willowbrook** Class Members: face to face ISP reviews should still occur every 6 months with the individual, his/her active representative, service coordinator, and service provider.
- Distribution of the ISP is not required when there are no changes.
 - The service coordinator must notify the individual and service providers verbally or in writing that there were no changes to the ISP.
 - Initial, date, and indicate if review was a face to face on front page of ISP.

ISP Changes – Instructions

- Special considerations for Willowbrook class members.
- Enhanced guidance for writing the Profile
- Enhanced guidance regarding Safeguards
- Annual Review of Service Coordination Agreement
- Appendix: Frequency of Waiver Services

Questions?

Questions regarding the Individualized Service Plan may be directed to Eric Pasternak, OPWDD HCBS Waiver Unit.

eric.pasternak@omr.state.ny.us

(518) 474-1274

New
Service Coordination
Agreement

MSC Program Documentation Streamlining Service Coordination Agreement

- New Service Coordination Agreement will clearly outline rights and responsibilities associated with MSC
- Service Coordination Agreement required to be reviewed and signed with the individual and others as applicable at the time of enrollment in MSC
- Reviewed annually with the participant and others during the annual face-to-face ISP meeting
- Phased in over 2010-2011 as each participant's Service Coordination Agreement comes up for renewal.

Questions



Due to limited time we plan to put together a Q&A that will include questions we have received to date. Please feel free to e-mail questions to: Lynda.Baum-Jakubiak@omr.state.ny.us

MSC Central Office Contact Information

Subject	Person	Contact Info
Program Questions	Carol Kriss, MSC Statewide Coordinator	(518) 474-5647 Carol.Kriss@omr.state.ny.us
Billing Standards/Billing Documentation	Jenny Haneman, Director, Medicaid Standards	(518) 408-2096 Eugenia.Haneman@omr.state.ny.us
Billing questions	Karla Smith, Director of Central Operations	(518) 402-4333 Karla.Smith@omr.state.ny.us
Fees/Allocations	Donna Cater	(518) 486-3815 Donna.Cater@omr.state.ny.us