



ADMINISTRATIVE MEMORANDUM - #2015-02

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of Agencies Authorized to Provide Fiscal Intermediary Services
Developmental Disabilities Regional Office and State Operations Office Directors
Medicaid Service Coordinators and MSC Supervisors

From: Katherine Marlay, Acting Deputy Commissioner
Division of Person-Centered Supports

Megan O'Connor-Hebert, Deputy Commissioner
Division of Quality Improvement

Kevin Valenchis, Deputy Commissioner
Division of Enterprise Solutions

Helene DeSanto, Deputy Commissioner
Division of Service Delivery

DATE: March 20, 2015

SERVICE EFFECTIVE DATE: November 15, 2014

SUBJECT: SERVICE DOCUMENTATION FOR COMMUNITY TRANSITION SERVICES

SUGGESTED DISTRIBUTION:

Administrative Staff of Fiscal Intermediary Services Providers
Administrative Staff of Agencies Operating Individualized Residential Alternatives
Quality Improvement Staff
Medicaid Service Coordinators (MSCs) and Supervisors who serve residents of IRAs and CRs
Regional Office Front Door Staff

Purpose:

Effective November 15, 2014, this Administrative Memorandum issued by the Office for People With Developmental Disabilities (OPWDD) describes the program standards, payment standards, and service delivery and service documentation requirements to support a provider's claim for reimbursement for Community Transition Services (CTS). This service is available for individuals who receive Fiscal Intermediary (FI) services from a non-state operated provider agency and who are enrolled in the Home and Community Based Services (HCBS) waiver by the date of payment.

In addition to the claim documentation requirements specified in this Administrative Memorandum (ADM), FI providers must continue to comply with quality service standards set forth in The Key: The Home and Community-Based Services Provider Guide (OPWDD, 2007).

Background:

18 NYCRR Section 504.3(a) states that by enrolling in the Medicaid program, "the provider agrees...to prepare and to **maintain contemporaneous records** demonstrating its right to receive payment under the medical assistance program and to **keep for a period of six years from the date the care, services or supplies were furnished, all records** necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to...the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health (emphasis added)." In addition, 18 NYCRR Section 517.3(b)(2) states that "All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later." It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OPWDD.

The regulatory basis for HCBS Waiver Community Transition Services is 14 NYCRR Sections 635-10.4(i) and 635-10.5(ae).

Community Transition Services:

Community Transition Services (CTS) is an HCBS waiver service that funds non-recurring set-up expenses for waiver enrollees who are moving. In order to be eligible to receive CTS, the individual must be moving from one of the following:

- an OPWDD operated IRA, community residence or other OPWDD operated residential setting
- an OPWDD certified IRA, community residence or other OPWDD certified residential setting

- a family care home
- a State funded private residential school
- a State operated private residential school
- an ICF/DD, developmental center, nursing facility or any other Medicaid funded institutional placement.

In addition, the individual must be moving to a non-certified community living arrangement within New York State where he or she will be responsible for his or her own living expenses (see acceptable documentation of this responsibility in the Service Documentation section below). People moving to certified community residential settings (such as a group home or supported apartment) are not eligible for community transition services because the residential provider is responsible for household expenses.

Community Transition Services has a single, maximum statewide fee which can only be accessed once in an individual's life time.

Payment for CTS requires prior authorization from the DDRO.

Billing Standard:

The unit of service for CTS is a one-time expenditure and the service must be provided and administered by an authorized FI agency.

To bill for the service, the transition must have already occurred and the FI provider must have documents verifying the amount of funds spent on qualifying expenses. The FI provider is then eligible to submit a claim through the eMedNY system for the amount of expenditures, up to the statewide cap of \$3,000.

Qualifying expenses are those specific to the establishment of a residence, and include, furniture, window coverings, rugs and floor coverings, lamps and light bulbs, food preparation items, linens, set-up fees, utility deposits (e.g., telephone, electricity, heating, water, etc.), services provided before the individual moves in that are necessary for his or her health and safety (e.g., pest eradication, cleaning) security deposits, and moving expenses.

Items not allowable under CTS include monthly rental or mortgage expenses, food, regular utility charges, cable/internet access charges, and diversion or recreational expenses (e.g., televisions, computers, video games, stereos, DVD players).

Effect of CTS on benefits

The FI provider may reimburse the individual receiving services, or his or her family, for items purchased for the transition which are qualifying expenses as outlined below.

The Social Security Administration considers the CTS service a social service, and therefore, would not consider reimbursement for the service as income for the individual in the month of receipt for Supplemental Security Income (SSI) purposes. Any funds remaining after the month of receipt would be considered an available resource for SSI. The SSI Resource Level at the time this ADM is issued is \$2,000.

Timeframes associated with allowable expenses:

OPWDD understands that an individual may leave a provider-controlled residential setting and temporarily reside with family or friends while an apartment is made ready for occupancy. Where the move from the provider controlled housing to the person's own apartment or home is not a direct move, the person may still access CTS. In any instance where the delay exceeds one month, the FI provider must retain a note in the service records that explains the reason for the delay. See "Service Documentation" section below for additional items that must be retained for audit purposes.

Allowable expenses can be reimbursed if the expense was incurred no more than ninety days prior to the individual's move to the new residence, and no more than ninety days after the move.

Service Documentation:

Medicaid rules require that service documentation be contemporaneous with the service provision. Required service documentation elements are:

- 1. Individual's name and Medicaid number (CIN).**
- 2. Name of the agency (FI provider) providing the CTS service.**
- 3. Identification of the category of waiver service provided (e.g., CTS or Community Transition Services).**
- 4. A summary of expenses paid on behalf of the individual along with supporting receipts/documents.** The documentation must include a list of expenses paid on behalf of the individual, the date it was paid for or purchased (e.g., the day the deposit was paid or the day the furniture was purchased), and the amount paid. Note, the date an expense included in the service was paid by the FI provider can be prior to the date the individual is enrolled in the HCBS waiver and prior to the date the individual moves into the non-certified location as described in the "FI Provider Billing Instructions" section below. The FI provider, however, will not be able to claim reimbursement for the service until the ISP identifies the services as authorized, the individual is HCBS enrolled and has moved into the non-certified location.
- 5. The date the person moved into the non-certified location.**

6. **The primary service location** (the individual's residence).
7. **The signature and title of the agency (FI provider) staff person documenting the service.**
8. **The date of the service and tally of expenses documented and signed by the agency (FI provider) staff person.**
9. **A copy of a document that verifies that the person is responsible for his or her own living expenses in the new apartment or home.** Verification may include a signed lease, a utility bill in the person's name, or in the absence of those items a signed attestation by the individual or his or her designee or an entry in the ISP stating that the individual is responsible for his or her own living expenses.

FI Provider Billing Instructions:

CTS is billed to Medicaid in \$10 increments, with one unit equal to at least \$10 in expenditures. Due to limitations within the eMedNY system, a maximum of 99 units may be billed to Medicaid on a given date of service. This system limit equates to \$990 per date of service toward the statewide fee for CTS. In regard to the \$10 increment, each \$10 threshold must be met to bill a unit of CTS service and there will be no rounding up.

The Fiscal Intermediary (FI) cannot bill CTS until the individual has completed the move and is HCBS enrolled. OPWDD suggests that the FI bill Medicaid as soon as possible after the effective date of the person's move for any CTS expenses incurred within the allowable timeframe identified above. In instances where the FI has receipts and documentation substantiating allowable expenditures beyond the daily billing limit of \$990, OPWDD suggests billing eMedNY using consecutive dates of service. For example, if receipts and documentation substantiate \$1,500 in qualified CTS reimbursement, OPWDD suggests submitting one claim for 99 units totaling \$990 on a given date of service and submitting an additional claim for the remaining balance of 51 units totaling \$510 on the next date of service. If the FI has incurred the total statewide CTS fee for an individual, OPWDD suggests billing the full amount to eMedNY by using four consecutive dates of service as follows: Day 1 = 99 Units/ \$990, Day 2 = 99 Units/ \$990, Day 3 = 99 Units/ \$990, and Day 4 = 3 Units/ \$30.

The monthly FI fee associated with CTS is to be billed to eMedNY on the first of the calendar month following the final CTS claim for an individual. If CTS is the only service provided to an individual by the FI, the FI is entitled to a single monthly FI fee for that individual even if the FI submitted CTS claims using dates of service in different months.

Other Documentation Requirements:

In addition to the documentation supporting the CTS billing claim, the FI provider providing CTS must maintain a copy of the individual's **Individualized Service Plan (ISP)**, developed by the individual's Medicaid Service Coordinator (MSC) or Plan of Care Support Services (PCSS) Service Coordinator.

For Community Transition Services, the following elements must be included in the ISP:

- Identification of CTS under the category of waiver service (i.e., Community Transition Services)
- Identification of the agency providing CTS (the FI provider).
- Specification of an effective date for Community Transition Services that is on or before the date of service for which the FI provider bills CTS for the individual. Note, the effective date is the date the individual moves into the qualifying location, therefore, billing should not take place prior to the person's move into the new setting.
- Specification of the frequency for Community Transition Services as "One Time Expenditure."
- Specification of the duration for Community Transition Services as "One Time Expenditure."

This service is not habilitative in nature, and therefore, does not require a habilitation plan.

Documentation Retention:

All documentation specified above, including the ISP and service documentation, must be retained for a period of at least six years from the date the service was delivered or when the service was billed, whichever is later.

For additional information on the documentation requirements contact the OPWDD Director of Waiver Management at (518) 486-6466.

cc: Provider Associations
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