

Community Habilitation Amendments

Effective: Wednesday, October 1, 2014

AMENDMENTS TO 14 NYCRR SUBPART 635-10

NOTE: *This is an unofficial version of 14 NYCRR subdivision 635-10.5(ab) and paragraphs 635-10.5(c)(7) and (9) as amended by proposed regulations that were finalized effective October 1, 2014 and by emergency/proposed regulations that were also effective on October 1, 2014. This version was prepared based on feedback from the field and consists of the full text of subdivision 635-10 (ab) and of paragraphs 635-10.5(c)(7) and (9) as they appear after both sets of amendments are incorporated into the pre-existing text that has not changed. (New material is underlined; deleted material, removed.)*

Please note that changes to sections 635-10.1 and 635-10.4 and subdivision 635-10.5(ac) that were also part of the proposed regulations finalized effective October 1, 2014 are NOT included in this version.

- (ab) **Hourly community habilitation (CH) services.** The following shall apply to CH services (see section 635-10.4(b)(3) of this Subpart).
- (1) Eligibility for CH services.
 - (i) The following individuals are eligible to receive CH services:
 - (a) Individuals who do not live in a setting certified or operated by OPWDD (e.g. a private home); and
 - (b) Individuals who live in the following residences certified by OPWDD: Individualized Residential Alternative (IRA), Community Residence (CR) and Family Care Home (FCH).
 - (ii) Prior to October 1, 2014, no individual who lived in a residence certified or operated by OPWDD (including a family care home) was eligible to receive CH services.
 - (2) Reimbursement shall be contingent upon prior OPWDD approval of the person's need for CH services.

- (i) For all individuals (except for those who live in an Individualized Residential Alternative (IRA), a Community Residence (CR), or a family care home (FCH)), OPWDD shall approve persons for CH services based on the individual's relative need for supports for daily living and the individual's need for community-based activities.
 - (ii) For individuals who live in an IRA, CR or FCH, OPWDD shall approve persons for CH services based on the individual's need for community-based activities.
- (3) Reimbursement shall be contingent on documentation that those receiving CH services have received the services in accordance with the person's individualized service plan (ISP) and hourly community habilitation plan (CH plan).
 - (i) Prior to August 1, 2011, notwithstanding any other provision of this Title, an ISP which identifies at home residential habilitation (AHRH) services shall be deemed to include CH services, with the same frequency and duration. The CH services shall be delivered in accordance with the parameters specified in the ISP for AHRH.
 - (ii) Prior to August 1, 2011, notwithstanding any other provision of this Title, the provider of CH services is not required to develop or review a CH plan if an AHRH plan is developed and reviewed in lieu of the CH plan. Prior to such date, CH services may be delivered in accordance with the AHRH plan in lieu of the CH plan.
- (4) Billable service time is time when staff are providing face-to-face CH services to an individual in accordance with the individual's CH plan. Only time when CH staff are present with the individual and providing services may be counted toward the billable service time.
- (5) Staff may deliver billable CH services on an individual basis (ratio of one staff to one individual) or on a group basis (ratio of one staff to two, three or four individuals at the same time).
- (6) In order to be billable, CH services may not be delivered at a site certified by OPWDD or at a site operated by OPWDD which would be required to be certified if it were operated by another provider. Examples of such sites include but are not limited to a certified day habilitation site, a family care home, a supportive or supervised IRA, and a free-standing respite center certified as an IRA. However, an exception to this rule is that CH services are billable if the services are delivered at clinic treatment facilities certified in accordance

with Part 679 of this Title (also known as "article 16 clinics") and the services delivered are in accordance with the exception in clause (7)(i)(e) of this subdivision.

- (7) Time spent receiving another Medicaid service cannot be counted toward the CH billable service time, except as follows:
- (i) If the individual lives in a setting which is not certified or operated by OPWDD (e.g. a private home) or a FCH:
 - (a) The individual may concurrently receive hospice and CH services.
 - (b) Time when the Medicaid service coordination (MSC) service coordinator is conducting the face-to-face MSC visit with the individual may be counted toward the CH billing as long as the CH staff is present. This concurrent billing is allowed in order to promote the coordination of services.
 - (c) Personal care/home health aide and nursing services may be provided concurrently with CH services, but only in cases where the CH plan describes supports and services that are distinct and separate from the supports and services being provided by the personal care/home health aide or nursing staff.
 - (d) CH may be billed when the CH staff is with the person at a medical appointment with a physician (including psychiatrist), nurse practitioner or physician assistant, or at a dental appointment. The time when an individual is being transported to and from the appointment may also be counted as long as the staff accompanies the individual and Medicaid is not being charged for a transportation attendant for the trip.
 - (e) CH may be billed when the CH staff is with the individual at an appointment for a clinical service of the type specified in this subparagraph in order to facilitate the implementation of therapeutic methods and treatments. The time when an individual is being transported to and from the appointment may also be counted as long as the staff accompanies the individual and Medicaid is not being charged for a transportation attendant for the trip.
 - (1) The need for the CH staff's participation in the specified clinical service must be described in the individual's CH plan.

- (2) The types of clinical service are: occupational therapy, physical therapy, speech therapy, psychology, dietetics and nutrition, and social work.
 - (3) For each calendar year, reimbursement is available for CH staff to participate in no more than 12 clinical appointments per service type, per person.
 - (4) Notwithstanding any other provision of this subdivision, CH services delivered in accordance with this clause are billable regardless of location (even if the clinical service is delivered at a facility certified by OPWDD).
- (ii) For individuals who live in an IRA or CR:
- (a) The individual may concurrently receive hospice and CH services.
 - (b) Time when the Medicaid service coordination (MSC) service coordinator is conducting the face-to-face MSC visit with the individual may be counted toward the CH billing as long as the CH staff is present. This concurrent billing is allowed in order to promote the coordination of services.
 - (c) Nursing services may be provided concurrently with CH services, but only in cases where the CH plan describes supports and services that are distinct and separate from the supports and services being provided by the nursing staff.
- (8) CH services are not billable while an individual is in a hospital, nursing home, rehabilitation facility, or ICF/DD. CH services are billable on the day of admission to or discharge from one of these settings so long as the services are not provided in the hospital, nursing home, rehabilitation facility, or ICF/DD.
- (9) For each continuous service delivery period or session, the CH provider must document:
- (i) the service start time and the service stop time;
 - (ii) the provision of at least one service/staff action delivered in accordance with the individual's CH plan;

- (iii) for individuals who do not live in an IRA, CR or FCH; the ratio of individuals to staff at the time of service delivery; and
 - (iv) for individuals who live in an IRA, CR or FCH; whether the CH service is delivered on an individual or group basis.
- (10) The unit of service for CH services shall be one hour equaling 60 minutes and is reimbursed in 15 minute increments. When there is a break in the service delivery during a single day, the provider may combine, for billing purposes, the duration of each continuous period of service provision (or session) that is provided during the day. In order to be combined, each session must have the same individual to staff ratio (for individuals who do not live in a residence certified by OPWDD). For individuals who live in an IRA, CR or FCH, all sessions being combined must be either "individual" or "group" but the individual to staff ratio in the group CH may vary.
- . (11) Billing limits for individuals who live in an IRA, CR, or FCH.
 - (i) Community habilitation services may only be reimbursed if the services are delivered on weekdays and have a service start time prior to 3:00 p.m.
 - (ii) CH services may not be reimbursed on a given day that the individual receives:
 - (a) one full unit of group day habilitation services; or
 - (b) one full unit of prevocational services; or
 - (c) one full unit of a blended service (which is a combination of day habilitation and prevocational services); or
 - (d) any combination of two half units of: group day habilitation, prevocational services or blended services.
 - (iii) On a given day, a maximum of the following may be reimbursed:
 - (a) six hours of CH services; or
 - (b) the combination of:
 - (1) one half unit of: group day habilitation, prevocational services or blended services; and

(2) four hours of CH services.

(12) Where more than one agency delivers services on a given day to the same individual who lives in an IRA, CR, or family care home the total number of units and/or hours of CH services billed for that day by all agencies may not exceed the maximum allowed daily units and/or hours described in paragraph (11) of this subdivision.

(13) CH which is self-directed or family-directed. The following requirements apply to CH services which are self-directed or family-directed, and are in addition to all other provisions of this subdivision.

- (i) Self-direction or family direction in CH services is established to permit greater flexibility and freedom of choice in obtaining such services.
- (ii) The management of these self-directed or family-directed services is described in a co-management agreement between the individual, the CH provider and, if one exists, an identified adult.
- (iii) CH services which are self-directed are available when all parties to the co-management agreement concur that the individual receiving the CH services:
 - (a) is an adult who is capable and willing to make informed choices and manage the self-directed services; or
 - (b) is an adult who:
 - (1) is capable and willing to make informed choices; and
 - (2) has selected an identified adult who is a family member or other adult, and the identified adult is willing to assist in making informed choices and co-managing the self-directed services; or
 - (c) is a minor and there is an identified adult who is either:
 - (1) a parent or legal guardian who is available and willing to make informed choices and co-manage the self-directed services; or
 - (2) a family member or other adult who is available and willing to make informed choices and co-manage the self-directed services.

(iv) CH services which are family-directed are available when all parties to the co-management agreement concur that an adult receiving the CH services does not

qualify for self-direction and there is an identified adult who is willing and able to make informed choices and co-manage the family-directed services for the benefit of the person.

- (v) Eligible individuals and identified adults (if they exist) assume the responsibilities as mutually agreed to by the provider, individual, and identified adult in the co-management agreement. The co-management agreement shall specify the responsibilities of the provider, the individual, and any identified adult who will be managing or assisting in the management of the self-directed or family-directed services. The co-management agreement shall be documented in the individual's record.
- (vi) The following responsibilities (except as noted in subparagraph [vii] of this paragraph) shall be the individual's and/or the identified adult's:
 - (a) recruiting staff;
 - (b) making recommendations for staff selection and discharge of staff;
 - (c) managing the staff schedule; and
 - (d) identifying when and on what schedule the habilitation activities identified in the individual's CH plan will be addressed.
- (vii) The provider may agree to assist with one or more of the responsibilities specified in subparagraph (vi) of this paragraph. The provider's agreement to assist with those responsibilities shall be documented in the individual's record.
- (viii) The provider's responsibilities shall include:
 - (a) monitoring that services are delivered in accordance with all applicable requirements;
 - (b) monitoring that services are properly documented, and collecting and maintaining all necessary service documentation;
 - (c) submitting requests for reimbursement;
 - (d) providing payroll services, and managing any employee benefits or other compensation for staff;

- (e) complying with and monitoring staff compliance with the applicable requirements of Parts 624, 633 of this Title, and this Part (*e.g.*, requesting criminal history record checks, training staff, and supervising staff);
 - (f) determining whether any staff training is necessary beyond the training required by Part 633 of this Title and providing the necessary training; and
 - (g) monitoring the individual's continuing ability and willingness to fulfill those responsibilities agreed to and specified in his or her record and/or the identified adult's continuing availability and willingness to fulfill those responsibilities agreed to and specified in the individual's record.
- (ix) The following requirement applies to self-directed and family-directed CH services. The individual receiving the CH service, any identified adults, and the provider shall review their respective management responsibilities to evaluate whether self-direction or family direction continues to be appropriate at least once every two years.
- (x) The following requirement applies to individuals receiving family-directed services. If the individual receives any services other than the CH services which are certified, authorized, operated or funded by OPWDD, the participation of a representative of at least one such service is required at a review of the individualized service plan (ISP) on at least an annual basis.
- (xi) All agencies authorized by OPWDD to provide CH are authorized to provide self-direction and family direction as an option under CH.
- (14) Community habilitation fee setting.
- (i) Hourly fee schedule structure. Hourly fees are based on the following:
 - (a) The Region in which the individual lives - Region I, Region II or Region III.
 - (1) Region I (NYC) is New York City and includes the counties of New York, Bronx, Kings, Queens and Richmond;
 - (2) Region II (NYC suburban) includes the counties of Putnam, Rockland, Nassau, Suffolk, and Westchester;

- (3) Region III (upstate New York) includes all other counties of New York State; and
- (b) The number of individuals being served simultaneously - Individual (1) or Group (serving 2, 3, or 4 individuals).
- (ii) Transitional hourly fees.
 - (a) Providers may be eligible to receive a transitional hourly fee for CH - Individual or CH - Group for services delivered during November and December, 2010. For these two months and for each region, there will be the standard hourly fee and there will be a transitional hourly fee. Providers are eligible for the transitional hourly fee if they met the criteria for receipt of the transitional hourly fee for 2010 for at home residential habilitation (AHRH). If a provider's fee for AHRH is reduced from the transitional hourly fee to the standard hourly fee in accordance with the regulations in effect for AHRH (see clause [b][21][ii][c] of this section), the fees for CH will also be reduced from the transitional hourly fee to the standard hourly fee.
 - (b) Beginning on January 1, 2011, there will be one hourly fee for each geographic region for CH - Individual and one hourly fee for each level of group service in each geographic region for CH - Group. There will be no transitional fees.
- (iii) Fee schedules.
 - (a) Effective November 1, 2010, the fees for CH are equal to the fees in subparagraph (b)(21)(iii) of this section that were in effect on October 31, 2010.
 - (b) Effective July 1, 2011, the fees are as follows:

| | | | | |
|--|---|--------------|--------------|--------------|
| | <i>CH Direct Support—Fee is hourly per person</i> | | | |
| | <i>Individual</i> | <i>Group</i> | <i>Group</i> | <i>Group</i> |

| | <i>Serving 1</i> | <i>Serving 2</i> | <i>Serving 3</i> | <i>Serving 4</i> |
|------------|------------------|------------------|------------------|------------------|
| Region I | \$38.78 | \$24.24 | \$19.39 | \$16.97 |
| Region II | \$39.85 | \$24.91 | \$19.93 | \$17.44 |
| Region III | \$38.78 | \$24.24 | \$19.39 | \$16.97 |

(c) The following fees will be effective on October 1, 2012 or the date as of which necessary Federal approval is effective, whichever is later:

| <i>CH Direct Support—Fee is hourly per person</i> | | | | |
|---|-------------------|------------------|------------------|------------------|
| | <i>Individual</i> | <i>Group</i> | <i>Group</i> | <i>Group</i> |
| | <i>Serving 1</i> | <i>Serving 2</i> | <i>Serving 3</i> | <i>Serving 4</i> |
| Region I | \$37.05 | \$23.16 | \$18.53 | \$16.21 |
| Region II | \$38.39 | \$23.99 | \$19.20 | \$16.80 |
| Region III | \$37.51 | \$23.44 | \$18.76 | \$16.41 |

(d) Effective on October 1, 2014, the fees for CH delivered to an individual who lives in a CR, IRA or FCH are as follows:

Fee is hourly per person

| | <u>Individual</u> | <u>Group</u> |
|-----------------|-------------------|--------------------|
| | <u>Serving 1</u> | <u>Serving 2-4</u> |
| <u>Region I</u> | <u>\$37.05</u> | <u>\$23.16</u> |

| | | |
|-------------------|----------------|----------------|
| <u>Region II</u> | <u>\$38.39</u> | <u>\$23.99</u> |
| <u>Region III</u> | <u>\$37.51</u> | <u>\$23.44</u> |

- (15) If there is a trend factor in subdivision (i) of this section, the CH fees shall be trended in accordance with such subdivision.
- (16) The fees established by this subdivision may not be appealed.
- (17) Use of funds. Use of funds.
 - (i) Effective October 1, 2012 providers of CH services must ensure that at least 90 percent of the Medicaid revenue billed and received for the provision of CH services is used to fund the direct support of individuals within the CH program. For the purpose of this calculation, such direct support includes allowable administrative expenses. Any Medicaid revenue below such 90 percent not spent on CH services is subject to recoupment.
 - (ii) Effective January 1, 2014 providers of CH services must ensure that at least 95 percent of the Medicaid revenue billed and received for the provision of CH services is used to fund the direct support of individuals within the CH program. For the purpose of this calculation, such direct support includes allowable administrative expenses. Any Medicaid revenue below such 95 percent not spent on CH services is subject to recoupment.
 - (iii) The fees contain funding for clinical oversight. Clinical oversight includes the training and mentoring of direct support staff on diagnostic issues, care plan/habilitation plan issues and behavior management issues, as well as the troubleshooting of any plan issues discovered during plan reviews. Effective October 1, 2012, clinicians must document discussions with direct support staff and include that documentation as supplemental clinical notes in individuals' files at least annually. The documentation requirement will be applicable for any 12 month period in which an individual is enrolled in CH for the entire 12 month period and has received any CH service during that period.

Paragraph 635-10.5(c)(7) is amended as follows:

- (7) Billing limits for group day habilitation, supplemental group day habilitation, and prevocational services (see subdivision (e) of this section).
 - (i) Limit of one full unit or two half units.

- (a) This limit applies to an individual who, on a given day:
 - (1) does not receive supplemental group day habilitation; and
 - (2) if the individual lives in an Individualized Residential Alternative (IRA), Community Residence (CR), or family care home (FCH), the individual also does not receive community habilitation (CH) services.
- (b) On a given day, a maximum of the following may be reimbursed:
 - (1) one full unit of group day habilitation; or
 - (2) one full unit of a blended service which includes group day habilitation (a blended service is a combination of day habilitation, prevocational services and/or supported employment services); or
 - (3) one full unit of prevocational services; or
 - (4) any combination of two half units of: group day habilitation, prevocational services or blended services.
- (ii) Limit of one and a half units or three half units.
 - (a) This limit applies to an individual who receives supplemental group day habilitation on a given day.
 - (b) On a given day, a maximum of the following may be reimbursed:
 - (1) one full unit of group day habilitation, supplemental group day habilitation, prevocational services or blended services and one half unit of any of these services; or
 - (2) three half units of any of these services.
- (iii) For individuals who live in an IRA, CR or FCH and receive community habilitation on a given day, additional billing limits are described in paragraph (11) of subdivision (ab) of this section.

- (iv) Where more than one agency delivers services on a given day to the same individual, the total number of units and/or hours of CH services billed for that day by all agencies may not exceed the maximum allowed daily units and/or hours described in subparagraphs (i) – (iv) of this paragraph.
- (v) Exceptions. The following applies only to requests made prior October 1, 2014.
 - (a) An agency providing, or proposing to provide, services to an individual who is eligible to receive supplemental group day habilitation may request a waiver from the limits established in subparagraph (ii) of this paragraph.
 - (b) The billing limits established in subparagraph (ii) of this paragraph may be waived on an individual basis by the commissioner if the commissioner finds, based on the request submitted by the agency:
 - (1) that services in excess of the limit are necessary to preserve the health or safety of the individual; and
 - (2) that alternative services which are not subject to the limit have been considered to meet the health or safety needs of the individual, but that the alternative services are either inappropriate and/or unavailable.
 - (c) Any waiver by the commissioner shall specify the maximum number of units of service that may be reimbursed for services to the individual on a given day and shall specify the duration of the waiver. In no case shall the waiver period exceed six months. The approval may be extended (or re-extended) by the commissioner at the end of the specified period for an additional specified period which cannot exceed six months.

Paragraph 635-10.5(e)(9) is amended as follows:

- (9) Billing limits for prevocational services, group day habilitation, and supplemental group day habilitation (see subdivision (c) of this section).
 - (i) Limit of one full unit or two half units.
 - (a) This limit applies to an individual who, on a given day:
 - (1) does not receive supplemental group day habilitation; and

- (2) if the individual lives in an Individualized Residential Alternative (IRA), Community Residence (CR), or family care home (FCH), the individual also does not receive community habilitation (CH) services.
 - (b) On a given day, a maximum of the following may be reimbursed:
 - (1) one full unit of group day habilitation; or
 - (2) one full unit of a blended service which includes group day habilitation (a blended service is a combination of day habilitation, prevocational services and/or supported employment services); or
 - (3) one full unit of prevocational services; or
 - (4) any combination of two half units of: group day habilitation, prevocational services or blended services.
- (ii) Limit of one and a half units or three half units.
 - (a) This limit applies to an individual who receives supplemental group day habilitation on a given day.
 - (b) On a given day, a maximum of the following may be reimbursed:
 - (1) one full unit of group day habilitation, supplemental group day habilitation, prevocational services or blended services and one half unit of any of these services; or
 - (2) three half units of any of these services.
- (iii) For individuals who live in an IRA, CR or FCH and receive community habilitation on a given day, additional billing limits are described in paragraph (11) of subdivision (ab) of this section.
- (iv) On a given day, a maximum of one full unit per individual, either one full unit or two half units, may be reimbursed for supplemental group day habilitation.
- (v) Where more than one agency delivers services on a given day to the same individual, the total number of units and/or hours of CH services billed for that day

by all agencies may not exceed the maximum allowed daily units and/or hours described in subparagraphs (i) – (iv) of this paragraph.

- (vi) Exceptions. The following applies only to requests made prior to October 1, 2014.
- (a) An agency providing, or proposing to provide, services to an individual who is eligible to receive supplemental group day habilitation may request a waiver from the limits established in subparagraph (ii) of this paragraph.
 - (b) The billing limits established in subparagraph (ii) of this paragraph may be waived on an individual basis by the commissioner if the commissioner finds, based on the request submitted by the agency:
 - (1) that services in excess of the limit are necessary to preserve the health or safety of the individual; and
 - (2) that alternative services which are not subject to the limit have been considered to meet the health or safety needs of the individual, but that the alternative services are either inappropriate and/or unavailable.
 - (c) Any waiver by the commissioner shall specify the maximum number of units of service that may be reimbursed for the individual on a given day and shall specify the duration of the waiver. In no case shall the waiver period exceed six months. The approval may be extended (or re-extended) by the commissioner at the end of the specified period for an additional specified period which cannot exceed six months.