

## Policy & Enterprise Solutions

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## 2010 MSC Redesign Questions and Answers

### **Purpose:**

The following question and answer document was developed from the questions OPWDD has received from providers and other stakeholders since the MSC restructuring.

As you know, the purpose for the changes to the MSC program, effective October 1, 2010, is to increase flexibility and streamline administrative burdens while also achieving fiscal sustainability of the program. The collective goal of all parties involved in the MSC program remains to deliver the highest quality MSC services possible within a streamlined service delivery system where each person to receives the needed amount of assistance from their service coordinator, at the right time, in the right place, and at a reasonable price.

As you read the guidance in the following document, keep in mind that the terms voluntary MSC agency, MSC agency, voluntary MSC provider, MSC provider, and MSC vendor all refer to a not for profit entity contracted by OPWDD to provide MSC Services.

Additional information on changes to the MSC program, forms, and other guidance can be found on the agency website at [www.opwdd.ny.gov](http://www.opwdd.ny.gov) . If you have additional questions regarding the redesign, please contact OPWDD at one of the following numbers:

- For program questions call the MSC Unit at 518-474-5647.
- For billing standards and documentation questions, call Medicaid Standards at 518-408-2096

## Communication

- 1. Is each MSC agency responsible for sending out notices/attachments to individuals and families, or will OPWDD send them out? Will the information to individuals include specifics, such as the new minimum number of face-to-face contacts?**

All information distributed thus far is available on the OPWDD website under "Information for Providers" at [http://www.opwdd.ny.gov/hp\\_provider.jsp](http://www.opwdd.ny.gov/hp_provider.jsp) and on the OPWDD Home page at [http://www.opwdd.ny.gov/hp\\_msc\\_redesign.jsp](http://www.opwdd.ny.gov/hp_msc_redesign.jsp).

We are NOT expecting DDSOs or voluntary agencies to undertake a massive mailing. We encourage you to use in-person contacts with families to share the materials or to use regularly-planned newsletters or mailings to direct families and individuals to the OPWDD web site to access a copy of the materials. Service coordinators can review these materials with individuals and families/advocates. OPWDD also recorded a video with a sign interpreter reading the letter to individuals.

- 2. How will the new ISP changes be communicated to habilitation providers – including the statement that hab providers will be responsible for distributing their own plans to all parties when they have exceeded the deadline?**

The new ISP Instructions will be distributed with the ISP Administrative Memorandum and made available to all OPWDD providers.

## MSC Contracts

- 3. Is OPWDD still the sole Medicaid provider for MSC? How will all requests for MSC State Plan services be approved?**

Under the October 1, 2010 MSC restructuring, OPWDD remains the sole provider of MSC services. Voluntary Not-for-Profit agencies may provide MSC services pursuant to an MSC Vendor Contract with OPWDD. There is no change to how MSC State Plan services are approved.

## Liability Notices

- 4. Will agencies be required to send out a liability notice including the new fee each time the fee/payment levels change?**

No. New notices do not need to be reissued each time a rate changes. However, for individuals and/or liable parties who are being billed for the services they receive, an account notice should be issued to alert the payor to the change. The Fillable Account Notice (OMR LIAB 03), located on the OPWDD website, at <http://www.opwdd.ny.gov/wt/publications/msc/index.jsp> should be used.

## OMIG and Audits

- 5. Is there any discussion taking place with the OMIG regarding the changes to this service?**

Yes, we have briefed the OMIG on the changes to the service and have provided the OMIG with a draft of the MSC Billing and Documentation standards Administrative Memorandum. We are waiting to hear back from the OMIG on any issues that they may have with the ADM so we can be sure that there is a clear understanding and consensus before the audit period begins. In return, the OMIG has agreed not to audit the first few months that the MSC changes are implemented. OPWDD is doing everything it can to finalize communications on the MSC payment and program changes. In the meantime, MSC vendors should follow the directions and

guidance provided on OPWDD's website under MSC Redesign where the new forms can be found along with the MSC Supervisory Training materials that clearly outline the new MSC minimum billing standards to claim payment for MSC services.

**6. Will the new ISP format be phased in as reviews take place? Also, is there an audit vulnerability if the changes are not made immediately after 10/1/10?**

Yes, the new format can be used the next time the ISP needs to be rewritten. The pre-10/1/10 ISP format can still be used because it contains all of the elements in the streamlined ISP. Therefore, it is not necessary to re-write the ISP prior to the scheduled review date. Also, agencies can include more information than what is outlined in the new ISP format, as long as the required elements are included. If the existing ISP is written correctly, there should not be additional audit vulnerability if the service coordinator waits for the review date to use the streamlined format.

**Scope / Function of MSC**

**7. With the limits in MSC functions, who will handle crisis intervention? Will MSCs no longer be expected to have on-call responsibilities for these situations?**

There is no change to the MSC contract provision which requires the MSC Vendor to provide a 24 hour emergency telephone number to each individual it serves. MSC Vendors must still inform each individual and his/her advocate(s) of any changes to the emergency number. The after hours emergency number must be answered by either an MSC agency staff person or an answering service which in turn contacts an MSC agency staff person. An answering machine can not be used unless it provides a forwarding number that leads to direct contact with an MSC agency staff person. There are also no changes to the core functions of MSC under the Targeted Case Management (TCM) framework which includes assessment, reassessment, assisting a person to access necessary services, service plan development, implementation, maintenance, monitoring, advocacy, referrals and follow up.

**8. MSCs are expected to arrange for transportation, but are not expected to provide transportation for individuals. Since families sometimes expect this service, can it be explicitly stated somewhere that MSCs do not provide this service?**

The August 5, 2010 Attachment emailed to all MSC providers and posted on the OPWDD website provides examples of activities that are not reimbursable under MSC. Provision of transportation solely for the purpose of transportation by the service coordinator is not a reimbursable case management service.

**9. SCORs are no longer required; however, if there are health or safety issues, should SCORs still be used as a documentation and notification tool? If not, can a letter from the MSC agency be used as the notification tool?**

Except for Willowbrook Class members, SCORs are no longer required. The SCOR can still be used by the service coordinator for collecting information when visiting an individual's home and can still be used to notify appropriate parties of health and safety issues.

**10. The MSC is expected to observe if a person appears healthy at a face-to-face meeting and will verify the health of the person with other individuals and service providers when they do not see the individual in person. How does the Service Coordinator observe and assess health and safety when he/she is not a clinician? What is the MSC's level of liability if the person actually has something wrong with him/her?**

The MSC Vendor is responsible for providing MSC services to participants within the scope of the MSC service. It is the responsibility of the Service Coordinator to follow up with the individual and others associated with

him/her as necessary to help him/her obtain necessary health care services to maintain his/her health and address any issues.

There is no expectation that the MSC be a clinician. The service coordinator observes or asks about a person's health, safety and satisfaction with services and brings concerns to the proper authorities. The service coordinator should observe and assess health and safety issues in the same way he/she did previously when using the SCOR. Although the SCOR is no longer required for non-Willowbrook Class members, it provides areas of assessment and guidelines for reporting issues. These efforts should be documented in the service coordination record.

OPWDD cannot comment or advise on an MSC's liability in situations where the person's health or safety is at risk. Any liability for the MSC would depend almost completely on the specific facts involved. Again, however, neither OPWDD, nor any other state or federal authority, requires that MSC's be clinicians. OPWDD's expectation is that the MSC will take steps to follow up with the individual and his/her caregivers on health status and will take appropriate steps when issues are discovered.

**11. Many individuals served by an MSC agency may have no OPWDD funded services, but utilize an MSC in order to maintain other benefits such as HEAP, Food Stamps, SSI, the use of food pantries, advocacy within the school setting, housing, etc. Are these actions considered part of the development, implementation, and maintenance of the ISP and do they meet the need for ongoing and comprehensive service coordination?**

Yes. Activities that help a person maintain benefits and housing, and advocacy activities that help the individual and family navigate the school setting would be considered part of the development, implementation and maintenance of the plan of care (i.e. the ISP) if such needs and valued outcomes are identified in the plan of care. OPWDD's definition of MSC under the Targeted Case Management (TCM) framework is that MSC helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential, and legal services in accordance with the person's needs and valued outcomes as expressed in the ISP.

**12. We serve many individuals who require assistance and advocacy in attending medical appointments, but access to other supporting services where staff would attend appointments is not always available. Will billing be denied or will the MSC agency be otherwise penalized for continuing to provide this service? What if the service is provided outside of the "billable" action for the month?**

Helping a person to access necessary supports and services and advocating on their behalf is an allowable service coordination activity under MSC. If the service coordinator attends the appointment with the individual for the purpose of monitoring and/or performing their duties within the scope and functions of MSC, the minimum billing standard has been met because it is a face-to-face meeting with the individual. In addition, the MSC ADM on billing standards will define a qualified contact which includes a medical provider. If the service coordinator has contact with the medical provider without the individual, a minimum of two of these types of activities is required during the month in order to meet the billing standard. Transportation to a medical service should never be the sole purpose of an MSC activity.

**13. Can an MSC agency bill when a Service Coordinator accompanies an individual to a medical appointment for the purpose of translating the interaction?**

The reason that the Service Coordinator accompanies a person to an appointment should not solely be for translating services as this would be considered a direct service and is not reimbursable through MSC. If the service coordinator accompanies a person to a medical appointment for the purpose of monitoring and collecting useful information to help the service coordinator perform service coordination functions within the scope of MSC on behalf of the person, then the face-to-face contact with the individual served would be for

monitoring, follow-up, assessment i.e., gaining useful information about the person's health, and would be considered a "billable" activity, not the translation activity itself.

## **ISP Reviews and Distribution**

### **14. Does the new 60 day distribution timeframe for ISPs apply to all individuals, or is there a different standard for Willowbrook Class members?**

The 60 day distribution timeframe will apply to all ISPs, including the ISPs of Willowbrook Class members.

### **15. If an ISP meeting was held in August, could the MSC use the new ISP format, or should he/she wait until meetings held after October 1st?**

Reserve the use of the new ISP format for meetings held after October 1, 2010

### **16. Since the ISP will now have an "ISP Date" which is to be the date of the face to face ISP review meeting, what would be the date in the following scenario?**

- **ISP meeting held on 11/1/10; all of the service providers are there but the person receiving services decides not to attend the meeting so the MSC then meets with the person on 11/15/10 to discuss the material from the meeting. The service providers would be looking at it as being the 11/1/10 ISP and likely date the hab plans 11/1/10 yet that was not the face to face. Which date is the ISP Date?**

It is not considered a complete review until the individual has input. The ISP date would be the date the Service Coordinator met with the person, 11/15/10. The review date of the hab plan can still be listed as 11/1/10 as it is not necessary that the review date of the hab plan be the same date as the ISP.

### **17. Should MSC's continue to send a copy of the ISP to article 16, 28, and 31 clinics?**

Article 16 clinics must have a copy of the ISP per ADM #2005-01. Since OPWDD does not have regulatory oversight of Article 28 and 31 clinics we can not require that they have a copy of the ISP on file but it is still considered a best practice. The reason for sending ISPs to the clinics for their review is 1) to help ensure there is no duplication of services and 2) so the information in the ISP can be considered when developing the clinic treatment plan. However, there have been times when these clinics (28 and 31) have specifically requested not to receive the ISP. In that case the service coordinator should not be required to send it.

### **18. What would be the time frame for development of the ISP for a person who is not newly enrolled in MSC but is a new admission to an MSC agency?**

Changing an MSC vendor does not necessarily impact the review timeline of the ISP. However there must be an ISP or ISP addendum signed by the Service Coordinator that identifies the new MSC vendor within 45 days of the date the change of MSC Vendor became effective. So if a change to the MSC vendor took effect on October 1<sup>st</sup>, then they must be listed as the MSC vendor on or before November 14<sup>th</sup> (45 days from October 1<sup>st</sup>).

### **19. Given the revised date lines on the new ISP format, please clarify the earliest date the provider must/may actually implement any changes agreed to at the meeting. Must the provider continue providing the old services and staff supports until the revised ISP is actually signed by the MSC? Must the provider begin providing the new services supports immediately (i.e. based on the ISP date)? Does the provider have the choice of implementing changes immediately or waiting for an actual copy of the revised ISP?**

Changes agreed to at the review meeting should be implemented as soon as possible and should not be withheld because the ISP has not been received. Some providers draw up a document at the meeting that describes the changes agreed to. This document is signed by the person and a copy given to the service coordinator at the end of the meeting. This practice can help cover the gap between the date of the meeting and actual receipt of the ISP, gives you the go ahead to start these changes right away, and helps to ensure that what is decided today is not forgotten weeks from now when the service coordinator goes to write the ISP. It is understood that some changes may not be implemented immediately (e.g. staff training) but waiting for the ISP should not delay the implementation of the agreed upon changes..

**20. If the ISP is reviewed within 44 days of October 1, does the Service Coordinator have an additional 15 days to distribute the ISP, or does it still need to be distributed within 45 days from the review date?**

The new ISP rules go into effect on 10/1/10. Any ISP reviews which take place prior to 10/1/10 should be handled using the existing rules, which includes the 45 day distribution timeframe. After October 1, 2010, the ISP, or Addendum, must be written and signed by the service coordinator within 45 days of the review and distributed within 60 days of the review.

**21. What is the definition of semi-annual? This was previously understood to mean every six months.**

Semi-annual means twice in a 365 day period. For quality purposes, it is recommended that an ISP review occur every six months; however, it is acceptable for the semi-annual review to take place before or after the sixth month as long as the change in date is in the best interest of the individual served, and the rationale is provided in the MSC monthly notes.

**22. Will language / guidelines be changed for providers of Waiver services to match the ISP review periods? For example, Hab Plans must be reviewed every six months, but ISPs will now be required to be reviewed two times per year.**

It is not anticipated that revisions will be immediately made to ADM #2003-03 which provides guidance on Habilitation Plan Requirements. This ADM requires that a Hab Plan be reviewed at least once every six months and that the Hab Plan review be conducted at least annually at the same time as the ISP review.

**23. Agencies use different wording on ISPs for the frequency and duration of Waiver services. Will the required information be clarified?**

All agencies should be using the frequency and duration outlined in the appropriate ADMs for each HCBS waiver service. An appendix to the revised ISP instructions also outlines the correct frequency that should be listed.

**24. In the provider section, does MSC require the listing of frequency, duration, effective date, and valued outcome?**

No. This information is only required for Waiver services. MSC is a State Plan service.

**25. Will there be a form for 6 month ISP reviews? If not, will there be minimum requirements for that document?**

No. There will not be a specific form to document semi-annual ISP reviews. However the MSC note must be completed accordingly and the Service Coordinator who conducts the review should initial and date the ISP (top of page 1) that indicates that the review occurred (see ISP instructions on OPWDD's website)

**26. Where should the CAB signature appear on the ISP for Willowbrook Class members?**

All OPWDD requires is that the Service Coordinator sign first. The chronological order of when signatures are obtained from that point on is not prescribed. There are no special considerations for order of signatures for Willowbrook Class Members.

**27. Does the MSC need to use the signature page that is included in the ISP draft, or can he/she use the signature page from the meeting?**

When the ISP is rewritten, new signatures indicate receipt of and general agreement with the written ISP. These signatures should be obtained on the ISP signature page.

**28. Do ISP Addenda require signatures of the individual and/or advocate?**

No. As of 10/1/10, the ISP Addendum only requires the signature of the Service Coordinator writing the addendum. There should be documentation which substantiates that the change was discussed with the individual and/or advocates.

**29. Does every change to an ISP need to be documented with an addendum or can minor changes be written in by hand, initialed and dated?**

Handwritten changes to the ISP should be limited to making only very minor changes or corrections. Any such changes must be "transparent" to auditors with strike through and initials and date.

**Documenting State Plan Services and Other Supports on the ISP**

**30. Page 5 of the new ISP instructions, under the required attachments, states clinic treatment plan recommendations for long term therapies provided by article 16 clinics. Is this new? Could you clarify what it is? Are we now required to attach the treatment plans for each discipline a person receives from the clinic?**

If a person receives a service from an Article 16 Clinic (these are clinics regulated by OPWDD) the clinic recommendations (not necessarily the whole clinic treatment plan) are required attachments to the ISP. Recommendations are usually a one to two page document summarizing the recommendations of the clinic plan without having to include the detail of the entire clinic plan. This is not new and is in fact a lot less strict than what is stated in the pre-10/1/10 instructions which indicate the Clinic Treatment Plan is a required attachment for all clinic services (Article 16, 28, and 31 clinics). What's changed is a) OPWDD only requires this for Article 16 clinics now (the other clinics aren't regulated by OPWDD) and b) OPWDD made it clear that only the recommendations are required, not the entire clinic treatment plan.

**31. When a person receives a state plan service (for example Primary Physician) but that service is also billed to Medicare, how should the service be listed in the ISP - under "State Plan", "Federal, State, or County Resources" or Both? Same question for Private Insurance.**

Any service paid for by Medicaid State Plan, even if payment is shared with another resource such as Medicare or Private Insurance, should be listed in the Medicaid State Plan section of the ISP. It is not necessary to list the service more than once. In the example above, the service should be listed only once, under "State Plan". Then list *Medicare* in the "Federal, State, or County Funded Resources" section. Private insurance should be listed under "Other Services".

**32. How should services such as SSI, SSDI, Medicare, Food Stamps be listed in the ISP under Federal, State or County Resources?**

The service coordinator should include the name of the resource (Medicare, SSI, etc) and, if you are using the ISP template, write "NA" under "name of provider". These are not really services so much as they are benefits

or resources. In each example there is no provider *per se*, so it is not necessary to list a provider when listing out these resources.

### **Face-to-Face Service Meetings and Home Visits**

#### **33. Since the service coordinators have already provided face-to-face services for most months in this year, do they need to provide face-to-face services for the rest of 2010?**

The MSC service provision year for the purpose of meeting the minimum number of face-to-face service meetings and in-home visits will be the calendar year (Jan. 1-Dec.31).

OPWDD recommends that at least one face-to-face service meeting occur between October 1, 2010 and December 31, 2010 to discuss the changes to the MSC program with the individual and his/her advocate. The new MSC Service Coordination Agreement form can also be reviewed and signed during this time. This meeting can be an in-home visit but is not required if a home visit already took place in calendar year 2010.

Note: A face-to-face service meeting must be provided during the month in order for MSC Vendors to bill MSC for Willowbrook class members. Quarterly in-home visits continue to be required for Willowbrook Class members.

#### **34. Does the three face-to-face service meeting rule apply to individuals residing in Supervised IRAs and CRs as well, even though they are allocated six units instead of twelve? Is it expected that individuals residing in Supervised IRAs and CRs will continue to be seen every other month in a face-to-face service visit?**

The minimum of three face-to-face service meetings per year applies to all MSC participants except for Willowbrook Class members regardless of their residential setting. The number of face-to-face service meetings is not based on the unit allocation. This rule replaces the previous "every-other-month" face-to-face requirement for individuals residing in Supervised IRAs and Supervised CRs which went into effect on 10/1/2009. This requirement is a minimum service level; it is expected that service coordinators will use professional judgment based on the individual's needs and individualized circumstances to decide how often to see the individual in consultation with the individual and other as appropriate.

At least one of the face-to-face service meetings should be an ISP review meeting and at least one of the face-to-face service meetings should be at the individual's residence (i.e., in-home visit).

Note: An MSC agency is allocated six units per year for Individuals residing in a Supervised IRA or Supervised CR, This does not mean that this is the number of services an MSC agency can provide to an individual living in a supervised residential setting. If an individual requires additional service throughout the year, it is expected that the MSC agency will provide additional supports (i.e., provide more than six (6) billable MSC services in the year to meet the individualized needs for each person).

#### **35. Will the yearly home visit be a Billing Standard or Program Standard? If it is a billing standard and the visit is not made, which months of billing would be ineligible?**

The yearly home visit is an OPWDD program standard for non-Willowbrook Class members. For Willowbrook Class members, a quarterly home visit continues to be the requirement. While not a billing standard, failing to meet the program standard can result in fiscal penalties during a program review.

#### **36. If the 3 face to face service meetings are not made in a 12 month period, what billing is at risk?**

The MINIMUM three face-to-face service meetings during a calendar year is an OPWDD program standard for non-Willowbrook Class members. For Willowbrook Class members, a face-to-face service meeting is required

each month in order for the MSC Vendor to bill for MSC services during the month. While not a billing standard, failing to meet the program standard can result in fiscal penalties during a program review.

**37. Is there a requirement for the frequency of the face-to-face service meeting (e.g. does it need to be conducted every four months, or can it be two months in a row)?**

Effective October 1, 2010, the minimum number of face-to-face service meetings annually is three, and one of the meetings can be the ISP review. It is expected that service coordinators will use professional judgment based on the individual's needs and individualized circumstances to decide when and how often to see the individual in consultation with the individual and others as appropriate.

**38. Can one of the three face-to-face service meetings be a home visit, or must the home visit be a separate item?**

The home visit can be integrated into one of the three required face-to-face service meetings. It does not have to be an additional meeting. It is expected that service coordinators will use professional judgment based on the individual's needs and individualized circumstances to decide when and how often to see the individual in consultation with the individual and others as appropriate.

**39. CSS plan participants require a circle of support (COS) meeting every three (3) months for a total of four per year. Will this change with the new MSC changes or will they be excluded similar to class members?**

Three annual face-to-face service meetings is the minimum service requirement for an individual receiving Medicaid Service Coordination.

COS meetings are required on a quarterly basis. It is recommended that MSCs attend these COS meetings in person as much as possible. When it is not possible to attend in person, participation in the meeting may take place via teleconference calls or by connecting with designated circle of support members prior to or after the meetings. For billing purposes, in-person attendance at COS meetings by the service coordinator would be considered a face-to-face meeting if the individual was also present.

**40. Will the individual and/or advocate be given the opportunity to choose if they would like to have more than three face-to-face service meetings per year as required? If no (i.e., the MSC determines the number of face-to-face service meetings), is this stated clearly in the MSC Agreement?**

Face-to-face service meetings and in-home visits must be provided as needed based on the individualized needs and circumstances of each person served. The minimum number of face-to-face service meetings is three annually based on the calendar year. The number and frequency of additional face-to-face service meetings with the individual that are necessary to provide quality service coordination activities and interventions is based upon professional judgment and assessment of the service coordinator and service coordinator's supervisor in consultation with the individual and others as appropriate and based upon the unique circumstances and needs of each person on the Service Coordinator's caseload. The assessment process to determine the need for additional face-to-face service meetings is not static but is ongoing based upon what is happening in each person's life and the regular contact that the service coordinator is having with the individual, the individual's circle of support, the individual's service providers, and other qualified contacts as appropriate.

Face-to-face service meetings should have a purpose and an outcome and are not to be used purely for social or recreational purposes. Face-to-face service meetings can help service coordinators to build relationships with individuals and their circles of support in order to more effectively assess needs and goals. These meetings are also helpful to see first hand how the individual is doing and observe non-verbal cues that can provide valuable information that may not be apparent through a phone call. Service coordinators should have

discussions with individuals (and their advocates) to discuss how face-to-face service meetings (and in-home visits) can be used to achieve service coordination outcomes.

The following are examples of some of the factors that are helpful to consider with individuals served and their advocate(s) when determining whether a face-to-face service meeting is necessary and appropriate (i.e., the face-to-face service meeting will have a purpose and outcome related to the provision of service coordination activities and interventions). This is not an all-inclusive list.

- Individuals newly enrolled in MSC who need to work on a person-centered plan with their service coordinators and others in their circle of support;
- When an individual has a new service coordinator, face-to-face service meetings are necessary to build trust and partnership in this new relationship;
- A person's ability to communicate their needs and goals effectively over the phone. In other words, individuals who do not communicate effectively over the phone may need to be seen face-to-face more frequently than those that do communicate their needs, status and satisfaction over the phone effectively.
- Individuals who have new needs, need or want to change services or service providers, are experiencing difficulties in participating in their current services, want to work on new valued outcomes, or are experiencing health issues likely need more frequent face-to-face service meetings with their service coordinators;
- Individuals who want to change their living situation may need more frequent face-to-face contact with their service coordinator.
- Individuals who communicate concerns regarding their living environment to their service coordinators will likely need more frequent in-home visits from the service coordinator. Similarly, individuals about whom advocate(s), service providers or others communicate to the service coordinator concerns about the person's living environment will also likely need more frequent in-home visits from the service coordinator.
- Individuals who are having difficulty with family members and/or have had recent changes in their family composition, circumstances, or family dynamics will likely need more face-to-face contact with their service coordinator.

**41. How much latitude do individual agencies have to determine when a face-to-face service meeting is necessary? For example, if there is a change in service coordinator, the new service coordinator could call the family to introduce themselves rather than having a face-to-face meeting. Who decides what meets the standard?**

It is expected that service coordinators will use professional judgment based on the individual's needs and individualized circumstances to decide when and how often to see the individual in consultation with the individual and others as appropriate. Best practice would be for the new service coordinator to have a face-to-face service meeting at the time s/he takes over the case. See answer to number 40 above for further guidance on face-to-face meetings.

**Service Coordinator Training**

**42. Will there be additional training for MSC Supervisors?**

MSC Supervisor's Video Conference on the MSC changes were held on August 12, 2010 and September 15, 2010. The materials from these sessions are available on OPWDD's website. In addition, there is a webcast from August 11, 2010 that walks through the MSC changes. This webcast is also available on OPWDD's website to use as a training resource. OPWDD has made recordings of the August 12, 2010 and September 15, 2010 MSC Supervisory Sessions available to the DDSOs to use as a training resource. The MSC Vendor

Manual will also be revised to reflect the MSC changes. MSC Training Consortiums, some DDSOs, and many voluntary agencies continue to offer MSC Supervisor and MSC Service Coordinator training.

MSC Supervisors have been instructed to hold in-house training with their service coordinators regarding the MSC changes and implementation in their respective agencies.

**43. If a service coordinator begins in August or September 2010, how long will he/she have to complete the Core Training, 3 months or 6 months?**

Anyone hired before September 30, 2010, must complete the Core Training within 3 months. If the person is hired on or after October 1, 2010, they will have six months to complete the Core Training; however, every effort should be made to complete Core Training as soon as possible after hire.

**44. Does the rule requiring three years of experience as an MSC, before the 15 hour/year training requirement is reduced to 10 hours /year, include experience providing case management/service coordination for other agencies (e.g. DOH), or must the experience be OPWDD MSC experience?**

No, the Service Coordinator must have at least three years of experience in providing service coordination within the OPWDD service system. Experience within other service systems cannot be used to meet this minimum level of experience.

**45. If a Service Coordinator is in her fourth year of experience and her anniversary is after 10/1/10, will she need to complete 15 hours of training in her training year, or will she only need to complete 10 hours of training in her training year?**

In this example, the service coordinator will only need to complete 10 hours in her next training year.

**46. When does the year start for training hours for MSC? Will the training year now start on October 1?**

The service coordinator's training year is not changing. A given service coordinator's anniversary date for determining a training year is the day s/he took on MSC responsibilities.

**General Billing Documentation**

**47. Why is the individual's CIN not included on the monthly service note?**

The CIN has never been a required element for service documentation. Agencies can include the additional information on the form if it makes billing easier and meets confidentiality requirements.

**48. Define contemporaneous.**

Contemporaneous means at the time of service delivery or shortly after. The Billing Standard ADM for MSC defines contemporaneous as having the monthly service note, including the monthly summary, completed and signed by the 15<sup>th</sup> day of the month following the service month.

**49. Will a service coordinator be able to add additional pages to the monthly note format if needed?**

Additional pages can be included with the monthly service note if more space is needed. Additional pages should include elements that clearly identify the individual, the service, and the service month.

**50. Since the monthly note should contain information that is considered “billable”, should the Service Coordinator continue to maintain a running record of interactions with the individual and other activities on behalf of the Waiver participants?**

Agencies may choose to continue keeping a running record of interactions that is separate from the monthly service note or agencies may choose to add elements to the monthly service note so that all of a Service Coordinator’s activities are on the same form. Agencies must include all of the elements of the OPWDD MSC Note format and must meet and document the minimum billing standards in order to claim MSC payment for a given month.

**51. Are service notes needed for a month where there is no billing?**

For the purpose of meeting minimum billing standards, notes are only needed in months when the MSC agency bills for services. However, for quality purposes, any contacts and/or services provided on behalf of an individual should be documented.

**52. If a service coordinator provides two activities from List B to meet the billing minimum, should the MSC agency submit two separate monthly claims?**

No, MSC remains a monthly service and only one claim can be submitted for a service month for a particular individual.

**53. Previously, the monthly service note was required to contain certain elements (ie: health and safety, satisfaction with services, etc). What elements will be required when the individual is seen face-to-face, and what will be required if there is no face-to-face meeting in a given month?**

To meet the minimum billing standard, all of the required billing elements must be documented. The OPWDD MSC Note contains a separate section to document face-to-face service meetings vs. non-face-to-face contacts.

**54. It is understood that MSC Vendors cannot bill for individuals in the hospital longer than 30 days, however, can they bill if the person is incarcerated?**

When a person is incarcerated, the DDSO should be notified as soon as possible. Due to a change in Social Services Law, local Medicaid districts are now required to suspend an individual’s Medicaid coverage when s/he is incarcerated for thirty days or more rather than close his/her case. An MSC Vendor cannot bill for an individual who has had his/her Medicaid suspended. Upon release to the community, the individuals’ Medicaid coverage must be reinstated.

Specific documentation is needed when an individual’s waiver services are suspended. See Waiver Key page 2-10 for additional information regarding the rules surrounding the suspension of HCBS services versus the termination of services. Additional questions can be directed to Field Operations in Central Office at (518) 402-4339.

**List A Billing Requirements**

**55. Can an MSC agency bill for a month when the ISP is re-written? For example if there is an ISP meeting on 10/15/10, the MSC agency can bill for October. Let’s say the hab plans which require corrections to the ISP are received on 11/13/10, can the MSC agency bill for November? Writing an Addendum is a billable service for the month, so would rewriting the ISP with the corrections be the same thing?**

Billable activities from List A (so a minimum of one activity must occur and be documented) include:

1. Face-to-face service meeting with the individual.
2. Semi-annual ISP reviews (which may include the creation of the initial ISP, a face-to-face ISP review, and any non-face-to-face ISP reviews).
3. Updates (addendum) to the ISP (this does not have to be a face-to-face service meeting).
4. Completion of the ICF/MR level of care eligibility determination or redetermination (this does not have to be a face-to-face service meeting).

In the example provided, it appears that the ISP review is conducted in one month and then “updating” the ISP in the next month. Since the billing minimum is met for both months, the MSC agency could bill for both October and November.

**56. Can an MSC agency still bill for the month if an annual ISP meeting is held without the individual being present (due to unexpected illness or behavioral issues)?**

An ISP review does not have to have the individual present at the time of the meeting for billing purposes. However, the MSC should always discuss with the individual what occurred at the meeting and get his/her input and this contact should be documented in the Monthly Note and/or case record to meet program quality standards.

At least one face to face ISP meeting must occur every 365 days.

**57. Is there an assumption that items in list A are all face to face? For example, if I did an addendum I would not necessarily see the individual to make this change. Would this still count or would I now need to see the individual to review that addendum.**

Updates (addendum) to the ISP do not have to be a face-to-face service meeting. Semi-annual ISP reviews also do not have to be a face-to-face service meeting. However, contact with the individual to review the ISP and ensure it accurately reflects the person’s needs and valued outcomes must occur and be documented to meet the program quality standards.

**58. The sample MSC Note did not include a section for “ISP addendums”. Since this is a Category A billing, where should this activity be documented?**

An addendum can be the result of an ISP review which is a List A activity. If an addendum is completed this may be documented in the monthly summary section of the note.

**59. If the individual is non-verbal, or does not communicate well, and the only real way to monitor his/her progress is to visit the individual in these different settings such as school, after school respite program, or Sunday program, can these visits count toward billing?**

Yes. Face-to-face service meetings count as an activity from List A and only a minimum of one activity from List A is needed to bill in a given month. However, all activities that are documented, including a face-to-face meeting, must serve to develop, monitor, or implement the valued outcomes of the person’s ISP.

**60. If the Service Coordinator checks “YES” to updating the LCED, is there anything else required on the case note form?**

The section on the monthly service note for the LCED must be completed in its entirety and the monthly summary section must still be completed. A copy of the updated/completed LCED must be present in the person’s service coordination record.

**List B Billing Requirements**

**61. Will a group of comprehensive notes be needed to meet the billing requirement, rather than just the documentation of two phone calls? Will all of the notes need to be written contemporaneously?**

To meet the minimum billing requirement, the MSC must complete the required minimum service documentation as identified in the MSC Billing Standards ADM. Program documentation requirements differ from minimum billing standards and will be specified in the revised MSC Vendor Manual. From a billing and quality standpoint, there must be enough of a description regarding the purpose and outcome of the contacts to justify billing Medicaid for an MSC service during the month. The MSC provider is responsible for determining when to bill Medicaid for an MSC service provided and should take care to ensure that it is reasonable to bill for given services for an individual served during the month based on the documentation of services provided.

**62. Currently, there is a best practice expectation that the Service Coordinator maintain documentation of all contacts, even those which would not be billable under the new billing standard. How will the new streamlined monthly service note address documenting contacts that may not be “qualified contacts?”**

Agencies may add elements to the monthly service note or have additional documentation that captures MSC activities that may not necessarily count toward the billing minimum.

**63. On the Service Coordination note, if there are two “qualified staff” who enter information on the form, who should (or is allowed to) sign the bottom summary?**

Any qualified Service Coordinator who is familiar with the individual and has provided services during the month can write the monthly summary and sign this section.

**64. Who is considered to be a “qualified staff” to provide an MSC service or action besides the Service Coordinator?**

Any MSC staff or other staff person such as the MSC Supervisor who meets the minimum requirement to be a Service Coordinator can be considered “qualified staff”; this includes other service coordinators besides the one regularly working with the person and MSC Supervisors.

**65. If an MSC goes to a supervisor or to a knowledgeable colleague for guidance about an issue or a type of service for an individual on their case load, will the contact count as an appropriate Qualified Contact for billing under LIST B from the billing standard?**

No. Supervisors or colleagues who are part of the Medicaid Service Coordination program at your MSC agency do not qualify as a Qualified Contact as they are not directly related to the identification of the individual's needs and care.

**66. Can referrals take place within an MSC agency for other services?**

Yes, referrals for other services within the same agency are acceptable, e.g. an MSC makes a referral for the individual to a day habilitation program that is operated by the same agency as the MSC program. The MSC participant must have free choice of qualified and available waiver service providers and to avoid potential conflicts of interest, the service coordinator should inform the person of their free choice of qualified and available waiver service providers and help the person to determine which provider can best suit their needs.

**67. Will the provision of Representative Payee services to individuals be considered a billable service under list B?**

No. Being a representative payee is a direct service and would not be reimbursable under OPWDD's MSC program which is a Targeted Case Management Program. The functions of MSC are assessment, service plan development, implementation, maintenance and monitoring, and making referrals and linkages. An activity

from List B must demonstrate that the purpose of the activity is related to the functions of providing MSC services i.e., referral/linkage, or monitoring of services to ensure that the ISP is implemented and addresses the needs of the person.

Allowable activities include non face-to-face contacts with the individual, direct contact with a qualified contact during which the service coordinator gathers information to assess or to monitor the status of the individual, and direct contact with other agencies to maintain benefits eligibility or to obtain referrals for services that might be appropriate for the individual.

**68. For individuals residing in supervised IRA/CRs, is it appropriate for the MSC to contact the residential administrator to obtain information about the individual(s)? In the past, this was considered a conflict of interest.**

Direct contact with a qualified contact during which the service coordinator gathers information to assess or monitor the status of the individual or direct contact with other agencies to maintain benefits or obtain referrals for services that might be appropriate is allowable to meet the billing standard (at least two such contacts during the month are required to bill). A qualified contact is someone directly related to the identification of the individual's needs and care and who can help the service coordinator with assessment, care plan development, referral, monitoring, and follow-up activities for the individual. Examples of qualified contacts include family members, medical providers, social workers, educators, and service providers. It is not a conflict of interest to contact staff of the person's residential provider to determine how the person is doing and whether they are healthy, and safe in accordance with the functions of MSC.

**69. For a non-face-to-face month, does a certain amount of time need to be spent on the activity for it to be billable?**

OPWDD does not specify a minimum amount of time that needs to be spent for non-face to face activities. However, the service coordinator should be using these contact exchanges to provide allowable service coordination activities within the scope of MSC services. The documentation that supports this activity should include a description of the purpose and outcome of the contact. From a billing and quality standpoint, there must be enough of a description regarding the purpose and outcome of the contacts to justify billing Medicaid for an MSC service during the month. The MSC provider is responsible for determining when to bill Medicaid for an MSC service provided and should take care to ensure that it is reasonable to bill for given services for an individual served during the month based on the documentation of services provided.

**70. Can the parameters of an email exchange be defined? What should be in the email?**

An email exchange with a qualified contact should be used to gather information, to assess or to monitor the status of the individual, to maintain benefits eligibility, or to obtain referrals for services that might be appropriate for the individual. An email exchange means that after the email is sent by the service coordinator, there is a response from the contact (i.e. exchange).

Note: All HIPAA requirements should be observed if using an electronic medium.

**71. Where do universal applications, Medicaid recerts, and food stamp recerts fall under for Lists A and B?**

If these activities do not include a face-to-face meeting with the individual, they may fall into List B as long as they are direct contacts with a qualified contact or another agency and the contact is a personal contact, a phone call, an e-mail exchange or letter exchange. In addition, these activities must be for a purpose that is related to referral/linkage, or monitoring to ensure that the ISP is implemented and addresses the needs of the person.

**72. There were a number of similar inquiries which fall into the same category. These questions include:**

- **Is sending out an ISP review meeting invitation and getting a response to the invitation a separately billed service from the ISP meeting itself?**

Answer: NO, this is not an MSC service, it is setting up a meeting.

- **If the Service Coordinator completes a DDP2, which is completed every other year, would that be a billable service?**

Answer. NO, this is not in and of itself an MSC service.

- **Is completing a DDP4 a billable service?**

Answer. NO, this is not in and of itself an MSC service.

- **If the MSC agency receives a response back from the annual individual satisfaction survey, can the MSC agency bill?**

Answer. NO, this is not an MSC service, it is an agency administrative activity.

Agencies are ultimately responsible for justifying billing Medicaid for the activities that are delivered in a given month. All activities that are delivered need to have a purpose and outcome and they need to demonstrate that these activities serve to develop, monitor, or implement the valued outcomes in the person's ISP. In addition, agencies should always strive to meet the quality standards which are above and beyond the billing minimum. Finally an MSC agency's administrative functions, such as annual surveys, are not considered billable activities.

## **Documentation Signatures and Electronic Recordkeeping**

### **73. Can signatures be typed, or do forms need to be printed and signed?**

Typed signatures are not acceptable. However, an electronic signature is acceptable when there is protection and security validating the signature and date. Agencies are responsible for ensuring that the electronic signature is secure and cannot be altered and meets all state and federal requirements for electronic systems.

### **74. On the MSC Notes, in the box for the initials of the Service Coordinator and the date – can these be typed in as long as there is either a hand-written or electronic signature at the bottom of the note?**

No, initials must be hand-written as well. The initials may also be electronically signed if the system is secure and protected.

### **75. Does the Service Coordinator need to sign and date each activity on the Monthly Note, or can they sign the bottom of the form to verify service provision?**

Activities need to be initialed and dated. This serves as verification that the activity occurred. As stated at the training, if an MSC agency is keeping the monthly service note in the computer (but not using an electronically secure system), an MSC may wait until the end of the month to print off the note and then initial and date all of the activities at that time as long as it is by the 15th of the month following the month of service.

### **76. Will agencies be required to use the CHOICES system when it is complete even if they have an in-house system in place?**

At this time, it is not expected that use of CHOICES will be mandatory; however, OPWDD encourages providers to consider using CHOICES as it is expected to result in greater efficiencies across the OPWDD system. A future phase of CHOICES is expected to allow for the exchange of electronic files with Voluntary Providers running their own computer systems.

### **Service Coordination Agreement**

**77. It is not clear as to whether the MSC Agreement needs to be completed and re-signed again when there is a new service coordinator (either within the same MSC agency or when an individual changes MSC vendor). Can this be clarified?**

The Service Coordination Agreement is signed only once at MSC enrollment for new individuals and is kept in the person's MSC record at all times. A copy of the signed MSC Agreement should be forwarded to the new MSC Vendor if the individual elects to change vendors. At the MSC agency's discretion, the new vendor may have the individual sign a new Service Coordination Agreement; however, it is not required. The Service Coordination Agreement is reviewed annually with the individual and this review is documented in the Monthly Note.

**78. Since the Service Coordination Agreement will include rights, does this document take the place of the other rights packet which also contains the appeals process that is usually given annually to the individual/advocate? Will the 633.12 appeals process be part of the Service Coordination Agreement?**

No, the rights packet with the appeals process stays in place. The 633.12 appeals process is not part of the MSC Agreement.

**79. Will waiting until the next scheduled review date (i.e. up to six month after the implementation date of the new rules) to change the MSC agreement and ISP place the MSC agency at risk for its billing? For example, if the current MSC agreement requires monthly face-to-face visits, and the new agreement is not signed for six months, technically, five months would not be billable.**

The letter to individuals, dated August 12, 2010 outlined that the changes to MSC take effect 10/1/10. This letter stated that "even if your agreement says you will have a meeting every month or two months, your service coordinator might meet with you less often after 10/1/10."

OPWDD encourages agencies to have individuals sign the new service coordination agreement as soon as possible.

**80. Is the same MSC Agreement to be used for individuals residing in both certified and non-certified settings and for Willowbrook Class members?**

The new MSC Agreement is used for all MSC participants including Willowbrook Class Members.

### **Level of Care Eligibility Determination (LCED)**

**81. What does "completion of Level of Care" mean?**

"Completion of the Level of Care" means that the LCED is filled in, reviewed, and signed by all required parties

The initial (first) LCED must be reviewed and signed by a physician and the DDSO Director. For the annual redetermination, the form must be reviewed and signed by a QMRP familiar with the individual's functional level, a physician, or a physician's assistant or nurse practitioner authorized by a physician, unless the

individual lives in a community residence, in which case only the physician, physician's assistant or nurse practitioner can sign the LCED. See ADM #2009-05 for further information.

**82. Is the initial LCED considered "completed" after it has been signed at the bottom by the director?**

Yes, for MSC billing purposes, the LCED is considered completed when it is signed by the appropriate qualified person. If the MSC did not conduct a review and/or participate in the process to complete the LCED, the MSC Vendor should not bill for a "completed" LCED.

**83. The QMRP is now allowed to review and sign the LCED in an annual renewal. Does this make an MSC agency vulnerable in an audit by another auditing agency which may be looking for a physician's signature?**

An MSC agency should not be vulnerable to an audit as the new HCBS Waiver agreement, dated 10/1/09, clearly allows a QMRP to review and sign the LCED redetermination. OPWDD described this change in ADM #2009-05 and in a clarifying memo issued on March 2, 2010.

**84. For an annual Level of Care Eligibility Determination (LCED), do the social notes need to be done annually or can an older note be used if it is still relevant? Similar to the psychological for adults.**

New social, psychological, and medical assessments are not required on an annual basis for an LCED redetermination.

**85. In the training presentation, it was stated that the annual LCED must be completed before the billing date; does this annual date mean within 365 days of the previous LCED signature, or is it like the ISP yearly dates? In other words, if last year's LCED was done on September 10th, 2009 and your claim and activity for billing was Sept. 25th, 2010 the LCED would still be OK, since it was still the month of September.**

LCED is a federal requirement and requires an annual renewal; therefore the review date must be within 365 days of the previous review date.

**86. On the LCED where it says enrollment date: should this be the day the service coordinator reviewed new Basic agreement or the date the individual was enrolled in MSC?**

On the LCED form, the enrollment date indicates the date the person was originally enrolled in the HCBS Waiver.

**Transition Billing**

**87. Is Transition billing still for two months?**

No. Transition billing is now one month only. The fee for Transition services is three times the standard MSC fee for each category. The rules for situations qualifying for the transition fee have also been changed. Starting 10/1/10, the only circumstances that qualify for transition billing are when an individual is new to OPWDD case coordination and when an individual moves from a Supervised or Supportive IRA or CR into an independent setting where he/she responsible for his/her own living expenses. See information on the OPWDD website on MSC Transition Billing.

**88. How will transition billing be handled?**

When an MSC agency meets the criteria to bill for transition, it should contact the DDSO to let the DDSO know that transition billing will occur. When billing is submitted, the correct locator code should be used (004) in conjunction with the appropriate rate code (5211 for non-Willowbrook Class or 5214 for Willowbrook Class members). Note: The month billed for transition will still count as one unit against the units allocated to the MSC agency.

**89. How will billing work for billing dates of September 1 and October 1, 2010 if an MSC agency has an individual who meets the pre-10/1/10 transition billing requirement? Does the MSC agency still bill for the second month of service even though it will fall after the implementation of the new service rules?**

MSC providers billing for transition situations which occur during the “crossover period” from August 2, 2010 through September 30, 2010, will be allowed TWO months of transition billing, but the Rate Code used for any October 2010 service month billing (11/1/2010 date of service) must be associated with the individual’s status (5211 non-Willowbrook Class Member or 5214 Willowbrook Class Member with locator code 004). August 2, 2010 is the start of the “crossover period” since any individual who qualified for transition billing prior to August 1, 2010 (see criteria for transition billing below) should have had two months of transition billing completed PRIOR to the October 2010 service month.

Following are the transition billing criteria prior to October 1, 2010

1. The person initially receives MSC
2. The person begins adult service
3. Following the person’s move to a more independent residential environment or from his/her family home to a certified environment.

When an MSC agency receives payment at the transition level, the service coordinator must document information in the individual’s record or maintain documentation that substantiates the eligibility for a transition payment. This documentation may include, but is not limited to, a monthly service note describing the circumstance, a copy of correspondence from the IRA Residential Habilitation provider regarding the change, or the addendum to the ISP describing the circumstance.

**90. In what month is the transition billing submitted if the person enters MSC mid-month or moves to his/her own apartment mid month? Should it be billed the first of the month following the half-month, or the next month?**

If an individual is new to MSC, the first month the MSC vendor bills for the individual should be billed as transition.

If an individual moves on the first day of the month into a situation which meets transition rules, the MSC agency should bill for the service with a service date of the first day of the month following the transition (e.g., the person moves on October 1, the transition level claim should use the date of service of November 1). When transition is billed, an MSC vendor must have documentation to support the billing claim. Transition cannot be billed just because an individual has moved.

If an individual moves on any day other than the first of the month into a situation which meets transition rules, the MSC agency should bill for the service with a service date of the first day of the month following the full month of service in the new living arrangement (e.g., if the person moves on October 15, November would be the first full month, so the transition level claim would use the service date of December 1). When transition is billed, an MSC vendor must have documentation to support the billing claim. Transition cannot be billed just because an individual has moved.

**91. Is it appropriate to bill the transition fee for an individual who moves from a certified residence to an uncertified situation with a family member?**

In order for an MSC agency to bill for the transition fee, the individual must move from a certified setting into an independent setting where s/he is responsible for his/her own living expenses.

**92. Is it appropriate to bill the transition fee for an individual who is moving from Early Intervention to MSC services?**

It depends upon the situation. If the individual was receiving PCSS services while s/he was receiving EI services to maintain an ISP to support a waiver service, then the MSC agency could not bill the transition fee, since that is an OPWDD case coordination service. Otherwise, the MSC agency could bill at the transition level, since the person would be new to OPWDD case coordination.

**93. Is it appropriate to bill for a transition payment for persons moving from PCSS to MSC?**

No. Billing for the transition level of payment is only permitted when an individual is new to OPWDD targeted case management (MSC, PCSS, or any state paid service coordination) or if the person is moving from an IRA/CR to an independent living arrangement where he/she is responsible for his/her own living expenses. Since the person is already receiving targeted case management through PCSS, the MSC agency could not bill for transition.

**94. Does someone utilizing an ISS contract or CSS to help pay for living expenses qualify for transition, since for transition billing the person must be “responsible for their own living expenses”?**

Yes, someone that moves from a certified IRA or CR to their own home or apartment is eligible to meet the transition requirements even if they are receiving assistance to pay their own rent or mortgage payment through an ISS contract or CSS price reimbursement.

**95. Is back billing for services the MSC provided (prior to getting the official OPWDD eligibility determination) still going to be allowed?**

The MSC vendor is compensated for activities prior to receiving the official OPWDD eligibility determination if the individual meets the transition rule of being new to MSC as the fee (billed for one month) will be three times the usual fee. The MSC vendor must meet the billing standard for the specific month of service that is being claimed. If the MSC vendor performed activities in June and eligibility was established in July with MSC enrollment as of August 1, in order to bill for the August service month, the Vendor must document services performed during the month of August that meet the billing standards. Work performed in prior months do not support claiming in a subsequent month.

**96. Does the person need a Representative Payee if he/she is moving from an IRA to an independent living arrangement?**

This depends on the person’s ability to manage money, and is governed by the rules of the benefit paying agency. (For example, Social Security Administration rules would govern the need for a representative payee for social security or SSI benefits.) OPWDD does not require that a person have a Representative Payee in order to qualify for an independent living arrangement.

**PCSS (see ADM 2003-02 for additional information)**

Please note, as per the Willowbrook Permanent Injunction (Appendix I), individuals who are Willowbrook Class members must have monthly case management services and, therefore, are not eligible to receive PCSS.

**97. What is the billing fee for PCSS? Is this rate expected to change?**

The current fee for PCSS is \$236.62; agencies will receive a new rate sheet any time this fee is adjusted. PCSS services can only be billed two times per year per individual.

OPWDD Rate Setting issues new rate sheets via OPWDD Secure Message Center accounts to designated individual(s) at each PCSS service provider.

**98. How will individuals receiving PCSS be weighted for the caseload requirement?**

Individuals receiving PCSS will not be weighted for Service Coordinators serving non-Willowbrook Class members. For those serving Willowbrook Class members, individuals receiving PCSS count as one unit against the 20 unit maximum for the caseload.

**99. Will there be guidelines for the number of people a service coordinator can serve under PCSS? Will PCSS cases be assigned a weighting for Service Coordinator caseloads?**

Since there is no official weighting for individuals receiving PCSS in regards to caseload size (except for service coordinators with Willowbrook Class members on their caseload which limits a caseload to 20 people regardless of the case management service or residential setting), the MSC Vendor will have discretion regarding the number of individuals receiving PCSS who can be added to a service coordinator's caseload and still provide quality service coordination services to all on the person's caseload.

**100. If a person switches to PCSS, is a monthly MSC service contact required because there is a monthly waiver contact?**

No, a monthly MSC service contact is not required. PCSS is a stand-alone waiver service which provides basic case management services for individuals who do not need ongoing, comprehensive case management services. It is expected that a Service Coordinator providing PCSS services meet with an individual twice a year to review and update the ISP as needed. To continue to meet the HCBS waiver eligibility requirements, individuals enrolled in the waiver must have the need for at least one monthly waiver service or monthly monitoring. An individual with PCSS only and no other waiver service that is provided monthly may not continue to qualify for HCBS waiver services.

**101. If a person lives on their own or with their family, how many PCSS units do they have allocated?**

PCSS is a waiver service which can only be billed two times per year, regardless of the living arrangement of the person. Unit allocations apply only to the MSC service. PCSS will be tracked separately from the MSC allocation.

**102. Can individuals residing in IRAs opt to receive PCSS instead of MSC?**

Yes. A non-Willowbrook Class member receiving any monthly HCBS waiver service and residing in any waiver appropriate setting may be eligible for PCSS if the individual has received a minimum of 90 days of MSC and meets all other requirements found in OPWDD regulations, 14 NYCRR § 635-10.5(a).

**103. If an individual opts out of MSC into PCSS, will they be able to work with the same MSC agency if they need to go back to MSC, but the MSC agency is unable to serve him/her?**

If this situation arises, the MSC provider should work with the DDSO on coming to a solution.

**104. What if the recommendation from the MSC agency is for an individual to move into PCSS, and the person and/or their advocate refuses to change services?**

MSC is an entitlement for individuals who qualify for the service. If the individual and/or his or her advocate refuses to change services, the individual can continue to receive MSC services if they meet the eligibility requirements including demonstration of the need for ongoing and comprehensive service coordination services. If the MSC agency finds that the person no longer meets the eligibility requirements for MSC, the MSC agency should consult with the DDSO and process the required MSC withdrawal form. If the DDSO

agrees that the individual no longer meets eligibility requirements for MSC, the DDSO will issue a Notice of Decision for MSC termination .

**105. Is supportive school health service preparation for the IEP considered an exclusion or conflict as this service is also billed as Targeted Case Management to Medicaid?**

Children participating in the Early Intervention (EI) program receive an IFSP (Individual Family Service Plan) for their EI services, but they must also have an ISP if they are receiving an HCB service at the same time. Because EI children receive service coordination from the EI program, they are ineligible for MSC. It is an approved practice for these children to receive PCSS and another HCB waiver service. Additionally, some families request PCSS alone to allow a seamless transition into HCBS either during or following their participation in the EI program. In such instances, children should receive PCSS when it is expected that they will receive another HCB waiver service within a year of waiver enrollment.

OPWDD has special billing instructions for providers who deliver PCSS to individuals participating in EI. Providers may contact OPWDD Central Operations at (518) 402-4333 for additional information.

**106. If a person is receiving PCSS two times a year for ISP maintenance, how is the PSCC provider expected to assist the person with funding and services?**

The purpose of PCSS is to maintain an individual's eligibility for waiver services through updates to the ISP and coordination of waiver services. This includes the maintenance of the LCED, assuring that necessary safeguards have been identified to protect the health and welfare of the person, notifying the DDSO if the person is no longer eligible for Waiver services, and initiating the re-enrollment in MSC if circumstances warrant the change.

**107. Is there a limit to the number of times an individual can move back and forth between MSC and PCSS?**

No, there is no limit. Individuals can move back and forth between the two services whenever their service needs change.

**108. If an individual has three months of MSC and is expected to be moved to PCSS, what should the MSC agency do if there is no Waiver service in place by the end of the original three months? Can MSC be extended?**

An individual new to OPWDD services would receive at least three months of MSC (if eligible) in order to develop a plan of care and establish his/her services. If the person does not have a monthly Waiver service in place at the end of three months, he/she could continue receiving MSC until such a time when PCSS is appropriate (in this instance, once a monthly Waiver service is in place).

**109. What will the process be for moving individuals between MSC and PCSS?**

At the present time, there is no change to the process for moving individuals between MSC and PCSS.