

**Plan of Care Support Services (PCSS)
Questions and Answers**

October 30, 2012

1. Does PCSS hold a weight value in regard to caseload size? **A: Yes. Persons who receive PCSS will be counted as 0.3 on the service coordinator's caseload regardless of residential setting. However, for Service Coordinators who serve a member of the Willowbrook Class, a person receiving PCSS counts as one (1) unit on the service coordinator's caseload.**
2. How was the weight determined? **A: PCSS offers 1/3 the total annual months of service of MSC. Total maximum annual units for MSC = 12. Total maximum annual units for PCSS = 4.**
3. Prior to 10/1/2012 PCSS was not weighted. With the changes effective 10/1/2012 it will be weighted 0.3. This could automatically cause some MSCs to exceed caseload maximum for those that have PCSS on their caseloads right now. We will have to hire new MSCs to cover. Will there be a grace period? **A: Yes. With the exception of Willowbrook, providers will have up to 90 days to come into compliance with the new caseload weighting requirements. Caseloads may not at any time exceed the maximum (1:20) for those serving Willowbrook Class Members.**
4. Our understanding of PCSS is in order to be eligible; the person must be receiving another waiver service. Is PCSS an option for new referrals without a waiver service, who do not need comprehensive MSC, just some assistance here and there? **A: A state paid (non-Waiver enrolled) option of PCSS will be offered at the discretion of the Regional Offices (formerly DDSOs) for certain circumstances such as these. PCSS alone is not reason enough for Waiver Enrollment. The person must also need another Waiver service in addition to PCSS to be enrolled in the Waiver. However there may be certain circumstances where a person may receive State Paid PCSS – similar to state paid MSC for those that are not Medicaid enrolled. The situation you describe would be a good fit for this alternative.**
5. Will service providers need to receive prior approval in order to serve a person for the 3rd & 4th PCSS service of any given year? **A: Prior approval will not be required for the extra two services – but the provider must be able to demonstrate that the service was indeed needed.**
6. Will a year be viewed as the State fiscal year still or will this be now changed to the calendar year? **A: The four services in a year will be based on a rolling year – not fixed to fiscal or calendar years. The provider will not be able to bill for more than 4 services in a 12 month period.**
7. For the criteria allowing the 3rd and/or 4th PCSS service in a year, will there be further definition coming from Central Office regarding what "necessary to meet the needs of the individual"

means. **A: For up to two additional months per twelve month period, PCSS may be provided if additional service coordination activities and assistance are provided during those months and are necessary to meet unexpected needs of the individual. Service coordination activities associated with an unexpected need must include at least one of the following:**

- 1. Addressing a newly discovered health or safety issue,**
- 2. Assisting and obtaining a needed service,**
- 3. Negotiating and resolving conflict, or**
- 4. Accessing entitlements and benefits for the individual.**

- 8. The additional two billable times – do they need to be in between the ISP reviews? Can you have 2 additional billable times within 6 months or do they have to be spread out – 1 additional billable within a 6 month period. A: No. Those additional billable months do not need to occur at any particular time. These additional months of service are intended to respond to an unexpected and temporary need. We therefore need to be flexible.**
- 9. Do the two additional services have to be a face to face or would they be like MSC and you could have a List A or a List B? A: The billing requirements are similar to those in MSC. In order to meet the billing requirement for the additional service months, the PCSS service coordinator must complete at least one face-to-face contact with the individual or two of the following contacts within a month: a non-face-to-face contact with the individual (e.g., phone calls), a direct contact with a qualified contact (see below), or a direct contact with other agencies. For each direct or indirect contact, PCSS service coordinators must document that the purpose of these contacts is related to at least one of the four items above.**
- 10. Will we be able to bill for completing a renewal of the individual's Level of Care? A: No. Completing the LCED alone is not a billable PCSS activity. Keeping the LCED up to date is a required part of the basic PCSS service. To meet the billing standard for basic PCSS there must be two ISP reviews per year and the annual LCED redetermination must be completed. To meet the billing standard for up to two additional months, the service must be related to addressing an unexpected need and the activities must include one of the following: Addressing a newly discovered health or safety issue, Assisting and obtaining a needed service, Negotiating and resolving conflict, or Accessing entitlements and benefits for the individual. Completing the LCED does not qualify for meeting the billing standard for an additional month of PCSS.**
- 11. Are annual home visits required? A: Home visits are not required to meet the billing standard but OPWDD strongly recommends that at least one home visit occurs during the course of the year. ISP reviews must include a face-to-face contact with the individual at the individual's**

residence or at an alternate site mutually agreed to by the individual and the service coordinator. However it is strongly recommended that at least one review per year take place in the residence.

12. What is the process and how flexible will it be to move from On-going and Comprehensive MSC to PCSS and back again based on need of the person? **A: This process will be the same as it has always been and is expected to be flexible and responsive to the person's needs. When a person moves from MSC from PCSS they will be withdrawn from MSC and all procedures for MSC withdrawal must be followed including notification of due process rights. See Chapter 8 of the MSC Vendor Manual on the process for MSC withdrawal and PCSS enrollment.**
13. How often must the ISP be reviewed? **A: Twice per year. Formerly the ISP had to be reviewed every six months. With the new PCSS regulations this will change to twice a year, similar to the ISP review requirement for MSC. Best practices would be to review the ISP every six months unless flexibility is needed.**
14. Will people living in IRAs be encouraged or be required to use PCSS? **A: People residing in IRAs will not automatically be required to transfer from MSC and enroll in PCSS. The concept of Ongoing and Comprehensive is to be applied equally to all individuals regardless of residential setting. Since a supervised IRA is a 24 hour setting and addresses many of the person's needs, a person residing in an IRA may have less need for ongoing and comprehensive service coordination. However this will not always be the case and the determination as to whether a person would be better served by PCSS is to be made on an individualized basis.**
15. The PSCC regulations state that providers will get 3 times the monthly rate for people who are being newly enrolled into PCSS. What was the methodology used to determine the initial payment? **A: This is the same concept as the MSC transitional rate (i.e. 3X the usual monthly rate), however ,it only applies to individuals who have never received any type of case coordination through the OPWDD service system. Since we are removing the requirement that a person must have MSC for the first 90 days before enrolling in PCSS we wanted a similar transitional rate to be offered for those who go straight to PCSS and not MSC.**
16. For new enrollees who need a waiver service and decide to enroll in PCSS rather than MSC, when should the vendor bill the 3-month rate? Would it be the month of the NOD date? **A: This would be handled similar to the transition rate for MSC. You bill that initial rate the first month you meet the billing standard. So the NOD may be June but the first service wasn't delivered until July: you bill the initial enhanced rate for the month of July.**

17. Will PCSS still be billed by date of service? **A: No, billing changes will also occur, including change to billing using the 1st of the month following the service month (like MSC billing). This will eliminate billing issues for individuals moving between MSC and PCSS, or PCSS to MSC. An individual may have authorization for MSC or PCSS in a month but not both.**

18. How should PCSS be listed in the ISP? **A: PCSS is listed in the ISP under the section “HCBS Waiver Services in the following manner:**

Name of Provider: *PCSS Provider Agency Name*
Type of Service: *Plan of Care Support Services*
Frequency: *Month*
Duration: *Ongoing*
Effective Date: *On or before first date of service*

19. For individuals currently enrolled in PCSS prior to 10/1/2012, the “frequency” is listed as “Once Every Six Months”. Does this frequency listing stay the same for those enrolled prior to 10/1/2012 or must it be changed? **A: It must be changed. The above listing protocol applies to ALL individuals receiving PCSS regardless of when they were enrolled. ISPs must be updated to reflect this new listing of frequency the next time the ISP is reviewed and no later than 4/1/2013.**