

Office for People With Developmental Disabilities

Medicaid Service Coordination (MSC)

Restructuring

**Provider Information Session for Executive
Staff**

8/11/10

Topics

- Background/Overview
- Expectations/Scope of MSC Services and Changes
- MSC Billing and Documentation Standards
- Reimbursement and Resource Management
- Quality Review
- MSC Restructuring Implementation Next Steps
- Answer questions e-mailed in

Why Restructuring MSC Now?

- MSC Program operating for almost 10 years
- Spring 2008- Informed Choice Design Team Formed
- 2009-10 and 2010-11 budget deficits accelerated need to restructure the program to ensure long-term sustainability
- Expedited stakeholder input plan developed/implemented beginning late 2009

Objectives

- Ensure ability to sustain MSC through efficient and cost effective service delivery
- Flexibility and responsiveness to individual needs
- Eliminate requirements, especially paperwork, that drive workload for service coordinators and are of little “value added” to individuals and their families
- Integrate, support and promote/enhance informed choice and individualized person-centered principles
- Integrate quality indicators into review processes

Important Factors to Keep in Mind

Increasing numbers of individuals seeking MSC entitlement services from OPWDD

+

Decrease in resources available to fund the MSC Program

MSC Restructuring

- Need to streamline service coordination workload
- modification of allowable caseload size while maintaining quality
- Refocus program requirements on MSC core functions and outcomes and ensure that individuals receiving MSC need “ongoing and comprehensive” service coordination
- Level of service tied to individual need
- Modify financial platform
- Measure quality by outcomes and service satisfaction

So What Is Not Changing?

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

Expectations/Core MSC Services and Related Changes

No Change to MSC Eligibility Criteria

Note: There is no MSC Cap!

- MSC is a State Plan service—it is an entitlement for all who meet the following eligibility criteria (outlined in 635-5):
 - Be enrolled in Medicaid
 - Have a documented diagnosis of DD
 - Choose to receive MSC
 - Demonstrate a need for **ongoing and comprehensive** service coordination
 - Must not reside in an institutional setting, ICF, or be enrolled in any other long-term service which includes service coordination

Federal TCM Definition

No Change to Core Functions of MSC

- OPWDD operates MSC in accordance with federal Targeted Case Management (TCM) requirements
- Federal definition of Case Management is “assisting individuals in gaining access to needed medical, social, educational, and other services.”

No Change to Core Functions of MSC

- Assessment
- Service plan development, implementation, maintenance, monitoring (includes assisting the person in maintaining benefits and HCBS waiver eligibility)
- Linkages and referrals to services
- Monitoring and follow-up
- Service documentation
- Advocacy is assumed within each of these functions

Informed Choice = Key MSC Outcome

A person has made an informed choice when he or she has made a decision based on a good understanding of the options available and a good understanding of how that decision may affect his or her life.

A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the person needs help making a good decision. Informed choices can be about everyday things, like what to wear, or big life changing things like where to live, what kind of work to do, or who to be friends with. These decisions can also be about what kinds of services or supports someone wants or needs, and where and how to get them.

When making an informed choice, a person should understand the possible risks involved and what can be done to reduce the risks. A person should also realize his/her ability or desire to make choices that may change over time, or may be different for different kinds of decisions.

Personal choices should be respected and supported by others involved in the person's life.

Activities That Do Not Fall Within the Scope of MSC

MSC Service Coordinators do not provide direct service

Examples:

- A service coordinator does not take the individual grocery shopping but arranges for community habilitation to build daily living skills such as grocery shopping
- A service coordinator does not take the individual to routine medical or dental appointments but works with the person/family or residential provider to arrange for transporting or escorting services.

MSC Service Coordinator

Required Experience, Education, and Training

- Minimum Education Level: Associate's degree in a health or human service field or an RN
- Minimum Experiential Level: One year experience working with people with a developmental disability or one year experience as a service coordinator with any population
- Minimum Training Level: Attendance at an OPWDD-approved Core service coordination training program within six (6) months of assuming MSC responsibilities

Annual Professional Development Requirement

- In addition to Core training, MSC Service Coordinators and MSC Supervisors must attend professional development on an annual basis
- MSC Service Coordinators and MSC Supervisors with less than three (3) years of experience need to complete 15 hours of professional development annually
- MSC Service Coordinators and MSC Supervisors with three (3) years of experience need to complete 10 hours of professional development annually
- MSC Service Coordinators and MSC Supervisors that serve Willowbrook class members need to complete 15 hours of professional development annually

Required and Recommended Professional Development

- MSC Service Coordinators are required to attend four (4) of the six (6) professional development programs within two (2) years of their employment
- The courses deemed essential to the enhancement of service coordination skills are: Waiver Services, Introduction to Person Centered Planning, The Individualized Service Plan, Self Advocacy/Self Determination, Benefits and Entitlements, Quality Assurance
- A special training on Informed Choice is being developed for MSC Service Coordinators

Tools/Methods Used in Provision of MSC Services

Face-to-face service meetings and in-home visits are tools that are used by service coordinators to assess, identify and deliver the appropriate level of service coordination activities and interventions within the scope of MSC services and the person's valued outcomes as indicated on the person's Individualized Service Plan (ISP)

Change to Minimum Number of Face-to-Face Service Meetings

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

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

Change to Minimum Required In-Home Visits

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

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

Change to Maximum Caseload Size

- Effective 10/1/10, maximum caseload is 40 units:

Supervised (24 hr. staffed) IRAS/CRs = .8

Family Care, Supportive settings, own home/apartment or living with family members

= 1

- OPWDD is not mandating this caseload size—it is a maximum caseload size.

- Willowbrook remains the same = 1:20 ratio

(Willowbrook weighting is 1 for everyone except VOICF which is .5)

MSC Program Documentation Streamlining

- Service Coordination Agreement
 - Signed once at enrollment
 - Provisions reviewed annually at ISP meeting

- ISP
 - Maximum distribution time increase from 45-60 days
 - Flexibility on review timeframes
 - Streamlined format

Overview of Documentation Requirements for Billing

Medicaid Standards

(518) 408-2096

What is not changing:

- Individuals must be prior authorized by the DDSO or Service Delivery and Development Region 2 (NYCRO)
- Individuals enrolled in the HCBS Waiver must have an Individualized Service Plan
- The unit of Service continues to be a month.

Billing Standards vs. Quality

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

Billing Standard

To bill for a month of service, the service coordinator must deliver and document a certain number of actions from the following lists:

- List A: When a service coordinator delivers and documents an action from this list, only one action is necessary to meet the billing minimum
- List B: When a service coordinator delivers and documents an action from this list, two actions are necessary to meet the billing minimum

List A

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

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

List B

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

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

List B Continued

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

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

Definition of a Qualified Contact

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

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

Billing Standard Continued

■ Hospitalization:

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

Billing Standard Continued

- Transition Payments are allowable when
 - the individual is new to service coordination, i.e. he/she has never received any type of OPWDD service coordination/case management service
 - the individual moves from an OPWDD certified Supervised or Supportive Individualized Residential Alternative or Community Residence to their own home or apartment where the person is responsible for their own living expenses.

- The service coordinator must document in the individual's record or maintain documentation that substantiates the eligibility for a transition payment.

Service Documentation Requirements

- Individualized Service Plan (ISP)
- Level of Care Eligibility Determination
- Evidence of an ISP review
- Monthly Service Note

MSC 10/1/10

How Billing Will Work

Changes effective October 1, 2010 for
October Service Month – Billing Date of
Service November 1, 2010

MSC Billing Questions – Contact
Central Operations at (518-402-4333)

What stays the same for billing

- MSC Program Enrollment in TABS still triggers Recipient Exception (R/E) code with Provider ID authorized for billing
- Provider IDs stay the same - district specific based on contract, single Provider ID if NYC contracts
- Locator Code 003 continues for regular billing
- Locator Code 004 continues for transition billing – BUT new rules

Changes for billing

- New transition billing rules – only ONE month and less situations qualify → details for crossover from current rules to new rules will be forthcoming in September
- Only TWO Rate Codes used (11/1/10 billing)
 - 5211 – ALL non-Willowbrook Class Members
 - 5214 – ONLY Willowbrook Class Members

MSC Fee Changes Effective October 1, 2010

Cost & Revenue Solutions

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

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

Unit Allocation Methodology

- The Unit Allocation methodology incorporated the input from various stakeholders.
- Each agency will be allotted a specific number of billable units based on the agency's case mix.

Portability

- When an individual chooses to change providers units will be adjusted accordingly.
- Guidance on portability of resources will be provided prior to October 1, 2010

Unit Allocation Based on a 6 – 10 – 12 Methodology

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

Unit Allocation Methodology

- The Unit Allocation Methodology does NOT cap Medicaid Service Coordination.
- If the need arises for additional resources providers need to demonstrate to their district how they have managed their current resources effectively.

Unit Allocation Methodology

- Providers have the flexibility to manage their MSC units in any manner they see necessary to meet the individualized need for service coordination interventions for each MSC participant served.

Unit Allocation Methodology

- Districts will be allocated total unit and dollar resources by 8/27/2010
- **Initial** allocation will be based on:

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

AND

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

Unit Allocation Methodology

- Initial allocation will be refreshed in April 2011 for any individual enrolled between 7/31/10 – 9/30/10.
- Districts will be responsible for notifying each Agency of their allotted unit resources by September 10.
- **Initial allocation questions** should be directed to the MSC Coordinator in your district.

Medicaid Service Coordination

Effective October 1, 2010

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

* Includes HCA VI and trend of 2.08%

Medicaid Service Coordination

Transitional Fees

Effective October 1, 2010

(new transition rules apply)

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

*Includes HCA VI and Trend of 2.08%

Resource Management and Planning

- DDSO's manage resources by providing MSC allocations to MSC providers based on:
 - providers case mix
 - an estimate of the providers anticipated collective utilization.
- DDSO's and Central Office have the ability to move resources between and among providers and between districts as necessary to meet the needs in their geographic areas and to ensure the most effective and efficient use of MSC resources to meet the needs.

Utilization Monitoring

- Central Office will run reports to monitor unit utilization.
- Reports will be provided to each District on a quarterly basis.

Quality Reviews/Framework

- DQM MSC Protocol will be revised
- Integrate quality indicators for informed choice and other key outcomes to help providers enhance individual outcomes
- Program/vendor level review of key agency and program systems that promote/ensure quality and provision of individualized MSC services
- Individual Satisfaction

Next Steps:

Effectuate Revised MSC Vendor Contract

- DDSOs will distribute revised MSC contracts to all vendors electronically prior to September 1, 2010 to provide required 30 day notice to vendors of existing contract cancellation.
- Vendors sign revised MSC contract prior to October 1, 2010. Revised contract automatically cancels existing contract when signed by vendors.
- Vendors return the revised vendor contract to DDSOs.

Next Steps

- MSC Supervisor Information Sessions:
 - August 12 and September 15
- MSC allocations to DDSOs and MSC providers
- Administrative Memorandum (ADM) on new Billing Standards.
- ADM on revisions to the ISP
- Issue streamlined forms and revised Vendor Manual

MSC Central Office Contact Information

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

Questions?