*Andrew M. Cuomo*
*Governor*

*Courtney Burke*
*Commissioner*

# Medicaid Service Coordination Vendor Manual

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# MSC Vendor Manual
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# PREFACE

## Purpose of Vendor Manual

This manual is written for service coordinators and administrative staff of vendors that provide Medicaid Service Coordination (MSC) under contract with the New York State Office For People With Developmental Disabilities (OPWDD). It incorporates information related to the MSC Restructuring that became effective October 1, 2010. This Vendor Manual, dated May 23, 2011, replaces all previous versions of the MSC Vendor Manual issued by OPWDD. The information in this manual is effective October 1, 2010 unless otherwise stated.

This manual describes the structure and operation of OPWDD's MSC program. Except for the pages mentioned in Attachment A to OPWDD ADM 2010-01, this Manual establishes "program standards" that govern the delivery of MSC services. A "program standard" means a standard that, if violated, can lead to potential sanctions, such as a plan of corrective action, which does not include payment recoveries. Sanctions that can be imposed for violation of program standards are those specified in the Mental Hygiene Law (including plan of corrective actions; non-renewal of operating approvals; suspensions and limitations of operating certificates; and fines or other fiscal sanctions as well as restitution).

MSC documentation elements and associated requirements that support payment of MSC service claims are considered "billing standards" or "payment standards". Payment standards establish the minimum service parameters that must be documented in order for MSC vendors to receive reimbursement for a particular service claim. MSC payment standards are contained in Administrative Memorandum (ADM) #2010-03 which is included as an Appendix to this manual and can also be accessed on OPWDD's website at www.opwdd.ny.gov. The payment standards in ADM #2010-03 are identified in the "grey-scaled" version of the ADM found in the "Links to OPWDD Guidance Documents with Payment Standards" ADM #2010-01.

An **MSC Vendor** is a non-profit agency or government entity approved to provide MSC services under contract with OPWDD.

There are three symbols that you will see throughout the text of this manual that will indicate particular obligations of MSC Vendors:

This symbol indicates a rule or procedure regarding document retention or distribution.

This symbol indicates a rule or procedure with a time limit.

This symbol indicates that the information applies to service coordinators serving Willowbrook Class members.

## OPWDD MISSION, VISION AND GUIDING PRINCIPLES: PROVIDES THE CONTEXT FOR MSC

OPWDD's mission, vision and guiding principles provide the context for all of OPWDD's programs and operations, including the administration and operation of the MSC program.

### OPWDD Mission Statement

We help people with developmental disabilities live richer lives.

### OPWDD Vision Statement

People with developmental disabilities:

- enjoy meaningful relationships with friends, family and others in their lives,
- experience personal health and growth,
- live in the home of their choice, and
- fully participate in their communities.

### Guiding Principles

OPWDD has identified the following principles to guide and direct all agency programs, policies and operations. It has strived to imbed these principles in the structure, administration and operation of the MSC program described in this Vendor Manual in order that together, MSC Vendors and OPWDD can pursue the OPWDD mission and vision.

- **Put the person first**
  - People with developmental disabilities are at the heart of everything we do, and this "person first" ethic is embodied in how we express ourselves and conduct our business.
- **Maximize opportunities**
  - OPWDD's vision of productive and fulfilling lives for people with developmental disabilities is achieved by creating opportunities for as many people as possible to access the supports and services they want and need.
- **Promote and reward excellence**
  - OPWDD places a high value on quality and excellence. To improve outcomes throughout the OPWDD system, we seek to recognize and promote excellence.
- **Provide equity of access**
  - OPWDD seeks to assure fair and equitable access to supports and services across all sections of New York State and to provide a range of options in all communities to ensure this access.
- **Nurture partnerships and collaborations**
  - The diverse needs of people with developmental disabilities are best met in collaboration with local and statewide entities who are partners in planning for and meeting these needs; parties such as people with developmental disabilities, families, non-profit providers, communities, local government, and social, health and educational systems.
- **Require accountability and responsibility**
  - OPWDD and its service providers are held to a high degree of accountability in how they carry out their responsibilities. Creating a system of supports that honors the individual's right to be responsible for their own life and accountable for their own decisions is of paramount importance.

## WHAT IS MSC?

Some people are capable of identifying and obtaining supports and services on their own. Others have family members and friends who can help them. For many it is a challenge to keep apprised of the vast array of available supports and services and creatively use these supports and services to meet their own or their loved one's needs. Accessing the most appropriate supports and services requires an understanding of how to make use of the natural supports available in someone's life and information about more traditional provider programs and community resources; such as program features, openings, eligibility criteria and application processes. MSC provides this kind of information and assistance to those who need ongoing and comprehensive services.

**MSC** is the active assistance offered persons as they navigate the community and various service systems in pursuit of the necessary and desired services and supports that will assist them in achieving or maintaining their personal goals.

MSC is a Medicaid State Plan service provided by OPWDD which assists eligible persons with developmental disabilities in gaining access to necessary supports and services appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person centered planning approach in developing, implementing and maintaining an Individualized Service Plan (ISP) with and for a person with developmental disabilities.

MSC promotes the concepts of informed choice, individualized services and supports, and satisfaction.

MSC is designed to help people strive for the highest quality of life. The focus of MSC is on assisting each person to achieve his or her unique goals and desires relative to the person's informed choices including but not limited to: choice of home; meaningful work and/or community activities; social and leisure activities; meaningful relationships; and access to services/supports that promote optimal health.

**Within the TCM framework, MSC helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential, and legal services <u>available</u> and in accordance with the person's <u>needs</u> and <u>valued outcomes</u> as expressed in the Individualized Service Plan (ISP).**

OPWDD's MSC program operates under the federal Targeted Case Management (TCM) program. As such, core services for eligible individuals under MSC include:

- **Assessment** – activities that focus on needs identification. Activities include but are not limited to assessment of an eligible individual to determine need for any medical, social, educational or other services. Specific activities may include taking the person's history, identifying needs of the individual, and completing related documentation. It also includes gathering information from other sources such as

family members, medical providers, educators, and other individuals/providers associated with the person, if necessary, to form a complete assessment (i.e., picture) of the person and his/her needs and goals.

- **Development, Implementation and Maintenance of Service Plans (i.e., care planning)** – builds on information collected through the assessment process and includes such activities as ensuring the active participation of the person and working with the individual and others to develop goals and identify courses of action to respond to the assessed needs of the eligible individual. Includes all ISP related activities outlined in ADM #2010-04.

- **Linkages and Referrals** – includes activities that help link an eligible individual with medical, social, educational providers and other programs, supports, and services that are capable of providing needed and desired services and supports. Examples include but are not limited to: making referrals to providers and scheduling appointments.

- **Monitoring and Follow-up** – activities and contacts that are necessary to ensure that the care plan (i.e., ISP) is effectively implemented and adequately addresses the needs of the individual. These activities and contacts may be made with the person and other qualified contacts (see ADM #2010-03 in Appendix 1). These contacts are made as frequently as necessary to help determine such things as whether services furnished are in accordance with the ISP, the adequacy of services in the ISP, changes in the needs or status of the person, whether the person is satisfied with services and supports, whether the person is receiving needed services to safeguard him/her in his/her home and community (i.e., health and safety monitoring) and determining other relevant information pertaining to the person.

- **Service Documentation –** preparing all required documentation in accordance with requirements.

As a State Plan service, MSC is available to all people with developmental disabilities who meet the eligibility criteria. In order to be considered eligible for MSC, the person must:

- be enrolled in Medicaid
- have a documented diagnosis of a developmental disability

as defined by Mental Hygiene Law and OPWDD guidelines
- demonstrate a need for ongoing and comprehensive service coordination in accordance with OPWDD guidelines
- not reside in a Medicaid institutional setting that provides case management/service coordination (e.g., ICF)
- not be enrolled in any other comprehensive long-term care service which includes case management/service coordination.

Further information on MSC eligibility is contained in Chapter 6, Enrollment of Individuals in MSC.

# CHAPTER 1 KEY CONCEPTS FOR THE PROVISION OF QUALITY SERVICE COORDINATION

This Chapter outlines some of the basic tenets of individualized services:

- Informed Choice,
- Person-Centered Principles, and
- Community Inclusion.

Service coordinators put these principles into practice to provide high quality service coordination.

All service coordinators are urged to learn about these tenets in greater depth through sources such as attendance at relevant training opportunities, information available on OPWDD's website and other sites devoted to people with developmental disabilities, and other professional development experiences.

## Informed Choice

Informed Choice is the foundation for all OPWDD services including MSC. Since Informed Choice is a quality outcome of MSC, it is the role of the service coordinator to facilitate, promote, and support Informed Choice for all individuals served.

Service coordinators help people to make informed choices so that people continue to develop and progress throughout their lives. The following is a definition of Informed Choice:

- *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 that his/her ability or desire to make choices may change over time, or may be different for different kinds of decisions.*

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

See Chapter 2 for more information on the role of the service coordinator in facilitating, promoting, and supporting Informed Choice.

## PERSON CENTERED PLANNING: WHAT IS IT?

Person centered planning is a process that focuses on the capabilities and strengths of an individual in order to create a vision for a desirable future. It focuses on each person's gifts, talents, and skills, not on deficits and deficiencies. It is an ongoing process of social change wherein the service coordinator works with the individual with disabilities and people who pledge their support to that person to identify the individual's vision of their best life and to pursue that vision in their community. All OPWDD supported MSCs are expected to employ person centered planning practices for individuals receiving MSC.

To implement person centered planning, the MSC brings together people who are important to and commit to the person with developmental disabilities to help identify the person's interests, talents, preferences, and needs and to create a plan for pursuing a fulfilling life for that individual. This group is often called the "Circle of Support." Participation in the circle of support and the planning process must be voluntary and usually entails a long-term commitment.

The membership of the circle of support is diverse. Although some members may represent service agencies, membership also includes people who are not human service workers. Family members, friends, and others who spend the most time with the person are considered the experts in this process. Of course, it is paramount that the person with developmental disabilities is at the center of all discussions and planning and that his or her expressed needs and choices are honored, where possible and reasonable. In addition, it is important that the planning group help the individual have greater control over his or her life.

Planning that is person centered uses a discovery process which helps identify and develop the unique gifts of the person with developmental disabilities. These gifts, capacities, and interests serve as a foundation for developing a vision for that person's life. It is the responsibility of the circle of support; together with the person they support, to make the vision a reality. Often it is necessary to build a community network of acceptance where the person with disabilities can be seen as a contributing member of society. Thus, in addition to discovery and planning, person centered planning is an ongoing process of implementing a vision by learning to solve problems, build community and change organizations over time. This process of planning for and pursuing positive change in the life of an individual and his or her community generates constructive energy and optimism that people can channel into personal growth and organizational change. It can effectively give people greater control and choice in their lives and help them to develop skills for realizing their visions and dreams.

The planning meetings of a person centered planning process are not dictated by professional authority nor characterized by technical language. These meetings may be orchestrated by the service coordinator, service coordination supervisor, or by a skilled facilitator (not necessarily the service coordinator) who guides the group to focus on important facets of the person's life and how the person can be included in the community, become as independent as they are able, develop personal relationships, and make social contributions.

There are several person centered planning systems that have been described by different practitioners. One example is "Personal Futures Planning" developed by Dr. Beth Mount, Ph.D. (Appendix 4).

## COMMUNITY INCLUSION

Self advocates, families and professionals in the field recognize how important it is for people to feel they are part of a community. Assisting people with developmental disabilities to become part of their communities is one of the most significant responsibilities of service coordinators. Service coordinators can do this by helping individuals join organizations, use community resources, and build personal relationships.

One of the service coordinator's biggest challenges is to ensure that community inclusion is built into the service plan and that activities are geared towards the person's interests and needs. The service coordinator must work with families, friends, community members and service providers: (a) to ensure that community inclusion is pursued in accordance with the ISP, and (b) to discover new, meaningful community experiences that will enrich the person's life.

Community inclusion goes beyond special, one-time events and routine schedules for recreation and leisure time. It requires the service coordinator to encourage individualized inclusion experiences that include:

- Reestablishing personal relationships with valued people from the past and cultivating relationships with new people,
- Building relationships that emerge from being part of a group or organization - for example, helping a person become a member of a club, a religious congregation, or a civic group,
- Promoting relationships that grow from repeated contact with businesses and other venues in the neighborhood - for example, helping a person become a "regular" at the pharmacy, coffee shop, library, barbershop or hairdresser, and
- Developing relationships through work and volunteer experiences.

Assisting someone to build a network of social relationships in these ways also creates a natural "quality assurance" system that provides informal oversight. Having friends and neighbors who are in regular contact provides the individual with continuous protection from harm or neglect, in addition to providing friendship and a sense of belonging.

See NYS OPWDD Guidelines for Willowbrook Community Inclusion updated 1/26/2011 available on OPWDD's website under the link "Beyond Willowbrook" www.opwdd.ny.gov.

# CHAPTER 2 THE SERVICE COORDINATOR

## Chapter Introduction

This Chapter covers material related to the required qualifications of service coordinators, key responsibilities and other program requirements.

### The Crux of Service Coordination

While the extent of involvement by a service coordinator and the exact tasks he or she undertakes in providing MSC services to each individual will vary, the objectives and focus of every service coordinator in every instance should be the same. Service coordinators must always:

- Help the person with developmental disabilities make informed choices,
- Continually focus on the aspirations of the person with developmental disabilities and assist that person to reach his or her personal goals,
- Promote self-advocacy and informed choice,
- Take all reasonable steps to ensure the health and safety of the person with developmental disabilities,
- Promote self-determination and community inclusion, and
- Make the satisfaction of the person with developmental disabilities a priority.

### Service Coordinator Skills and Abilities

To do all these things with excellence, service coordinators will find they must be able to undertake many different types of activities requiring a wide range of values, skills, and abilities. These skills and abilities include, but are not limited to:

- Facilitating, promoting and supporting Informed Choice and self-advocacy,
- Understanding and using person centered planning principles,
- Listening carefully to what people say,
- Ability to use professional judgment and assess the needs of individuals,
- Recognizing and addressing health and safety issues,
- Facilitating meetings,

- Communicating effectively (verbally and in writing) with individuals, families, advocates, and providers,
- Ability to develop and maintain a thorough working knowledge of available services and supports (both traditional OPWDD funded and community based resources),
- Ability to facilitate and develop natural supports for people,
- Ability to act accordingly in crisis situations,
- Negotiating and resolving conflict,
- Accessing entitlements and benefits,
- Advocating for people,
- Taking steps to ensure the quality of someone's living environment,
- Maintaining an up-to-date ISP for the person,
- Keeping an up-to-date service coordination record, including the required MSC documentation and associated organizational skills, and
- An understanding of service coordination ethics and conflict of interest.

## REQUIRED EXPERIENCE, EDUCATION, AND TRAINING

MSCs must meet all of the following minimum educational, experiential, training and other requirements.

### Minimum Educational Level

MSCs must possess the following minimum education:

- An associate's degree in a health or human services field (see text box) from an accredited college or university or a degree in nursing as a Registered Nurse (RN).

- An individual with credits toward a bachelor's degree may meet this educational requirement by providing a letter from his or her college verifying that he/she has completed course work equivalent to an associate's degree both in the total number of credits received and the number of credits earned in a health or human services field. An associate's degree is usually equal to 60 credits.

- An individual with an associate's degree or a bachelor's degree or who has a minimum of 60 credits toward a bachelor's degree in a field other than health or human services may meet this educational requirement if a

**Examples of Acceptable Health/Human Services Degrees**

- Social Work
- Sociology
- Psychology
- Health
- Nursing
- Medicine
- Rehabilitation Counseling
- Therapeutic Recreation
- Nutrition
- Occupational Therapy
- Physical Therapy
- Speech Pathology
- Audiology
- Music Therapy
- Education
- Special Education

minimum of 20 of his/her college credits are in health and human services. The vendor agency should review the individual's college transcript to verify that the educational requirements have been met and retain this documentation.

Service coordinators who serve Willowbrook Class members must be Qualified Mental Retardation Professionals (QMRP).

Providers should verify the educational credentials of all service coordinators that they hire.

**Minimum Experiential Level**

At a minimum, MSCs must possess the following experience:

- One year experience working with people with developmental disabilities, or
- One year experience as a service coordinator/case manager with any population.

The minimum experiential level does not have to be met if the person has a master's degree in a health or human services field.

Documentation that the service coordinator meets the minimum educational and experiential requirements must be retained for review by OPWDD and other applicable entities.

**Minimum Required Training (Core MSC Training)**

Once hired, in order to continue to work as an MSC, the service coordinator must attend an OPWDD-approved Core (i.e., basic) service coordination training program within six months (180 days) of assuming MSC responsibilities, unless the person can produce a certificate verifying past attendance at a Core training.

A copy of the service coordinator's Core certificate or other valid proof of attendance at Core training should be retained by the vendor indefinitely. Proof of attendance at other professional development training must be kept on file and be available for OPWDD review for at least six years. Service coordinators

should keep their own personal copies for future verification purposes. See "Documentation of Training Records" below.

**Criminal Background Check**

Effective April 1, 2005, criminal background checks are required on employees in a presumptive title, i.e., presumed to have direct contact with individuals served. 14 NYCRR Section 633.22 (d)(2)(i)(g) of OPWDD's regulations states that a criminal history record check is required for a service coordinator and a supervisor of a service coordinator. The requirement does not apply to individuals hired before April 1, 2005.

**"Grandfathering"**

MSC consolidated and replaced two earlier OPWDD service coordination programs, Comprehensive Medicaid Case Management (CMCM) and Home and Community Based Services Waiver Service Coordination. As of March 1, 2000, service coordinators who were qualified to provide services under one of these earlier programs were automatically eligible to provide MSC. For these individuals, core training was required prior to July 31, 2000 to remain a qualified service coordinator.

**Annual Professional Development Requirements**

In addition to Core training, MSC service coordinators must attend professional development annually. For the first three (3) years from the date of hire while employed as a service coordinator a minimum of 15 training hours of professional development is required annually. Thereafter, the minimum number of training hours required is reduced to 10 hours annually.

This professional development may include lectures, workshops, and other training sessions conducted by OPWDD, other agencies, educational institutions, or generic community organizations. This may include online courses, webcasts or other electronic communication media, offered by OPWDD or other entities. The subject of the training must enhance the service coordinator's ability to serve individuals with developmental disabilities.

The service coordination vendor (e.g., supervisor) is responsible for verifying that the subject matter of all training applied to the 15-hour/10–hour annual training requirement is appropriate.

Service coordinators serving Willowbrook Class members must attend 15 hours of professional development training annually no matter how long they have been employed as service coordinators.

Attendance at the Core training cannot be counted towards the required annual training hours.

At the discretion of the MSC vendor agency, service coordination training may carry over from another MSC vendor that the service coordinator was employed by if there was no significant break (i.e. no more than a few months) in employment as a service coordinator. In these cases, the MSC vendor should have formal documentation from the prior MSC vendor agency that the service coordinator completed the training hours that will be carried over.

**The Training Year**

The twelve-month period in which the service coordinator must participate in the required 15/10 hours of annual training is called the "training year." A training year is the twelve-month period following the MSC's "MSC anniversary date" i.e., the month the service coordinator first began providing MSC services.

**Required and Recommended Courses/Curricula**

OPWDD has developed six professional development programs (curricula) that can enhance service coordination knowledge and skills. Service coordinators are required to attend/complete four of these six programs within two years of their employment as an MSC. It is highly recommended that service coordinators complete all six professional development programs at some time during their career. The professional development program consists of the following courses/content:

- Home and Community Based Services (HCBS) Waiver
- Introduction to Person Centered Planning
- The Individualized Service Plan
- Self Advocacy/Self Determination
- Benefits and Entitlements
- Quality Assurance

**Verified attendance**: When a certificate of attendance or attendance sheet is not available, a vendor's note attesting to attendance is acceptable.

In addition to the required professional development program/curricula, OPWDD recommends the following additional training programs/curricula:

- Informed Choice
- Valued Outcomes: The ISP and Habilitation Plans
- How to Facilitate an ISP Meeting
- Advanced Individualized Service Plan
- Advanced Person Centered Planning
- Community Inclusion
- Introduction to Day and Employment Services
- Positive Approaches to Behavior Changes
- Residential Habilitation Services
- Day Habilitation Services
- Community Habilitation
- Start to Finish – Steps to Successful Special Education Services
- The Next Step: Transition Services
- Cultural Competence
- "We have Choices"

Attendance/completion of any of these required or recommended programs counts toward the required hours of professional development for a particular training year only when attended/completed during that training year.

The MSC's participation in the training must be verified by either providing proof of attendance or being verified in the MSC's training record or equivalent tracking system by the MSC vendor (e.g., supervisor) (See below).

Organizations wishing to provide their own version of the required and recommended professional development courses as a substitute for the OPWDD programs must submit their curricula to OPWDD's Talent Development and Training unit for approval. An OPWDD topic-area expert will review the curricula to determine if the content and duration is equivalent.

A catalog of OPWDD sponsored professional development programs is available on the OPWDD website (www.opwdd.ny.gov).

**Documentation of Training Record**

MSC Vendors must record service coordinators' attendance at the Core Training and professional development programs on the MSC Service Coordinator's Training Record (MSC6-TRN) (Appendix Two) or an equivalent documentation tracking system that allows for the tracking of each service coordinator's training during each training year. A separate MSC Service Coordinator's Training Record (or equivalent tracking mechanism) should be maintained for each "training year" for each service coordinator. The training record must be available for review by OPWDD and other applicable entities and must be retained for a minimum of six years. However, a vendor may require a longer retention period based on its own standards. The vendor should retain a copy of the service coordinator's Core training certificate indefinitely.

The training record (or equivalent tracking mechanism) should contain all of the following information:

- Title and subject matter of training
- Date(s) of training
- Total duration (number of hours)
- Organization sponsoring the training session or professional development program
- Service coordination supervisor's initials to verify attendance

For each entry, a copy of the workshop or training announcement should be attached to the Service Coordinator's Training Record or equivalent tracking system. A copy of each MSC's training record should be retained in the vendor's personnel or training files. The service coordinator should also retain a copy. These records can be retained electronically as an alternative to paper based filing systems.

## CONFLICT OF INTEREST

To avoid a potential conflict of interest and to promote the independence of the service coordinator, staff providing direct services to a person cannot also serve as that person's service coordinator. This includes but is not limited to: residence managers, clinicians (e.g., psychologists, nurses), habilitation specialists, Family Care home liaisons and direct support staff.

It is important to remember that the service coordination provider and the service coordinator (to the greatest extent possible) are chosen by the person with developmental disabilities. A service coordinator should be as independent as possible to best represent the interests of the person.

## CASELOAD REQUIREMENTS

The following paragraphs describe the maximum MSC caseload limitations for service coordinators who do not serve Willowbrook Class members:

- The maximum caseload is 40 units. There is a .8 weighting factor for individuals residing in an OPWDD certified Supervised Community Residence (CR) or Supervised Individualized Residential Alternative (IRA). For all other individuals, including Family Care, there is no weighting factor (one individual = one unit).

- When a service coordinator's caseload is mixed, i.e., some individuals live in a certified supervised residence, some live in a supportive residence and some live in a non-certified setting on their own or with others, the maximum number of individuals that can be served falls between 40 and 50.

  Example: a service coordinator provides MSC for 10 individuals living in a supervised IRA. These 10 people are counted as 8 units (.8 X 10 = 8). This service coordinator can therefore serve up to an additional 32 individuals living in supportive sites, Family Care or living on their own or with others and still be within the maximum caseload limit of 40 units (8 + 32 = 40 units). In this instance, the weighting of the individuals living in the certified IRAs allows the service coordinator to serve a maximum of 42 (10 + 32) individuals.

- Staff who are not working full time as a service coordinator should have their caseload size adjusted proportionately, e.g., a staff person who works 50% or .5 FTE (half-time) should have no more than half the maximum caseload size which is 20 units.

- Persons served by the service coordinator who receive Plan of Care Support Services (PCSS) instead of MSC are not counted in the service coordinator's caseload.

## CASELOAD REQUIREMENTS FOR WILLOWBROOK CLASS

When an MSC service coordinator serves even one member of the Willowbrook Class, his or her maximum caseload must not exceed 20 units. See the box below for additional information on calculating the Willowbrook workload.

### Willowbrook Caseload Rules

- OPWDD is obligated to provide service coordination at the equivalent of 1:20 for class members.
- A staff person who works as a full-time service coordinator can carry 20 work units. When a staff member is a full-time employee, but works only part-time as a service coordinator, work units are adjusted appropriately. For example, a staff person working half-time as a service coordinator may carry 10 work units, while a staff person working quarter-time may carry 5 work units.
- Each individual living in a Voluntary Operated ICF, though not MSC eligible, counts as .5 of a work unit, with the understanding that matching case management services are provided within the residence.
- Each individual living in any residential setting other than a Voluntary Operated ICF is considered one work unit. This is true for each individual living in an IRA, a SOICF, a community residence, a Family Care home, or in an uncertified setting.
- Each person receiving Plan of Care Support Services, regardless of whether or not the person is a class member, counts as one (1) work unit.

## KEY MSC RESPONSIBILITIES AND TOOLS/METHODS

In order to help a person determine and access necessary and available supports and services, a service coordinator performs person centered activities related to: assessment; service plan development; implementation; maintenance and monitoring; linkages and referrals; monitoring and follow up; advocacy; and record keeping.

Service coordinators have a variety of tools and methods at their disposal to provide appropriate and quality service coordination activities. Some of these tools and methods are requirements of the MSC program and others can be used at the discretion of the service coordinator in conjunction with the participant and his or her circle of support.

The remainder of this chapter outlines the key responsibilities of service coordinators and some of the major tools and methods that are used to provide quality service coordination.

## IT IS THE PRIMARY ROLE OF SERVICE COORDINATORS TO PROMOTE AND SUPPORT INFORMED CHOICE

People with developmental disabilities, like all of us, seek control over their lives. They want, and deserve the right, to choose where they will live and work, who will be their friends, and how they will spend their money and leisure time. People with developmental disabilities have the right to determine their personal goals and decide how they will pursue them.

Informed Choice is a quality outcome of MSC and is the foundation for all other service coordination activities.

MSC service coordinators play a significant role in helping individuals with developmental disabilities exercise their right to choose personal goals and decide which supports and services they want and need to achieve these goals. Supports and services include: those available from natural and community sources; traditional agency services; and individualized and self-directed service options.

**Informed Choice** means that a person makes a decision based on a good understanding of the options available to them and a good understanding of how each option may affect his or her life.

OPWDD, service providers, and MSC vendors support Informed Choice by ensuring that individuals know all the options available to them and how each option may impact the person's life.

Service coordinators promote Informed Choice when they support individuals with the necessary information to make choices about the things in their lives that are important to them.

A person can make an informed choice on his or her own or may ask family members, friends or others for assistance.

Informed choices can be about everyday things, like what to wear, or about big, life-changing things like where to live, what kind of work to do, or who to be friends with. Informed choices can also be about the kinds of services or supports someone wants or needs, and where and how to get them.

Making an informed choice means the person making the choice understands the risks and benefits involved in the options available.

Choices have outcomes; they make a difference in what happens to the person. It is important for an individual to understand the possible outcomes of different options and things that can be done to reduce the risks. Informed Choice is unique for each person and every point in time in the person's life. One's ability to make choices may change over time or may vary for different kinds of decisions.

Informed Choice is the foundation for all service coordination activities. It is a quality outcome for MSC.

## RESPONSIBILITIES ASSOCIATED WITH THE ISP

### Individualized Service Planning via a Person Centered Approach

Service coordinators focus their planning for each individual on the needs and desires of the person with developmental disabilities, drawing input from the important people in the individual's life. Family members, friends, agency staff, and others who spend time with the person, along with the service coordinator, come together to form a "circle of support" to assist the person with developmental disabilities. Members of this circle communicate regularly together and with the individual with developmental disabilities to discuss and plan the best way to meet the individual's needs and fulfill his or her personal goals. Together, the circle of support and the individual with developmental disabilities work with the service coordinator to document a life plan for the individual.

A **"Circle of Support"** is a group of people dedicated to overseeing the planning of services and supports to meet the needs and fulfill the personal ambitions and goals of an individual with developmental disabilities.

This life plan is known as an Individualized Service Plan (ISP). It describes who the person is by depicting the person's strengths, capacities, needs, and desires (valued outcomes). It also lists the supports and services needed by the person to achieve these outcomes. Through the process of creating this life plan, service coordinators assist people to identify their goals and secure the needed services and supports, including natural supports and community resources, to attain those goals.

The service coordinator's most fundamental responsibility is to develop, implement and maintain the ISP—this activity is not static but is a continuous and ongoing process. The following is a brief summary of specific MSC responsibilities associated with the ISP.

(Refer to Administrative Memorandum #2010-04 Program Standards: Individualized Service Plan (ISP) Format and Timeframes for Review and Distribution along with the ISP Format and Instructions for complete information and instructions regarding ISPs. These documents are located in Appendix 1 and on OPWDD's website.)

**Developing the Person's ISP**

The service coordinator:

- Uses a person centered planning approach to develop the ISP. The service coordinator identifies the desired goals and valued outcomes of the person and the supports and services that person wants and needs to achieve those outcomes,
- Helps a person with developmental disabilities plan by promoting and supporting informed choices and developing a personal network of activities, supports, services, and community resources based on the person's needs and desires,
- Documents in the ISP the supports, services, community resources needed and chosen by the person with developmental disabilities and the entities that will supply them,
- Helps the person with developmental disabilities to identify the service coordination activities and interventions that the person wants and needs to meet his or her individualized goals and valued outcomes as described in the ISP,
- Develops the Preliminary ISP (PISP) (if applicable) for people enrolled in the HCBS Waiver, the preliminary ISP is a

OPWDD requires that vendors use a person centered planning process appropriate to each individual's planning needs. The basic principles outlined in this section and in Appendix 4 should be applied to the development of each person's Individualized Service Plan. This is often referred to as using a "person centered approach."

"first cut" description of the person and what he/she needs to live healthy and safe in the community. It is a component of the HCBS application process, and

- Develops the MSC Activity Plan for Willowbrook Class members and for non-Willowbrook Class members who choose to have one.

**Implementing the Person's ISP**

The service coordinator:

- Uses knowledge of the community and available resources to support the person with developmental disabilities to make informed choices regarding how to achieve his or her valued outcomes,
- Coordinates access to and the delivery of supports and services identified in the ISP,
- Helps to locate and/or create natural supports and community resources,
- Locates funded services,
- Helps determine eligibility,
- Makes referrals,
- Facilitates visits and interviews with family members, service providers, housing options, etc. and
- Ensures essential information is made available to the person and providers and others, to the extent permitted by federal and state privacy and confidentiality rules (e.g., Mental Hygiene Law Article 33.13 and 45 Code of Federal Regulations Part 164, HIPAA) and assists the individual or other authorized parties in signing consents for disclosure of information where required .

**Maintaining the Person's ISP**

The service coordinator:

- Uses a person centered planning process to review the ISP at least twice annually (at least once annually through a face-to-face meeting with the individual and major service providers) and makes any necessary revisions to ensure the ISP is up-to-date and supports and service are consistent with the needs and goals of the person,
- Works with the person and others as appropriate to assess the person's satisfaction with his or her ISP and the services,

supports, valued outcomes/goals therein and related service coordination activities and makes adjustments as necessary,
- Continuously supports the person with developmental disabilities to make informed choices and achieve his/her valued outcomes,
- Establishes and maintains an effective communication network with service providers and others involved with the person with developmental disabilities,
- Keeps up to date with changes, choices, temporary setbacks and accomplishments related to the ISP and incorporates changes to the ISP as needed, and
- Advocates for the person with developmental disabilities when his or her rights, protections, or health and safety needs and safeguards are not being met. .

**Who is in Control?**

While the service coordinator is responsible for the development, maintenance, and implementation of the ISP, the person with developmental disabilities, with the help of his or her family, an advocate, or chosen circle of support, is in control and guides the service coordinator's actions. The service coordinator encourages the person with developmental disabilities to play as active a role as possible in all three areas (developing, maintaining and implementing the ISP). The service coordinator may also help to find someone who can assist the individual, or if necessary, represent the person in planning and decision-making.

## Advocating

Most of the activities performed by service coordinators involve some element of advocacy. A person may have a formal "advocate" who performs a variety of functions, but what is referred to here is something different. Advocacy is the act of actively supporting, encouraging, and/or negotiating for a particular purpose or outcome. For example, a service coordinator may advocate with a landlord to convince the landlord to allow the person to move into their chosen apartment.

A service coordinator "advocates" by actively supporting, encouraging and/or negotiating for particular outcomes on behalf of and together with the person.

Whenever a service coordinator helps an individual obtain a service or helps an individual participate in an activity, a service coordinator may be advocating on behalf of the individual. Advocacy is also inherent in the health and safety monitoring performed by service coordinators as well as ensuring continued eligibility for Medicaid and HCBS Waiver services (if applicable).

Another example of advocacy is when a service coordinator who serves individuals residing in certified residences actively seeks to ensure that the individual's right to a monthly personal allowance is maintained. Any individual with income, including Social Security Disability and SSI benefits, is entitled to a personal allowance. An individual's personal funds should be used to support the person's preferences, choices and interests and the service coordinator's advocacy in this area helps ensure the person's rights are upheld.

**Protecting and Upholding Individuals' Rights**

Because MSCs are active in helping to plan and coordinate the activities, supports, and services of individuals with developmental disabilities, service coordinators are in an ideal position to observe when the rights of an individual are potentially being violated. An extremely important responsibility of the MSC is to note any such instances and advocate on behalf of the person whose rights are being denied. To fulfill this obligation, the MSC must be knowledgeable of the rights of individuals and mindful of developments within the life of each individual they serve. Situations in which rights can be infringed upon can range from housing to education to issues of accessibility. In each such situation, it is imperative that the MSC speak up and take action on behalf of the individual.

## Monitoring Health and Safety

A critical role of the service coordinator is monitoring the health and safety needs of the person and working to improve the quality and safety of the person's living environment if necessary (e.g., through advocacy).

Service coordinators are responsible for reporting any suspected unmet health or safety needs to the DDSO. If an unmet health or safety need places an individual in imminent danger of being harmed, the service coordinator is expected to do whatever is reasonable to protect that individual (e.g., call for emergency assistance and remain on site until the situation is addressed). In these situations, the service coordinator must immediately inform the executive director of the residential agency or his/her designee, and the service coordination's supervisor.

The health and safety reporting requirements and standards are different for individuals who live in OPWDD certified residences and for individuals who live independently or with family members.

A **quality living environment for a certified residence** is defined in terms of the specific needs of each individual. The environment must be safe (free from potential hazards), clean, suitably furnished, with adequate space, and designed to reasonably accommodate each individual's needs, supports, services, and privacy.

Regardless of where the individual lives, MSCs must inform the appropriate DDSO of any dangerous situations and of any reports made to outside state or law enforcement agencies. This includes reporting any suspected child abuse to the State Central Register of Child Abuse and Maltreatment at 1-800-342-3720.

To fulfill responsibilities related to health and safety monitoring for individuals living in OPWDD certified settings, an MSC must:

- Report any suspected unmet health or safety needs to the applicable DDSO,
- Report suspected unmet health or safety needs for any Willowbrook Class member living in any OPWDD certified residential setting using the Service Coordination Observation Report (MSC7-SCOR) (See Appendix Three),
- Ensure that IRA residents have Individual Plans of Protective Oversight (IPOP),
- For people living in CRs, IRAs, or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk, including any fire safety actions or provisions necessary,
- Comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD) and take reasonable steps to prevent violation of Part 633 (Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and subpart 635-9 (Provision of Required Services).

**Service Coordinators are responsible for following up on whether a person has received necessary health care services.** If a person has a medical condition, the service coordinator should monitor whether or not the prescribed medication, equipment, or medical care is being provided.

For individuals who live independently, with others, or at home with family, the service coordinator must:

- Document in the safeguards section of the ISP that there are safeguards in place to protect the person's health and safety, including a summary of fire safety needs,
- Report suspected child abuse to the State Register of Child Abuse and Maltreatment at 1-800-342-3720.
- Address other suspected abuse, neglect, and financial exploitation of children or adults, including situations where an individual cannot care for him or herself. This may require a call to the local adult protective service system. In New York City, suspected abuse or neglect of adults is reported to Protective Services for Adults. Outside New York City, the local county department of social services should be contacted to determine which office has responsibility for this function in the county where the individual lives,

- Take all reasonable steps to ensure that the person with developmental disabilities obtains adequate health care. If a service coordinator believes an individual may be sick, the service coordinator must advocate for the individual by helping him or her access health care as necessary.

For further information regarding the actions to be taken when it is suspected that an individual is in a dangerous situation, service coordinators should refer to the Handbook for All OPWDD Providers - Part 624. Vendors can obtain copies of the handbook from OPWDD's Regulatory Affairs or on OPWDD's website (www.opwdd.ny.gov).

**24-Hour Emergency Telephone Number**

MSC vendors must provide a 24-hour emergency telephone number to each individual served. The emergency number must be answered by either an MSC agency staff person or an answering service who contacts an MSC agency staff person. An answering machine cannot be used unless it provides a forwarding number that is answered by an MSC agency staff person. See ISP Instructions in Appendix 1. MSC vendors should have a reliable system in place to ensure that each individual has been provided with this number and that this number is reviewed with the person at least annually and their advocates, family members.

## FACE-TO-FACE SERVICE MEETINGS AND IN-HOME VISITS

Face-to-face service meetings and home visits are some of the 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 ISP.

The face-to-face service meeting:

- Helps service coordinators to build relationships with individuals and their circles of support in order to more effectively assess and address needs and goals,
- Helps service coordinators 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,
- Enables the service coordinator and the person, family, and others to discuss various aspects of the person's ISP. The face-to-face ISP meeting is a tool used to find out whether the individual is satisfied with the quality, frequency, and types of services he or she is receiving and whether he or she wants to make changes to the ISP,
- Acts as a quality check. The service coordinator has the opportunity to observe the person and, when doing a home visit, observe the person's home environment to identify potential health and safety problems,
- Should be of sufficient length to allow the service coordinator to review the person's current status and determine his or her satisfaction with services and any needed changes.

Service coordinators are expected to meet face-to-face with all individuals on their caseloads as frequently as needed based upon each person's individualized needs and circumstances. However, there must be <u>at least</u> three face-to-face service meetings provided annually (based on the calendar year) to all non-Willowbrook Class Members.

The frequency of face-to-face meetings with the individual that are necessary to provide quality service coordination activities and interventions (within the scope of MSC services) is based upon the professional judgment and assessment of the service coordinator and service coordinator's supervisor in consultation with the individual and others as appropriate.

The assessment process to determine the need for face-to-face meetings is not static but is ongoing based on what is happening in each person's life and the regular contact that the service coordinator engages in with the individual, the individual's circle of support, the individual's service providers, and other qualified contacts as appropriate.

Face-to-face meetings should have a purpose and an outcome (e.g., observing for health and safety). This means that it is not appropriate for face-to-face meetings to be used purely for social or recreational purposes.

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 at a given time. This is not an all-inclusive list.

- Whether or not the person receives regular/frequent services in which other service providers are able to observe and interact with the person regularly;
- 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 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 with current services, want to work on new valued outcomes, or are experiencing health issues;
- Individuals who want to change their living situation;
- Individuals and their advocate(s), their service providers, or others who communicate concerns regarding the person's living environment to the service coordinator (indicates need for more in home visits);
- Individuals who are having difficulty with family members and/or have had recent changes in their family composition, circumstances, or family dynamics.

Service coordinators should facilitate conversations 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 and to ensure that the person and their circles of support understand the purpose of face-to-face service meetings.

### Minimum Required Number of Face-to-Face Meetings

For non-Willowbrook Class members, a service coordinator must meet with the individual face-to-face at least three times in a calendar year. If the person is enrolled in MSC for the first time during the calendar year, the following is the minimum number of face-to-face visits expected based on the month MSC began:

January – April = 3
May – August = 2
September – December = 1

This is the minimum number of face-to-face meetings required. As discussed above, if the needs of the individual warrant more face-to-face meetings, the service coordinator should meet with the individual more frequently.

For Willowbrook Class members, a service coordinator must make every attempt to conduct a face-to-face meeting with every class member on his or her caseload during each calendar month. A face-to-face meeting is a requirement to bill for MSC services for Willowbrook Class Members in any given month.

### Face-to-Face Meeting for Annual ISP Review

ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. The annual face-to-face meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365th day occurs.

The annual face-to-face ISP meeting counts towards the minimum number of required face-to-face meetings during the calendar year. See ADM #2010-04 ISP, for more information and the ISP instructions.

### Location of Face-to-Face Meetings

The person, family or advocate and service coordinator agree upon the location of the face-to-face service meeting(s). The meeting may take place at a program site, in the person's home, in the community, or any other setting agreed upon. It is best practice to

vary the locations of the face-to-face meetings in order to observe the individual in a variety of his or her everyday settings.

## PERIODIC IN-HOME SERVICE MEETING REQUIREMENT

### Non-Willowbrook Class Members

For non-Willowbrook Class members, a face-to-face service meeting (i.e., home visit) in the person's home is required at least once annually, based on the calendar year. This is the minimum requirement. A service coordinator may have more in-home meetings if the service coordinator feels that it is needed to monitor the individual's health and safety or if the individual and the service coordinator agree to additional meetings in the individual's home.

The visit to the individual's home allows the service coordinator to identify potential hazardous conditions in the home, as well as cleanliness or maintenance problems.

If the service coordinator becomes aware of any conditions that place an individual in imminent danger, the service coordinator must do whatever is reasonable to protect the person (e.g., call for emergency assistance and remain on site until the situation is addressed). In these situations, the service coordinator must immediately inform the executive director of the residential agency or his or her designee, and the service coordinator's supervisor.

If the service coordinator observes or becomes aware of any event or situation which may be considered abuse according to the definition in Part 624, the procedures for notification and follow-up outlined in this regulation must be followed.

The service coordinator should report in a monthly note or service note any serious issues uncovered that may place the individual in danger, any steps he or she took to protect the individual, and any necessary follow-up activities.

The service coordinator should notify his or her supervisor if any serious problems noted in the Medicaid Service Coordination Notes are not resolved in a reasonable timeframe. The supervisor should contact the residential agency regarding the unresolved issue. If the issue remains unresolved, the supervisor should contact the DDSO regarding his or her concerns.

Completion of a Service Coordination Observation Report (SCOR) is optional for non-Willowbrook Class Members but may be a useful tool/guide to help the service coordinator assess concerns in the home environment and take appropriate action.

(Also see "Monitoring Health and Safety" in this Chapter for additional information.)

**Home Visit Requirements for Willowbrook Class Members**

For Willowbrook Class members, a face-to-face service meeting in the person's home is required at least once during each three-month quarter of a calendar year. A calendar year is divided into four, three month quarters:

1st quarter – January through March
2nd quarter – April through June
3rd quarter – July through September
4th quarter – October through December

If a person is enrolled in MSC during the last month of a calendar quarter, an in-home service meeting does not have to occur until sometime during the next calendar quarter. For example, if a person is enrolled in MSC during the month of March, an in-home service meeting does not have to take place until sometime during the April through June calendar quarter.

**The Service Coordination Observation Report is Mandatory for Willowbrook Class Members**

The Service Coordination Observation Report (MSC7-SCOR) (see Appendix 3) was developed for service coordinators to use as a tool to document health, safety, and environmental issues in OPWDD certified residences.

The Service Coordination Observation Report (SCOR) must be completed for all Willowbrook Class members living in certified settings, except those living in Developmental Centers. A SCOR must be filed at least two times in a calendar year, (but not in consecutive quarters), even if there is no issue to report.

## Ensuring Eligibility for Medicaid and HCBS Waiver Services (if applicable) is Maintained

The service coordinator ensures that all necessary documentation is completed so that a person's enrollment in Medicaid and the HCBS Waiver (if applicable) is not unnecessarily interrupted.

- People receiving Supplemental Security Income (SSI) are eligible for Medicaid based on their eligibility for SSI. The Social Security Administration determines whether they are eligible for SSI and conducts periodic disability reviews.

- Most people enrolled in Medicaid who are not receiving SSI must have their Medicaid cases re-certified on an annual basis. The service coordinator may assist the person to gather and complete the necessary documentation to maintain these benefits.

- The local OPWDD Revenue Support Field Office (RSFO) can provide assistance with Medicaid-eligibility issues (see OPWDD's website for the latest listing of RSFO offices).

### Home and Community Based Services (HCBS) Waiver

- The HCBS Waiver was developed to enable states to address the needs of individuals who would otherwise need costly institutional care by furnishing cost effective services to assist people to remain in their homes and communities.

- In accordance with OPWDD's regulations, (Subpart 635) persons enrolled in the HCBS waiver must reside in an appropriate living arrangement (i.e., his/her own home or apartment or that of a relatives, or a supervised or supportive community residence or an individualized residential alternative, or in a certified family care home).

- Persons enrolled in the HCBS Waiver need an annual level of care determination that documents their continued eligibility for an ICF level of care. It is the responsibility of the service coordinator to ensure the timely completion of the level of

The service coordinator ensures that there is timely completion of annual LCEDs for all HCBS waiver enrolled individuals.

care re-determinations. Administrative Memorandum #2009-05 Level of Care Eligibility Determination (LCED) and the LCED form and instructions provide further information on these requirements (see Appendix 1).

- Service coordinators should be aware that people enrolled in the HCBS Waiver must demonstrate a reasonable indication of the need for waiver services in order to maintain continued eligibility. In order for an individual to be considered to require a level of care specified for the HCBS waiver the person: (a) requires at least one waiver service (as evidenced by the service plan) and (b) requires the provision of waiver services at least monthly or, if less frequently, requires monthly monitoring (as documented in the service plan) to assure health and welfare.

- Service coordinators should review the ISP and other appropriate documentation to assess whether these requirements continue to be met. If not met, the service coordinator should notify the appropriate DDSO's HCBS Waiver Coordinator.

## MSC RECORD KEEPING

The MSC record keeping responsibility focuses activity on keeping accurate and current records on service coordination activities and other services provided to the person.

The documents and notes within the person's service coordination record should provide a chronological, ongoing written record of relevant information about the person and his or her life that helps a service coordinator provide person centered quality services.

Additionally, high quality professional notes demonstrate the service coordinator's comprehensive and personal knowledge of the individual and his or her ISP along with substantiating billing for service coordination and key quality indicators.

The service coordinator's record keeping should be clear and comprehensive enough to enable effective transition of service coordination services to another service coordinator or vendor if necessary. The records should be organized and clear to ensure that oversight entities can obtain a complete picture of the person

and the MSC activities that are being provided on behalf of the person.

The service coordinator must maintain required documents in the individual's Service Coordination Record (Chapter Four). These documents keep a detailed record of supports and services the individual with developmental disabilities has received over time and substantiate a vendor's billing for federal and state audits.

## A Reminder About Activities That Fall Outside the Scope of MSC

It is important for all parties associated with the MSC program to understand the scope and functions inherent in MSC services under Targeted Case Management (TCM).

A key principle to keep in mind is that service coordinators do not provide direct services. The service coordinator's role is to assist an individual in gaining access to needed medical, social, educational or other needed services, not directly providing such services. Service coordinators arrange for services, they do not provide services directly.

For example, a service coordinator arranges for community habilitation so that an individual can build his or her daily living skills such as grocery shopping. The service coordinator does not take the individual grocery shopping.

Occasionally, however, some individuals, family members or advocates may request support from their service coordinator (such as taking an individual grocery shopping) which does not align with the scope of reimbursable MSC services. When this occurs, it is important for the service coordinator to recognize the limits of reimbursable MSC services and work with their supervisor and others as appropriate to communicate this to the person making the request and to help the person served and their circle of support to understand the purpose and scope of MSC and to identify other individuals in the person's life, other natural supports, community resources, etc. that can provide these direct services to meet the individual's needs.

# CHAPTER 3 THE SERVICE COORDINATION SUPERVISOR

## REQUIRED EDUCATION, EXPERIENCE, AND TRAINING

### Minimum Educational/Experiential Level

Staff providing direct supervision to MSCs must meet all of the following minimum criteria:

- A master's degree in a health or human services field (see text box) with no additional experience required, or
- A bachelor's degree in a health or human services field plus
- One year experience working with people with developmental disabilities, or one year experience as a service coordinator with any population.

MSC vendors must retain for OPWDD review documentation that the MSC supervisor meets the minimum educational and experiential requirements. Vendors should verify the educational credentials of all MSC supervisors and service coordinators that they hire.

**Examples of Acceptable Health/Human Services Degrees**

- Social Work
- Sociology
- Psychology
- Health
- Nursing
- Medicine
- Rehabilitation Counseling
- Therapeutic Recreation
- Nutrition
- Occupational Therapy
- Physical Therapy
- Speech Pathology
- Audiology
- Music Therapy
- Education
- Special Education

### Core Training and Additional Professional Development

Once hired, in order to continue to work as an MSC supervisor, the MSC supervisor must attend:

- An OPWDD-approved Core MSC training program within six months (180 days) of assuming MSC supervisory responsibilities, unless the person can produce a certificate verifying past attendance at a Core MSC training, and
- At least fifteen (15) hours of professional development annually for the first three years of employment, or
- At least ten (10) hours of professional development annually after three (3) years of employment as a service coordinator or supervisor.

- If the service coordination supervisor provides service coordination directly to class members he/she must meet the 15 hour professional development requirement annually regardless of how long he/she has been employed in that capacity.

The training year starts with the date of appointment as an MSC or MSC Supervisor. Professional development may include lectures, workshops, and other training sessions conducted by OPWDD, other agencies, educational institutions or generic community organizations.

MSC supervisors who also carry a caseload must meet all professional development requirements for service coordinators (see Chapter 2). Attendance at these trainings must be documented in the supervisor's MSC Service Coordinator's Training Record (MSC6-TRN). The staff person who oversees the work of the MSC Supervisor must verify the attendance of the MSC supervisor by initialing the MSC6-TRN.

MSC vendors must retain a copy of the MSC supervisor's Core training certificate indefinitely and proof of attendance at professional development training for at least six years for review by OPWDD and other applicable entities. The MSC Supervisor should also maintain his or her own copy. See Chapter Two, "Documentation of Training Record" for further information on retention requirements.

**Criminal Background Checks**

Effective April 1, 2005, criminal background checks are required on employees in a presumptive title, i.e., presumed to have direct contact with individuals served. 14 NYCRR Section 633.22 (d)(2)(i)(g) of OPWDD's regulations states that criminal history record checks are required for service coordinators and a supervisor of a service coordinator. The requirement does not apply to individuals hired before April 1, 2005.

## CONFLICT OF INTEREST

Program managers with direct (first-line) administrative control over an individual's services or programs may not supervise the individual's service coordinator. For example, the same staff person cannot supervise an individual's service coordinator and an individual's house manager.

## SUPERVISORY RESPONSIBILITIES

The role of the MSC supervisor is to ensure that service coordinators provide high quality, person centered MSC services and meet all requirements of the service.

At a minimum, MSC supervisors must:

### Ensure Training

- Ensure that newly hired service coordinators are appropriately oriented, trained, and supervised.
- Verify that all service coordinators participate in the required MSC training activities (see Chapter Two) and pre-approve service coordinators' professional development programs.
- Verify the service coordinator's attendance at professional development training activities and initial the service coordinator's MSC Training Record (MSC6-TRN) (Appendix 1).
- Support service coordinators to appropriately assess individuals in accordance with their individualized needs and circumstances.

### Ensure Quality Program Administration

- Oversee the implementation of all applicable OPWDD expectations, policies and procedures by:
    - Ensuring policies and procedures in this manual are followed.
    - Ensuring that ISPs are developed and maintained in accordance with Administrative Memorandum # 2010-04 and the ISP form and Instructions.
    - Ensuring that documentation adheres to Administrative Memorandum # 2010-03.
    - Ensuring that service coordinators ensure the timely completion of LCED re-determinations.
    - Ensuring that the Service Coordination Agreement is signed for all persons served and reviewed with them annually by the service coordinator.
    - Ensuring that no service coordinator's caseload exceeds the maximum caseload.

**Ensure Quality ISP Activities**

- Support service coordinators in developing, implementing, and maintaining the ISP and the Service Coordination Activity Plan if required by:
    - Verifying that ISPs and Service Coordination Activity Plans have been properly prepared using a person centered planning approach and in accordance with Informed Choice.
    - Reviewing and signing the ISP.
    - Confirming that the service coordination activities identified in the Service Coordination Activity Plan (if applicable) are appropriate and obtainable.
    - Confirming that service coordinators are providing face-to-face service meetings based on individualized needs and circumstances.
    - Ensuring Quality Advocacy

**Support Service Coordinators in their Advocacy Role**

- Reviewing and following up on any evidence that the personal or civil rights of the person with developmental disabilities have been denied or abridged.
- Taking all reasonable steps to ensure that all health, welfare and fire safety needs are met.
- Ensuring that service coordinators take appropriate steps if abuse or neglect is suspected.
- Ensuring that service coordinators take appropriate steps if they believe an individual is ill due to inadequate health care.
- Ensuring that service coordinators take appropriate steps if they have reason to believe that an MSC participant's programs are not in compliance with applicable OPWDD regulations.
- Ensuring that service coordinators act to assure the person's safety if they become aware of a situation that endangers the person.
- Confirming that service coordinators comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD), and are taking reasonable steps to prevent the violation of Part 633 (Protection of

Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and Subpart 635-9 (Provision of Required Services) (Appendix 1).

**Ensure Quality Record Keeping**

- Ensure that all records that substantiate the vendor's MSC billings are retained for a minimum of six years from the date the services were billed and all clinical records are retained indefinitely (Chapter Four).

- Ensure that service coordination records meet the standards outlined in Chapter Four of this manual as well as Administrative Memoranda #'s 2010-03 and 2010-04.

**Ensure Adherence to Requirements for Willowbrook Class Member Case Management**

- Ensure that service coordinators who provide case management to class members understand and adhere to the requirements contained within Appendix One of the Willowbrook Permanent Injunction for Service expectations. This information is covered on OPWDD's website "Beyond Willowbrook" www.opwdd.ny.gov.

- Ensure that service coordinators who serve class members attend training on expectations for services for class members.

- Ensuring that the Service Coordination Observation Report (MSC7-SCOR) is completed for Willowbrook Class members who live in OPWDD certified residences as required and any time a serious problem is discovered.

- Reviewing the SCOR for Willowbrook Class members and if problems are reported, sending copies of the SCOR to the responsible voluntary agency or the DDSO or the Family Care home's liaison and the agency/DDSO family care coordinator as required, and ensuring the service coordinator took appropriate action to resolve the problems reported.

# CHAPTER 4 THE SERVICE COORDINATION RECORD

## OVERVIEW

The service coordinator is responsible for maintaining a separate record for each person receiving MSC. This record is known as the Service Coordination Record. The Service Coordination Record provides an ongoing written account of the service coordination activities needed by and provided to the person. The Service Coordination Record also contains the documents that verify the person's eligibility for various services.

The Service Coordination Record has four main sections, each with minimum required information.

**Section I:** **Eligibility/Enrollment Documentation (including the Medicaid Service Coordination Agreement)**

**Section 2:** **Written Evaluations**

**Section 3:** **The Individualized Service Plan (ISP) with Attachments (including the Service Coordination Activity Plan, if applicable)**

**Section 4:** **Medicaid Service Coordination Notes**

Additional sections (such as a medical section) and additions to the sections listed above (such as vendor-specific forms) may be added at the discretion of the service coordinator, supervisor, vendor.

The Service Coordination Record must be maintained as separate and distinct from other service provider records and must include the four sections identified above. Service Coordination Records must be retained for a minimum of six years from the date the service was billed. Clinical records must be retained indefinitely.

See ADM #2010-03 for further information on MSC Billing Documentation and Standards.

Documents included in the four sections of the Service Coordination Record substantiate the vendor's billing for federal or

state audit purposes and are program requirements of MSC. These requirements are described in the following sections.

## SECTION 1: ELIGIBILITY/ENROLLMENT DOCUMENTATION

The first section of a Service Coordination Record contains the eligibility and enrollment documentation for the individual with developmental disabilities and should include:

- **Consumer Application for Participation in Medicaid Service Coordination (MSC1-APPL)** for people enrolled in MSC after March 1, 2000 (Appendix Two).
- Documentation that the person has a **developmental disability.**
- Documentation that demonstrates a need for ongoing and comprehensive service coordination.
- Documentation of **Medicaid eligibility** and enrollment in Medicaid.
- **Notice of individual rights and responsibilities** per Part 633.4. (For Willowbrook Class members, there must be the Notice of Rights for Willowbrook Class members only).
- **Medicaid Service Coordination Agreement (MSC5-SCA)** (See Appendix Two).
- **Request for Change of Medicaid Service Coordination Vendor (MSC2-CHNG) or Withdrawal from Medicaid Service Coordination (MSC3-WITH)**, if applicable (Appendix Two).

**For people enrolled in the HCBS Waiver**, the following HCBS Waiver enrollment information/documents should also be included in this section:

- Waiver Enrollment forms:
  - Application for Participation,
  - Preliminary ISP,
  - Documentation of Choices,
  - Initial Level of Care Eligibility Determination (LCED) and required documentation supporting the determination,
  - Notice of Decision.
- Current re-determination of ICF/MR Level of Care eligibility. It is recommended that vendors retain the initial LCED (the first determination), the current re-determination and six

years prior to the current one in the person's active service coordination record.
- Name of the person's advocate or statement that the person is self-advocating.

## SECTION 2: WRITTEN EVALUATIONS

This section of the Service Coordination Record contains written, professional evaluations regarding the person that the service coordinator receives and/or deems necessary to understand the needs of the person. It should include but is not limited to:

- Clinical assessments and recommendations, service provider reports, and medical information.
- The ICF/MR final summary and post discharge plan for people enrolled in the HCBS Waiver who moved directly from an ICF/MR to Waiver enrollment.
- Other service plans for non-HCBS Waiver services (e.g., day treatment plans).

## SECTION 3: THE INDIVIDUALIZED SERVICE PLAN CONTENT AND ATTACHMENTS

### Contents of the ISP

This section of the Service Coordination Record contains the Individualized Service Plan (ISP) with appropriate attachments. The ISP, with its required attachments, constitutes the "plan of care" for purposes of the HCBS waiver. The attachments include:

- HCBS Waiver habilitation plans (residential habilitation, day habilitation, community habilitation, pre-vocational, supported employment, consolidated supports and services etc.) for HCBS Waiver enrollees.
- The Individual Plan for Protective Oversight if the person lives in an IRA.
- The Medicaid Service Coordination Activity Plan for all Willowbrook Class members, and for all others who choose to have one.

**See Administrative Memorandum #2010-04 ISP Program Standards (along with the ISP format and instructions) for complete details on ISP requirements.**

### Coordination of the ISP with the Attached Habilitation Plans

The ISP, which is written by the service coordinator, identifies all supports and services the individual receives. If the individual is enrolled in the HCBS Waiver, all of his or her Waiver habilitation plans should be attached to the ISP. All waiver habilitation services are required to have a habilitation plan. Some examples of waiver habilitation services include: residential habilitation, community habilitation, prevocational, supported employment.

The waiver habilitation provider writes the habilitation plan. For self-directed services, the habilitation plan is written by the participant or his or her designee. Either way, the plan describes the habilitation activities that will be put in place to pursue the valued outcomes as described in the ISP.

The ISP's description of the Waiver service (i.e., the Name of Provider, Type of Service, Frequency of the Service, Duration of the Service and Effective Date) must be consistent with the description of the service in the habilitation plan. Inconsistency between the ISP and the habilitation plans may jeopardize the service provider's billing. For example, if habilitation services began on November 1, 2010 and the ISP indicates an effective date of December 1, 2010 for these services, the habilitation provider's billing for November will be in jeopardy.

## A PERSON'S RIGHT TO OBJECT TO ISP CHANGES

Under NYCRR 633.12, the ISP along with its attachments constitutes a "plan of service." Any changes to the ISP and its attachments, including the Medicaid Service Coordination Activity Plan, are subject to the requirements of this regulation:

- MSC Vendors must advise individuals with developmental disabilities and their advocates of their right to object to changes to the ISP and the procedures for doing so.
- The vendor must have a mechanism for resolving objections, and
- A hearing must be held when an objection cannot be resolved by the MSC Vendor or the DDSO.

## THE MEDICAID SERVICE COORDINATION AGREEMENT (I.E., BASIC AGREEMENT)

All people enrolled in MSC must have a signed Medicaid Service Coordination Agreement (MSC5-SCA) (Appendix Two).

The Medicaid Service Coordination Agreement describes the responsibilities of the MSC service coordinator, the MSC Vendor and the person receiving MSC.

The MSC Agreement:

- States the rights and responsibilities of the person receiving MSC and the role of the MSC service coordinator in developing, implementing, and maintaining the person's ISP.
- Indicates that the person receiving MSC also has certain responsibilities and should actively participate in the attainment of his or her valued outcomes, to the extent possible.
- Provides information on how the person can withdraw from MSC or change his or her MSC service coordinator or MSC Vendor.
- States for non-Willowbrook Class members that they can choose to use an Activity Plan at any time
- States that Willowbrook Class members must have an Activity Plan.

The Medicaid Service Coordination Agreement does not have to be attached to the ISP, although a copy of the Agreement should be given to the person and/or to his or her family and advocate. A copy must be placed in Section One of the person's Service Coordination Record.

The Medicaid Service Coordination Agreement should be reviewed annually and this review is documented in the Medicaid Service Coordination Notes. It is recommended that this review occur during the annual face-to-face ISP review meeting.

If an individual changes MSC Vendors, a copy of the original Agreement should be sent to the new MSC Vendor. The new service coordinator and the individual can decide if they would like to complete a new Service Coordination Agreement, but another one is not required to be completed if a copy of the original is in the service coordination record.

A Medicaid Service Coordination Agreement should be reviewed and completed with the person with developmental disabilities before an individual first begins receiving service coordination services (i.e. during the MSC application

process). However, the agreement must be completed within 60 days of a person's enrollment in the MSC program. A copy of a signed Service Coordination Agreement must be retained in the Service Coordination record for each individual served by the Vendor.

## THE MSC ACTIVITY PLAN

The MSC Activity Plan describes certain short-term service coordination activities that are most important to the person. Generally, these activities are directed towards meeting the individualized valued outcomes described in a person's ISP. The Activity Plan also identifies the parties who are responsible for carrying out these activities. A start date should be entered for each activity included in the plan. When an activity is completed, the "task is done" box should be checked. **The Activity Plan should be attached to the person's ISP.**

**All Willowbrook Class Members must have an MSC Activity Plan. All other individuals may choose whether or not to use an MSC Activity Plan. All non-Willowbrook Class members can decide at any time whether they would like an MSC Activity Plan.**

**For Willowbrook Class Members, the Activity Plan must be reviewed and updated at least every six months. New activities that the individual with developmental disabilities would like to occur may be added at any time. This review should be documented in the service coordination notes.**

An MSC Activity Plan should include any short-term service coordination activities that are needed to achieve a specific outcome that is of special importance to the person, his or her family or advocate. It can also be an activity that helps the service coordinator serve the person better. Some examples are:

- Planning a special vacation or trip
- Finding a new home or job
- Searching for an advocate
- Finding or creating a unique service to meet a valued outcome or need
- Arranging for supports or services at a new school or program

The Activity Plan should single-out the specific high priority activities to be carried out over the next several weeks or months. Not all activities need to relate to the person's valued outcomes.

- Following-up with a service provider about a current issue or problem
- Finding ways to promote community inclusion
- Uncovering information about a person to gain a better understanding of the person's needs/interests/wishes
- Providing supports (problem solving, phone calls, etc.) for a situation that needs resolution, such as helping with a difficult living situation or with a medical condition
- Finding ways for the individual to make contributions to home, work and community.

Identifying service coordination activities for an MSC Activity Plan can sometimes be difficult because the person with developmental disabilities may be unable to communicate what is important to him or her or it appears that very little needs to be changed in the person's life. Though stability in life is an achievement, the person centered planning process and the ongoing pursuit of the person's valued outcomes should reveal activities that can be incorporated into the Activity Plan. These may include making arrangements for new life experiences or learning more about the person's personality from people who spend the most time with the person.

On rare occasions it may be appropriate for the person's valued outcomes to reflect the need to maintain services at the current level, (e.g., maintaining current health status or maintaining daily routines). In these instances, the Activity Plan should identify specific activities the service coordinator will perform to accomplish the valued outcomes. This may include: making sure a certain doctor's appointment is made, arranging for the repair of a piece of equipment, or assuring daily attendance at a job or program.

The service coordinator will carry out many of the activities identified in the MSC Activity Plan. However, there may be times when the individual, a family member, advocate, or other person is identified as responsible for completing certain tasks. Regardless of who is identified as responsible for completing an activity, it is the service coordinator's responsibility to ensure that all activities are completed.

The Activity Plan should not include ongoing services that are part of the routine maintenance of the person's ISP or are required MSC activities. For example, the Activity Plan should not include any of the following activities:

- Planning and conducting ISP or other required meetings
- Making routine referrals

- Monitoring supports and services
- Keeping required monthly notes
- Completing required MSC forms
- Writing the ISP
- Reviewing the ISP
- Keeping the ISP current

**Time Frame for completing the MSC Activity Plan**

An Activity Plan is written after the ISP has been developed and reflects the results of a person centered planning process. For Willowbrook Class Members, the Activity Plan must be reviewed at least every six months, but activities may be added at any time. The six month review must be documented in the service coordinator's notes. If the individual changes his or her MSC service coordinator, the Activity Plan should be reviewed by the new MSC service coordinator and, if necessary, revised.

Willowbrook Class Members - All Willowbrook Class members must have an Activity Plan completed within 60 days of a person's enrollment into the MSC program.

Non-Willowbrook Class Members - When a non-Willowbrook Class member chooses to have an Activity Plan, the Plan should be completed within 60 days of the day the individual chooses to have an Activity Plan. An individual can decide at any time to choose an Activity Plan.

**Distribution of the Activity Plan**

A copy of a completed Medicaid Service Coordination Activity Plan should be distributed to the individual and/or his or her family for all Willowbrook Class members and for non-Willowbrook Class members who choose to have an Activity Plan. The MSC Activity Plan should be retained as an attachment to the ISP. It does not require signatures.

The Activity Plan should be attached to the ISP.

## SECTION 4: MEDICAID SERVICE COORDINATION NOTES

The Medicaid Service Coordination Notes provide a chronological written record of services provided by the service coordinator during a month. The notes must indicate the types of services provided and whether the billing standard was met for the month.

See ADM #2010-03 for MSC Documentation and Billing Standards. Also see Sample MSC Monthly Note and Instructions.

Documentation of each service required for billing must include specific elements (See ADM #2010-03 for MSC Documentation and Billing standards)

**Complying with Documentation Requirements for Monthly Notes**

Service coordinators may comply with the documentation requirements for service coordination notes by completing the Medicaid Service Coordination Notes format. See sample form and instructions in Appendix One. MSC Vendors may develop their own form as long as it contains all the elements in the OPWDD developed format.

**Timeframe for Completing the Service Coordination Note**

The Medicaid Service Coordination Note must be completed by the 15th of the month following the month of service. This form must be signed and dated by the service coordinator. Best practice is to complete the form at the time the service is provided.

**DOCUMENT RETENTION AND REVIEW**

Service Coordination notes are required to ensure quality and continuity of services as well as to substantiate the MSC Vendor's billing. The Medicaid Service Coordination Notes must be retained in the person's Service Coordination Record for review by OPWDD and other authorized entities. Auditors may examine vendor service documentation for MSC claims made for six years from the date the service was delivered or billed, whichever is later.

# Chapter 5 MSC ADMINISTRATIVE AND PAYMENT STRUCTURE

## ADMINISTRATIVE STRUCTURE

The Office For People With Developmental Disabilities (OPWDD) provides MSC services in New York State. Services are provided directly by the DDSO (i.e., the service coordinator is a DDSO staff person) or are provided by non-profit agencies or governmental entities that subcontract with the local DDSO outside of New York City or with Service Delivery and Integrated Solutions Region 2 (SDIS2) in New York City. The entities subcontracting with the DDSO are known as MSC Vendors.

MSC activities are billed to Computer Sciences Corporation (CSC), the fiscal agent responsible for operating the eMedNY (New York State's Medicaid Management Information System) under the supervision of the NYS Department of Health.

### Individual Registration in TABS

The DDSO registers all individuals receiving MSC, along with the MSC Vendors from which they are authorized to receive services, in OPWDD's Tracking and Billing System (TABS). Individuals served by State MSCs (i.e., DDSO staff) are also registered in TABS with the appropriate DDSO.

eMedNY, only pays a vendor for a person's MSC services if that person is registered with the vendor in TABS. Procedures for MSC enrollment are discussed in Chapter Six.

OPWDD Central Office Field Operations uses the TABS MSC program enrollment data to enter into the Welfare Management System (WMS) the Restriction/Exception '35' (R/E) codes for MSC recipients. These R/E codes identify the particular vendor or DDSO that is eligible to bill eMedNY for an individual's MSC services. Once this R/E data is registered in WMS, Medicaid payments will only be issued for the vendor or DDSO associated with the R/E "35" code. The local RSFO can provide technical assistance with R/E coding issues (see OPWDD's website for a listing of RSFOs).

### MSC Contracts

OPWDD contracts with MSC Vendors using a standard MSC contract that details service requirements and establishes that the vendor may only bill for individuals the vendor has been authorized to serve (See Appendix Four). The contract also specifies that the

vendor bills Medicaid directly through New York's Medicaid billing system (eMedNY) for MSC services using an MSC-specific Provider ID.

Each DDSO outside New York City establishes and maintains MSC contracts with vendors serving individuals in its catchment area. Some MSC Vendors have contracts with more than one DDSO. For example, if a vendor delivers MSC services to individuals in both Central New York and Finger Lakes DDSOs, the vendor must have an MSC contract with Central New York DDSO and a separate and distinct MSC contract with Finger Lakes DDSO.

MSC Vendors operating in New York City have one contract for all MSC services they provide within the New York City DDSOs. MSC Vendors are only permitted to bill eMedNY for the people authorized by a New York City DDSO. SDIS2 manages the MSC contract process, and each New York City DDSO manages enrollment in TABS for individuals living in its catchment area.

## BILLING FOR SERVICE COORDINATION

Each vendor subcontracting with a non-NYC DDSO for MSC will have a unique eMedNY Provider ID for billing MSC services to eMedNY. The vendor must use this Provider ID to bill all services covered under the contract with the DDSO. Please note, if the vendor has more than one MSC contract, there is a unique Provider ID and group of individuals associated with each contract.

Each vendor subcontracting with a NYC DDSO for MSC will have a single NYC-specific eMedNY Provider ID for billing MSC services to eMedNY. The vendor must use this Provider ID to bill all services covered under the NYC DDSO contract. If the NYC vendor also has a contract with a non-NYC DDSO, the vendor will have a separate Provider ID for the individuals associated with that contract.

MSC is billed as a monthly service, and the billing date is usually the first day of the month following the month of service. This means that a billing date of November 1, 2010 is used for MSC services delivered in October 2010. There are only two exceptions to this rule. If an individual dies, the date of death should be used as the billing date, and if an individual loses Medicaid, the last day of Medicaid coverage (assuming reauthorization has been sought and denied) should be used as the billing date.

## Billing for Non-Willowbrook Class Members

To bill for services for non-Willowbrook Class members, the service coordinator must document at least one activity from List A or at least two activities from List B. The activities included in these lists are all intended to help the individual receive needed or wanted services and to help the individual live the life he or she desires. The lists of acceptable, billable activities and how to document them are outlined and described in Administrative Memorandum #2010-03. (see Appendix One).

## Billing for Willowbrook Class Members

To bill for a month of service for individuals who are members of the Willowbrook Class, service coordinators must deliver and document a minimum of one face-to-face service meeting per month. A vendor's monthly billing must be substantiated by contemporaneous documentation of a face-to-face service meeting with the person. If the face-to-face service meeting does not take place in the month (e.g., the individual is on vacation or in a rehabilitation center), the MSC Vendor cannot bill for that month.

## Hospitalizations

When hospital admissions are initially expected to last 30 days or less, the relationship with the service coordinator may be continued and counted towards the billing requirements as follows:

- For Willowbrook class members a face-to-face meeting that takes place in the hospital can be counted toward the billing requirement.
- For non-Willowbrook class members, activities from List A (including a face-to-face meeting) and List B can be counted towards the billing requirements.

The basis for the initial expectation that hospital admission will last 30 days or less should be documented in the Service Coordination Record.

After the first 30 days of hospitalization, a vendor cannot bill for MSC services provided.

### Third Party Billing

The vendor must notify OPWDD when it becomes aware of any individuals who are eligible for third-party (e.g., private insurance) reimbursement for MSC services.

### The Role of OPWDD's Revenue Systems Unit

The MSC Vendor bills eMedNY directly for MSC services. OPWDD's Revenue Systems Unit receives payments, paper remittance statements and Medicaid correspondence and transmits all such payments, paper remittance statements and Medicaid correspondence to the vendor.

The Revenue Systems Unit also assists vendors who are experiencing difficulty with billing the eMedNY for MSC services. For assistance, vendors are invited to contact:

Revenue Systems Unit
Office For People With Developmental Disabilities
44 Holland Avenue
Albany, NY 12209
(518) 402-4333

## TRANSITION PAYMENTS

In recognition of the additional workload, an MSC Vendor is eligible to receive a special, higher level of payment for the provision of MSC to people "in transition." The transition payment is triple the "non-transition" MSC monthly payment. Beginning with the October 1, 2010 service month, the vendor may bill the transition payment level in lieu of the regular monthly payment level for one month upon meeting the requirements for transition payments as follows:

- The individual with developmental disabilities is new to service coordination, that is, the person has never received any type of service coordination/case management service through OPWDD's system, i.e., MSC, CMCM, PCSS, HCBS Waiver, state paid service coordination, Care at Home, etc.

- The person moves from an OPWDD certified supervised or supportive IRA or supervised or supportive Community Residence to his or her own home or apartment and is responsible for his or her own expenses.

The service coordination documentation notes must document that the person meets one of the two transition payment level criteria to support the vendor's transition billing. As part of its review of MSC services, OPWDD staff and other audit entities will examine the vendor's appropriate use of the transition payment level.

If individuals are receiving MSC for the first time, the MSC Vendor may bill the first month of MSC as transition.

If an individual moves from a certified residence into a situation that meets the transition rules on the first day of the month, the vendor may bill at the transition level for the service month following the move (e.g., if the person moves on October 1, the vendor may submit a transition level claim with a service date of November 1).

If an individual moves on any day other than the first of the month into a situation which meets the transition rules, the vendor may bill at the transition level on the first day of the month following a 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 in the new living situation and so the vendor may submit a transition level claim with a date of service of December 1).

## MSC BILLING RATES AND CODES

MSC uses a monthly unit of service and has four separate billing rates as follows:

| Payment Level | MSC Participants |
|---|---|
| Basic Rate | All Non-Willowbrook Class Members |
| Willowbrook Rate | All Willowbrook Class Members |
| Transition Basic Rate | All Non-Willowbrook Class Members receiving transition services (can be billed for only one month). |
| Transition Willowbrook Rate | All Willowbrook Class Members receiving transition services (can be billed for only one month). |

There are two MSC rate codes that correspond with the Basic Rate and the Willowbrook payment levels. In addition, the MSC Vendor will use two locator codes under the MSC provider ID to distinguish between regular and transition service billing. Locator 003 will be used for 'regular' (i.e., non-transition) MSC billing. Locator 004 will be used for transition billing.

| MSC Payment Level Codes | |
|---|---|
| **Rate Codes:** | |
| **Basic Level of MSC** | 5211 |
| **Willowbrook** | 5214 |
| **Locator Codes:** | |
| **Regular MSC** | Locator Code 003 |
| **Transition MSC** | Locator Code 004 |

For example:

If the vendor provides MSC services to a person living at home with family, the provider bills eMedNY using rate code 5211 under locator 003.

If the vendor provides MSC services to a person living in a family home who is receiving service coordination from OPWDD for the first time, the vendor bills eMedNY using rate code 5211 under locator 004.

(See Billing Chart in Appendix Four for a more detailed description of the MSC payment levels.)

## Billing Methods

MSC Vendors have the option of using the following methods to bill for services:

- Paper claim form UB-04
- eMedNY eXchange
- FTP (file transfer process)
- CPU to CPU
- ePACES
- SOAP (Simple Object Access Protocol)

Additional information on billing eMedNY is available at www.emedny.org and by calling the eMedNY Call Center at (800) 343-9000.

## Paper Claims

MSC Vendors are strongly encouraged to submit claims electronically to eMedNY. Nonetheless, authorized MSC Vendors may elect to submit paper claims to Computer Sciences Corporation (CSC) using form UB-04. The UB-04 form is not supplied by Computer Sciences Corporation. It must be purchased from national suppliers.

## Magnetic/Electronic Billing

To bill eMedNY for MSC services electronically, an MSC Vendor must be enrolled in MSC as an MSC subcontractor of OPWDD and have an eMedNY provider ID number exclusively for MSC services.

Vendors not currently billing eMedNY must apply to CSC for an Electronic/Paper Transmitter Identification Number (ETIN) by completing a:

- Provider Electronic Transmitter/Paper Identification Number (ETIN) Application, and a
- Certification Statement for Provider Billing Medicaid.

These forms may be obtained by accessing the www.emedny.org website (Select "Information", "Provider Enrollment Forms", "Provider Maintenance Forms" and "Provider Electronic/Paper Transmitter Identification Number (ETIN)". The Provider Electronic Transmitter/Paper Identification Number (ETIN) Application and the Certification Statement for Provider Billing Medicaid are available as one document.

Vendors who already bill eMedNY must submit a completed Certification Statement For Provider Billing Medicaid form using the eMedNY Provider ID used exclusively for MSC services and the vendors' existing Electronic Transmitter Identification Number (ETIN). This will add MSC services to the vendor's current ETIN.

Completed forms should be sent to the following address:

Computer Sciences Corporation
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, NY 12144 - 8614

Computer Sciences Corporation will process the application in approximately one week and send written notification of the 3-digit supplier number assigned to the eMedNY provider number. Upon receipt of the notification, MSC Vendors can submit a test tape or electronic transmission. Testing verifies that Computer Sciences Corporation can successfully read the media. Test claims are not processed for payment unless requested by a provider. To have test claims processed for payment, simply submit a written request with the test submission.

## Contract Compliance Review

OPWDD monitors a vendor's compliance with requirements specified in the contract and in this manual. This monitoring includes, but is not limited to, reviews to ensure that:

- MSC service coordinators and service coordinator supervisors have the appropriate educational qualifications,
- training requirements have been met,
- maximum caseload size has not been exceeded,
- protections against conflicts of interest are followed as discussed in this manual,
- Quality service coordination is being provided.

In addition, to ensure that individuals' services are being billed at the correct level of service and that transition payments are correctly billed, OPWDD will routinely monitor vendor MSC billing.

Transition payments, as well as questionable billing will be reviewed on a post audit basis. In addition, other auditing entities (such as the Office of the Medicaid Inspector General) will review the use of MSC transition payment levels by examining applicable service note documentation to identify that the billing transition standard was met.

# CHAPTER 6 ENROLLMENT OF INDIVIDUALS IN MSC

## OVERVIEW

Since OPWDD is the provider of MSC services, vendors must forward all individual requests for MSC services to the appropriate DDSO. All eligible individuals who request MSC and all vendors must be enrolled in OPWDD's Tracking and Billing System (TABS). The vendor cannot be paid for services unless the DDSO has enrolled the vendor into TABS. This Chapter describes the eligibility criteria for MSC and enrollment procedures.

The MSC application process is time sensitive. Medicaid rules state that the DDSO has 90 days to approve or deny an individual's MSC application. A vendor must ensure that all required information is sent to the DDSO so that the application can be processed within 90 days.

## ELIGIBILITY FOR MSC

To receive MSC, an individual must meet all of the following criteria:

- The person must be enrolled in Medicaid.
- The person must have a developmental disability as defined in Section 1.03 (22) of the New York State Mental Hygiene Law and be evaluated in accordance with the August 10, 2001 OPWDD Advisory guidelines on determining eligibility for services.
- The person must demonstrate a need for ongoing and comprehensive rather than incidental service coordination.
- The person with a developmental disability or an individual authorized to give consent on behalf of that person must choose to receive MSC.
- The person must not permanently live in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Developmental Center (DC), Psychiatric Hospital, Small Residential Unit (SRU), Nursing Facility, Hospital or any other Medicaid funded institutional setting that provides service coordination.
- The person cannot be enrolled in any other comprehensive Medicaid long-term care service that includes service coordination (e.g., individuals in a Long Term Home Health

Care program or who receive Early Intervention service coordination are not eligible to participate in MSC).

## DOCUMENTATION OF A DEVELOPMENTAL DISABILITY

Please refer to information on eligibility for OPWDD services on the OPWDD website for further information about the process for determining eligibility.

## DEMONSTRATION OF THE NEED FOR ONGOING AND COMPREHENSIVE SERVICE COORDINATION

The need for ongoing and comprehensive service coordination means that the ongoing assistance of a service coordinator is necessary for the development, implementation and maintenance of an ISP. This need must be documented in the ISP.

It is an ongoing requirement that MSC Vendors ensure that individuals served continue to meet all eligibility requirements including demonstration of the need for ongoing and comprehensive service coordination. OPWDD's Division of Quality Management Survey of the MSC Program for all MSC Vendors will include a review of MSC eligibility under this criteria.

## DOCUMENTING THE INDIVIDUAL'S CHOICE TO RECEIVE MSC

The person with developmental disabilities or an individual authorized to give consent on behalf of the person documents the choice to receive MSC by signing the Application for Participation in Medicaid Service Coordination form (MSC1-APPL) (Appendix Two). He or she also signifies this choice by signing the ISP that lists MSC as a requested service.

## RESIDENTIAL STATUS AND ELIGIBILITY FOR MSC

People permanently residing in an intermediate care facility or any other Medicaid facility that provides service coordination (a nursing facility or a psychiatric center, for example) may not receive MSC. However, an individual receiving MSC who is temporarily residing

in one of these excluded settings can continue to receive MSC if the placement is anticipated to last less than 30 days.

In the case of an individual who is a Willowbrook Class member, billing for MSC is allowed only if the monthly face-to-face visit occurs outside of these residential settings. However, good clinical practice dictates that service coordinators visit individuals temporarily residing in an excluded setting regardless of billing implications.

## PROCEDURES FOR ENROLLING AN INDIVIDUAL IN MSC

To request enrollment of an individual in MSC services, the following documents must be completed and sent to the DDSO MSC coordinator.
For All Applicants:

- ❑ The Application For Participation in Medicaid Service Coordination (MSC1-APPL) and any required attachments (e.g., Supplemental information that demonstrates that the person has a need for ongoing and comprehensive service coordination).

**Note:** A **DDP4** (OPWDD's Confidential Needs Assessment Registration Form) must be completed for any person served by OPWDD who has unmet needs.

For Applicants who are not currently enrolled in the HCBS Waiver and who have not applied for HCBS enrollment:

- ❑ Documentation verifying that the applicant has a developmental disability (see above).

The DDSO MSC coordinator verifies that the person is enrolled in Medicaid, that the person has a developmental disability and that the person is eligible for Medicaid Service Coordination and needs ongoing and comprehensive MSC. Thereafter, the DDSO sends the individual a Medicaid Service Coordination Notice letting him or her know that the application has been approved or denied. The MSC Notice includes information about an individual's right to appeal the decision. A copy of the MSC Notice is sent to the vendor and the family or advocate. (See sample MSC Notice in Appendix Two.)

If a class member is deemed not eligible for enrollment or continuation of MSC the DDSO's MSC Coordinator should consult with the DDSO's Willowbrook liaison to ensure the class member's

receipt of case management pursuant to the Willowbrook Permanent Injunction.

## THE INDIVIDUAL'S DUE PROCESS RIGHTS

Certain actions of the DDSO related to MSC services require that the individual with developmental disabilities be notified of his or her right to request a Fair Hearing under Medicaid. These actions include:

- Authorization of Enrollment in MSC
- Denial of an MSC Application
- Termination of MSC Enrollment

Should any of these actions occur the DDSO issues a Medicaid Service Coordination Notice. This serves to notify the individual that he or she has the right to request a Medicaid Fair Hearing through the New York State Office of Temporary and Disability Assistance (NYS OTDA).

If an individual's application for MSC is denied or his or her MSC enrollment is terminated, the DDSO Director signs the MSC Notice. If a person's application for MSC has been accepted, the DDSO Director or a designee signs the MSC Notice that informs the person that he or she has been enrolled in MSC.

## TABS PROCESSING OF APPLICATIONS

OPWDD's TABS database automatically generates an MSC Notice when an MSC application is sufficiently complete and demonstrates eligibility to enroll an individual in the program. For an individual to be successfully added, the following must be true:

- The individual must be registered in OPWDD's TABS system.

- The vendor must be able to serve an additional individual in its MSC program.

- The individual cannot be registered in a prohibited residential setting in TABS (e.g., ICF, Multiple Disabled Unit (MDU), Small Residential Unit (SRU), developmental center, or nursing facility).

- The individual must not be currently enrolled in another Medicaid funded service coordination program (such as the Early Intervention program) or in an OPWDD Care-At-Home Waiver (CAH).

- There must be documentation that the individual is enrolled in Medicaid.

- The individual must not be registered in a Plan of Care Support Services (PCSS) program in TABS.

The DDSO may ask the MSC Vendor to provide additional information if an individual's application is pended (i.e., put on hold) by TABS.

# CHAPTER 7 CHOICE OF VENDOR & PROCEDURES FOR CHANGING MSC VENDORS

## HONORING CHOICE

All MSC participants have a choice of MSC Vendors, within available options. The selected MSC Vendor or DDSO must be identified in the person's ISP.

The Service Coordination Agreement explains a person's right to change vendors. The MSC service coordinator must ensure the person with developmental disabilities is aware of his or her right to choose a different vendor.

## PROCEDURES FOR REQUESTING A NEW MSC VENDOR

A person receiving MSC services or their advocate may initiate a change in MSC Vendor by following these procedures:

- Notify the current MSC Vendor or the DDSO directly.
- The DDSO then works with the person with developmental disabilities to complete Sections I and II of the Request For Change of Medicaid Service Coordination Vendor form (MSC2-CHNG) (Appendix Two).
- The DDSO provides the individual with information on MSC Vendors in the district.
- The individual selects a new vendor, and the new MSC Vendor completes Section III of the MSC2-CHNG form. The form is signed and dated by the staff person completing Section III and the individual/designee.
- Send the signed form to the DDSO MSC coordinator (i.e. Administrator) for processing.
- The DDSO MSC coordinator then determines whether the chosen vendor is qualified to serve an additional individual.
- If the DDSO determines that the vendor can serve an additional individual and the change of vendor transaction passes through TABS, a notification letter is sent to the individual, family/advocate, the "old" vendor and the "new" vendor. The letter notifies all parties of the effective date of the vendor change.

The effective date of the change of vendor must always be the first of the month.

All requests for a change in vendor must be referred to the DDSO. An MSC Vendor cannot directly refer an individual to another vendor. Only the DDSO can provide an individual with the most complete and up to date list of available vendors.

If a Willowbrook Class member requests a change of MSC Vendor, the DDSO's MSC Coordinator should consult with the DDSO's Willowbrook liaison who will provide guidance on MSC Vendors that can accommodate Willowbrook entitlements for service.

The DDSO must process an individual's request to change vendors within 30 days of receiving the Request For Change of Medicaid Service Coordination Vendor form (MSC2-CHNG).

## TRANSFER OF MSC PAPERWORK TO THE NEW MSC VENDOR

When a person chooses a new MSC vendor, the prior MSC vendor should transfer copies of all necessary and required documents to the new MSC vendor including but not limited to:

- The most current ISP,
- LCED determinations and related documentation including the initial LCED and supporting evaluations,
- The executed service coordination agreement(s),
- The Notice of Decision (NOD) authorizing MSC for the person.

# CHAPTER 8 WITHDRAWAL FROM MEDICAID SERVICE COORDINATION, INITIATING PLAN OF CARE SUPPORT SERVICES (PCSS)

## REQUIRED PARTICIPATION IN SERVICE COORDINATION

In accordance with OPWDD HCBS Waiver requirements, all waiver enrolled individuals must have MSC or PCSS to ensure the proper development, implementation, monitoring, reviews and revisions to ISPs.

Children enrolled in the Early Intervention (EI) program who receive EI service coordination and are also enrolled in the HCBS Waiver will automatically receive PCSS services.

PCSS is not an option for Willowbrook class members as PCSS does not comply with the provisions for case management services within the Willowbrook Permanent Injunction.

## PROCEDURES FOR WITHDRAWAL FROM MSC

HCBS enrollees whose requests to withdraw from MSC are approved by the DDSO must be enrolled in Plan of Care Support Services. People receiving MSC who are not participating in the HCBS Waiver may ask to withdraw from MSC at any time.

The request for a withdrawal from MSC must originate with the person with a developmental disability, the person's family, or his or her advocate, and not from the MSC Vendor.

To request withdrawal from MSC:

- The individual or his or her advocate or family member must submit the Withdrawal From Medicaid Service Coordination form (MSC3-WITH) to the DDSO's MSC Coordinator (Appendix Two). The most current copy of the individual's ISP and Service Coordination Agreement should be submitted with the MSC3-WITH form. The DDSO, the current MSC Vendor, family members and advocates can assist the individual with the completion of the MSC3-WITH form as necessary.

- The DDSO MSC coordinator will review the MSC3-WITH form for completeness. If the withdrawal request is complete and appropriate (see DDSO review below). the DDSO MSC coordinator completes the MSC-Consumer Withdrawal Verification form (MSC4-VER) (Appendix Two).

The individual with developmental disabilities and the MSC Vendor will be notified with an MSC Medicaid Notice that the request to withdraw from MSC has been processed. The MSC Vendor must continue to provide MSC services until notified that the request to withdraw from MSC has been approved by the DDSO. The effective date of the withdrawal is the last day of the month in which the withdrawal has been approved by the DDSO. The date will be indicated on the MSC4-VER.

## DDSO REVIEW OF REQUESTS TO WITHDRAW

When the DDSO receives notice that an individual receiving MSC wishes to withdraw from the MSC program, the DDSO must contact the person, the person's family, or advocate ensuring that he or she:

- Understands the consequences of the decision to withdraw from MSC,
- Was not coerced into making the request, and
- Clearly wants to withdraw from MSC and is not expressing dissatisfaction with his or her current MSC service coordinator or vendor.

If the person requesting the withdrawal is dissatisfied with his or her current vendor, the DDSO will provide a list of other available MSC Vendors in the area. The DDSO may also offer itself as an option if there is available capacity (see process for changing vendors).

In accordance with HCBS Waiver requirements, an HCBS Waiver enrollee's request to withdraw from MSC will be denied if the DDSO feels that withdrawing from MSC jeopardizes the person's health or safety. If a request to withdraw is denied, the DDSO must work with the person to develop an acceptable alternative to withdrawal. The DDSO must also:

- Specify the basis for the denial on the back of the MSC4 Consumer Withdrawal Verification form and provide the person with a copy of the form, and
- Inform the person of his or her rights to a 633.12 appeal.

If the DDSO approves the request to withdraw from the MSC program.

The DDSO must respond to the individual's request to withdraw from MSC within 30 days of receiving the MSC3-WITH form.

**Requests to Withdraw for Willowbrook Class Members**

If a class member is deemed not eligible for enrollment or continuation of MSC the DDSO's MSC coordinator should consult with the DDSO's Willowbrook Liaison to ensure the class member's receipt of case management pursuant to the Willowbrook Permanent Injunction.

## MSC WITHDRAWAL WHEN A PERSON NO LONGER MEETS MSC ELIGIBILITY REQUIREMENTS

The MSC Vendor must notify the DDSO MSC coordinator whenever a person who has been receiving MSC services no longer meets all of the eligibility criteria for the program. **MSC services must continue to be provided to the individual until the DDSO MSC coordinator verifies that the person is no longer eligible for MSC services.**

A typical reason for the loss of MSC eligibility is the termination of Medicaid coverage. This is why an important part of the advocacy function of an MSC is to work with individuals, or with their advocates, family members or residential or day services agencies to ensure there is no preventable loss in Medicaid coverage.

The OPWDD Field Operations unit issues reports each month identifying people where Medicaid will require recertification in the next month or where Medicaid has already expired. These reports are sent directly to the MSC Vendors serving the identified individuals. The local OPWDD Revenue Support Field Office (RSFO) can assist if an individual's Medicaid status jeopardizes his or her continued enrollment in MSC. In some cases, retroactive Medicaid coverage can be obtained, allowing gaps of up to 90 days in coverage to be filled and potentially eliminating the need to

terminate MSC services. The RSFO addresses and phone numbers are located on OPWDD's website at www.opwdd.ny.gov.

## TERMINATION FROM MSC AND DUE PROCESS RIGHTS

If the DDSO terminates an individual's MSC services, the DDSO will issue an MSC Notice notifying the individual that he or she has the right to request a Medicaid Fair Hearing. In most cases, the individual will be notified of the termination from MSC 15 days prior to the effective date of the termination. The DDSO Director (or designee) must sign the MSC Notice that terminates the individual's enrollment in MSC. The 15-day advance notice of termination from MSC is not required if:

- Medicaid eligibility is lost.
- The individual enrolls in another Medicaid service coordination program (e.g., Care at Home or OMH Intensive Case Management).
- The individual dies.

## PLAN OF CARE SUPPORT SERVICES (PCSS)

Plan of Care Support Services (PCSS) is a separate and distinct HCBS Waiver service. It supports individuals enrolled in the HCBS Waiver by ensuring that each participant who has opted out of MSC (or is no longer eligible for MSC) continues to have:

- A current Individualized Service Plan (ISP)
- A current Level of Care Eligibility Determination (LCED)

An MSC Vendor that also has an HCBS Waiver Provider Agreement from the NYS Department of Health may provide Plan of Care Support Services. The Provider Agreement must specify Plan of Care Support Services as an authorized service. At a minimum, the PCSS provider must:

- ensure that the annual re-determination of ICF/MR Level of Care (LCED) is completed,
- notify the DDSO if the individual's eligibility for HCBS Waiver services changes, and
- maintain, monitor, review and revise the person's ISP.

PCSS services are billed to eMedNY.

Staff providing Plan of Care Support Services must meet the eligibility criteria and training requirements for an MSC service coordinator (Chapter Two).

**The ISP for People Receiving PCSS**

An ISP is still required for people enrolled in the HCBS Waiver who have withdrawn from MSC and are receiving PCSS. The PCSS provider should ensure that all required habilitation plans are attached to the ISP (i.e., residential or community habilitation plans). For IRA residents who opt out of MSC, the ISP must still include the Individual Plan for Protective Oversight.

The completed ISP is retained in the person's PCSS Record and distributed according to the guidelines in ADM #2010-04.

Participants who are enrolled in PCSS do not need a Service Coordination Agreement.

**The Plan of Care Support Services Record**

The HCBS Waiver provider delivering PCSS must maintain a PCSS Record for all individuals receiving PCSS. The PCSS Record contains:

**SECTION I: Waiver Enrollment Forms**

- Application for Participation;
- Preliminary ISP;
- Documentation of Choices;
- Notice of Decision;
- Initial, current, and each annual (re-determination) of ICF/MR Level of Care;
- Name of the advocate for the person with developmental disabilities (or a statement that the person is self-advocating).

**SECTION II: Written evaluations/clinical assessments**

- Any clinical assessments that support the person's ICF/MR Level of Care;
- ICF/MR final summary if applicable;
- Post discharge plan for a person who moves directly from an ICF/MR to HCBS Waiver enrollment.

**SECTION III: Individualized Service Plan with attachments**

- HCBS Waiver habilitation plans;
- Individual Plan for Protective Oversight if the person lives in an IRA.

**SECTION IV: Notes to substantiate claims for Plan of Care Support Services**

- Re-Enrollment Steps
- A person who wishes to re-enroll in MSC should contact the PCSS provider for assistance. MSC enrollment procedures are presented in Chapter Seven of this manual.

See PCSS ADM for more information.

# CHAPTER 9 VENDOR ENROLLMENT IN MSC

## THE APPLICATION PROCESS FOR BECOMING AN MSC VENDOR

In New York State, OPWDD (through its DDSOs) is the sole provider of Medicaid Service Coordination (MSC) to people with developmental disabilities. OPWDD enters into contractual arrangements with vendors that are qualified to deliver MSC. Any non-profit or governmental agency may send a written request to the local DDSO director or to Service Delivery and Integrated Solutions Region 2 (SDIS2) Associate Commissioner to become an MSC Vendor. There are four steps to the vendor application process:

- Review of Agency Qualifications.
- Enrollment in eMedNY (NYS's Medicaid Management Information System) as an MSC subcontractor of OPWDD.
- Establishment of a contract between OPWDD and the Vendor.
- Enrollment of the vendor in TABS and transmission of MSC Fees to the OPWDD/Vendor Provider ID in eMedNY.

## REVIEW OF AGENCY QUALIFICATIONS

OPWDD approval of MSC vendors is based on the following factors:

- The applying agency is a non-profit or a government agency.
- The applying agency has experience serving persons with developmental disabilities.
- The applying agency's articles of incorporation identify services to people with developmental disabilities.
- The applying agency is fiscally viable.
- The applying agency has a history of providing quality services and does not have ongoing program deficiencies.
- A need exists for a new MSC Vendor.

The DDSO or SDIS2 will first review an agency's qualifications and determine if the resources are available to support a new vendor.

The appropriate OPWDD Associate Commissioner and the Central Office Division of Quality Management (DQM) will then determine if the applying agency is fiscally viable and has not been cited for ongoing program deficiencies. The DDSO or SDIS2 will then advise the applicant if the request is approved or denied.

## ENROLLMENT IN eMedNY

Once the qualifications of the applying agency have been established, OPWDD's Revenue Systems Unit in Central Office will submit a provider enrollment application (completed by the applying agency at OPWDD's request) to the Department of Health (DOH) on behalf of the applying agency. This application will establish a unique eMedNY Provider ID number for each OPWDD MSC Vendor.

## ESTABLISHMENT OF THE MSC CONTRACT

The third step in becoming an MSC Vendor is the development of a contract with the DDSO or SDIS2. The contract:

- Identifies the vendor's service provision requirements including maintenance of the ISP and other required documents,
- Describes the vendor's ability and responsibility to bill eMedNY for MSC services,
- Identifies the dollar amounts associated with each payment level, and
- Requires the vendor to limit the use of this Provider ID to MSC services provided to individuals authorized by the DDSO the vendor is executing the contract with.

## Vendor Enrollment in TABS & Establishing Vendor Billing with eMed NY

In the final phase of vendor enrollment, OPWDD will register the new vendor in TABS and post the appropriate information to eMedNY to allow the vendor to bill. The DDSO MSC Coordinator will refer the new MSC Vendor to MSC enrollment and other applicable information.

The Vendor will receive an approved copy of their MSC Vendor contract.

# CHAPTER 10 CONTRACT REVIEW AND CANCELLATION

## MONITORING CONTRACT PERFORMANCE

The DDSO will review an MSC Vendor's contract with assistance from OPWDD Central Office. The DDSO may elect to review contract performance when the contract is amended or renewed or when there are concerns regarding the vendor's compliance with contract requirements.

OPWDD Central Office will periodically review MSC contract performance to ensure that:

- Caseload sizes do not exceed program requirements (Chapter Two).
- There is no conflict of interest in the provision and supervision of service coordination (Chapters Two and Three).
- Educational and training requirements for service coordinators and supervisors are met (Chapters Two and Three).
- The vendor provides quality services.

## MSC CONTRACT CANCELLATION

As the provider of MSC, OPWDD may cancel an MSC contract immediately if it deems the health or safety of individuals is jeopardized.

In addition, OPWDD may cancel the contract without cause with 30 days written notice to the other party. The 30-day notification must be sent by certified mail, return receipt requested.

When an MSC Vendor's contract is cancelled, the following must occur:

- A transition plan is developed and executed for all people receiving MSC services from the vendor (see text box).
- The vendor's eMedNY fees are end dated.
- The vendor's MSC status is changed in TABS.

A **transition plan** must identify activities that will ensure no interruption occurs in any person's MSC services. The plan should also identify staff from the DDSO and/or vendor agency who are responsible for each activity.

The party that is initiating the contract cancellation (OPWDD or the MSC Vendor) sends a certified letter, return receipt requested, advising the other contract party that the MSC contract will be cancelled in 30 days (for non-emergency cancellations). The letter must include the following information:

- Date on which the MSC Vendor will stop providing services.
- Roster of individuals presently served showing their first and last names and TABS ID numbers.
- Statement regarding the canceling party's commitment to work with the other party (either the DDSO or the MSC Vendor) to jointly develop an acceptable transition plan.

# CHAPTER 11 QUALITY MANAGEMENT

## QUALITY MANAGEMENT

OPWDD's Division of Quality Management (DQM) monitors the MSC Program. The Quality Management survey team conducts reviews of two (2) areas in order to determine whether MSC Vendors comply with the intent and requirements of the MSC program. The DQM Service Team will conduct:

- A program/vendor-level review of key agency and program systems to identify whether MSC Vendors employ program-wide mechanisms that promote and ensure quality service coordination.

- Individual MSC reviews to verify the effectiveness of program-level systems through the review of quality outcomes for individuals and a review of required documents.

DQM survey activities include:

- Review of documentation at the Vendor-level and review of the individual MSC record.

- Interviews with the person receiving MSC services, and in some cases, with family members, advocates, vendor staff, the Consumer Advisory Board who represent non-correspondent Willowbrook Class members, and the MSC service coordinator.

- When appropriate, observation of the services provided to the individual at OPWDD authorized programs, excluding family care.

## SCOPE AND LEGAL AUTHORITY OF THE MSC REVIEW INSTRUMENT

### Legal Authority

OPWDD is the sole provider of MSC for persons with developmental disabilities. OPWDD provides MSC services directly and also subcontracts with not-for-profit agencies or government entities for the provision of MSC services. These "MSC Vendors" are bound by the terms of the Medicaid Service Coordination

contract. The MSC contract forms the major basis for the Division of Quality Management's review.

**Scope of Review**

The DQM review addresses the following items:

Does the vendor have systems in place to ensure that service coordinators have the knowledge and skills necessary to provide required service coordination functions?

Has the Medicaid service coordinator fulfilled his/her role and responsibility in developing, implementing and monitoring the person's ISP? This will include a review that the service coordinator:

- Implements person-centered planning to identify the individual's valued outcomes.
- Promotes and ensures that individuals make informed choices in the development of the individual service plan.
- Ensures that ISPs meet the requirements for service planning identified in HCBS waiver assurances.
- Makes certain that the ISP identifies and documents that there are adequate safeguards in place to ensure the individual's health and welfare, including but not limited to any medical concerns, fire safety concerns and issues related to protection from harm.
- Meets the requirements for service coordination services listed in the MSC Vendor Manual, including the maintenance of required documents.

Is the person receiving MSC satisfied with the activities, supports and services he or she is receiving as well as the efforts made by the service coordinator to assist in obtaining the needed and desired supports and services?

In addition, DQM may also review to determine if the MSC Vendor is acting in compliance with NYCRR Part 624 (Reportable Incidents and Abuse), Part 633 (Protection of Individuals Receiving Services), and Part 635 (General Quality Control and Administrative Requirements).

## REVIEW METHODOLOGY

Each MSC Vendor or DDSO (in the case of state-delivered MSC) is reviewed annually. (A copy of the review instrument used by the DQM is available on the OPWDD website.) The sample selected for review will consist of at least five percent (5%) of the total number of persons served by the vendor or DDSO and will include people who live in each type of residence (certified residential programs, private homes and Family Care). In addition, a representative sample of the vendor's total number of service coordinators who assist individuals in a variety of living arrangements will also be reviewed. The survey methodology will include:

- A review of a vendor's MSC documentation,
- Review of the service coordination record,
- Interviews, and
- When appropriate, observation of certified programs and other services as specified in the person's ISP.

### Documentation Review

The survey team will ask to review documentation related to MSC. This documentation may pertain to, but is not limited to, the following:

- MSC Caseload – Caseloads will be reviewed to determine that the agency has a means to monitor service coordinators' caseloads and ensure they comply with requirements.
- MSC Qualifications - The qualifications (education and experience) of the MSC service coordinators and MSC Supervisors will be reviewed to ensure that they meet the requirements for their positions; the agency's hiring processes will be reviewed to ensure that the agency only hires qualified staff.
- MSC Training - The training records of the MSC Service Coordinators and MSC Supervisors will be reviewed to determine that the MSC Service Coordinators and MSC Supervisors have received all required training and that the vendor has a process to ensure that service coordinators and supervisors have the skills and knowledge to provide quality MSC services. The vendor should have a process to identify training needs of service coordinators and provide the needed training, including a method of monitoring the

performance of its service coordinators. Review of the MSC record and interview of the MSC will be used to verify that the agency process is effective.

- Individuals' satisfaction with MSC – Satisfaction records maintained by the vendor or the DDSO in the case of state-delivered MSC.
- Individual Service Coordination Records including:
    - Eligibility and enrollment documentation.
    - ISP and all appropriate attachments, including; but not limited to:
        - The ISP
        - Program or service plans (including all Waiver Habilitation service plans)
        - The Service Coordination Agreement
        - The Activity Plan, when applicable
        - Any safeguarding plans

Notes – The survey team will review that notes exist to support billing. The survey team will also determine if the service coordinator has kept notes that provide chronological, ongoing, relevant information about the person that is needed for continuity of services.

**Interview**

A sample of persons who receive MSC services from the vendor and the MSC service coordinator will be interviewed to determine the efficacy of the vendor's or DDSO's MSC services. If a person cannot advocate for him or herself, others authorized to advocate and speak on the person's behalf will be interviewed. This may include, but may not be limited to, a family member (if possible), significant others in the person's life, staff who provide services to the person and/or the CAB for non-correspondent Willowbrook Class members.

The person receiving MSC services, a family member or significant others in the person's life will be asked whether they are actively involved in the development, implementation and review of the ISP. They will be asked what they know about services that are available to them. They will also be asked if they are satisfied with activities, supports and services and the efforts made by the service coordinator to advocate for and assist them in obtaining the desired services and supports.

The relevant staff and the service coordinator will be interviewed about several topics. For example, they may be queried about their knowledge of the desires, valued outcomes and preferences of the person receiving service coordination. They may be asked about the nature and extent of the service coordinator's contact with the person receiving MSC, and how the service coordinator determines what contact or services are needed by the person. They may be asked questions about how the person's choices are incorporated into the ISP and the services the person receives, and they may be questioned about the service coordinator's understanding of the role the service coordinator plays in incident management, etc.

### Observation

When an MSC review occurs in conjunction with a certified program review, the person receiving MSC services will be observed engaging in everyday activities. The purpose of this observation will be to determine if the service coordinator has advocated for services and supports that:

- provide the safeguards the person needs,
- are meaningful to the person, and
- are based upon the person's preferences and chosen outcomes as identified in the ISP.

## TRANSMITTING SURVEY RESULTS

Consistent with current DQM review procedures, in most cases, the survey team will communicate any findings, recommendations and comments verbally during an exit conference with staff members who are present during the survey, and in writing on an Exit Conference Form (Form 400). Although the vendor will be expected to correct negative findings, the exit conference form will not require a written response from the vendor. If, however, DQM reviewers find a deficient practice that is systemic, egregious or that presents an immediate danger to an individual, a statement of deficiencies will be issued and a written plan of corrective action will be required. In cases of immediate danger, a plan of corrective action will be required immediately from the vendor.

## CONTRACT RECOMMENDATIONS

Based on the review of the findings from a vendor's MSC reviews conducted during a State fiscal year, the survey team will make a recommendation to the local DDSO regarding the status of the MSC contract. The recommendation may be:

- Contract Continuation
- Contract Amendment to Impose Limitations – In some instances, DQM's review of MSC may identify that the MSC Vendor has systemic or consistent deficiencies in meeting MSC requirements or has problems maintaining the quality of service coordination being provided to individuals. In these cases, the DDSO may renew the contract so that the agency can continue to provide MSC services, but impose a limitation until deficient practices are corrected. Limitations may include a shorter term length of the contract, a directed plan of correction, a cap on new admissions to the service program, etc. Both the DDSO and the MSC Vendor sign the amended contract. The DDSO and DQM would monitor the vendor to see that corrections are being made.
- Contract Termination

## APPENDIX 1 MSC RELATED ADMINISTRATIVE MEMORANDA AND RELATED FORMS/INSTRUCTIONS

### Administrative Memoranda

#2011 - 01 LCED

#2010 – 03 MSC Documentation Requirements for billing
MSC Service Note Format
MSC Service Note Instructions

#2010 – 04 Program Standards: ISP Format and Timeframes
Cover Memo
ISP Format
ISP Instructions

#2009 -- 05 and LCED clarifying instructions
ICF/MR Level of Care Eligibility Determination Form (LCED)
QMRP Authorized to Sign LCED Forms
LCED Form
Clarifying Memo

## APPENDIX 2 MSC FORMS

Individual Application for Participation in
Medicaid Service Coordination (MSC1-APPL)

Request for Change of Medicaid Service
Coordination Vendor (MSC2-CHNG)

Withdrawal from Medicaid Service Coordination (MSC3-WITH)

MSC – Individual Withdrawal Verification Form (MSC4-VER)

Medicaid Service Coordination Agreement (MSC5-SCA)

Medication Service Coordination Activity Plan (MSC5-SCA Plan)

MSC Service Coordinator's Training Record (MSC6-TRN)

The Service Coordination Observation Report (MSC7-SCOR)

The Service Coordination Activity Plan (MSC 9-SCAP)

MSC Note Format and Instructions (in Appendix 1)

ISP Format and Instructions (in Appendix 1)

## APPENDIX 3 REFERENCE INFORMATION PERTAINING TO MSC FOR WILLOWBROOK CLASS MEMBERS

### Completing the SCOR for Willowbrook Class Members

For each MSC recipient living in an OPWDD certified residence, the service coordinator must complete the Service Coordination Observation Report (SCOR). The SCOR is based on information provided by the individual(s) visited and observed by the service coordinator during visits to the certified residence. Thus, for Willowbrook Class members, the SCOR must be completed for each person living in an IRA CR, Family Care Home or ICF (although ICF residents are not MSC eligible). The SCOR does not need to be completed for Willowbrook Class members who live in developmental centers.

To avoid unnecessary travel, service coordinators are advised to **complete the SCOR at the time of their quarterly in-home face-to-face service meeting.**

The three questions on the SCOR direct service coordinators to identify:

1. physical care, health or hygiene problems,
2. hazardous conditions, and
3. cleanliness and maintenance problems in the home.

Examples of possible problems/issues are:

- The person is unusually lethargic or agitated.
- The person is wearing torn or soiled clothes.
- The home has exposed wires, broken windows, or blocked exits.
- The home has an offensive smell.
- The toilet does not flush.
- There is no hot water.
- There is a cracked floor tile.

On the SCOR, the service coordinator must indicate whether he or she has observed or become aware of any conditions that place any individual in the home in imminent danger or of any event or situation which may be considered abuse according to the definition in Part 624. If the service coordinator does find any evidence of imminent danger or abuse, he or she must take appropriate action to protect the individual(s) at risk.

Issues relating to the appearance of the home, such as a crack in a wall tile that does not pose a danger, drapes that do not match a bedspread, or a messy bedroom should not be reported on the

SCOR. Some of these issues, however, may need to be explored further by the service coordinator as part of the advocacy role. If the service coordinator determines that these are real problems for the individual receiving MSC and should be resolved, the service coordinator should record them in the service coordination notes and should follow-up as necessary.

Some other examples of issues that may warrant further exploration but do not need to be included in a SCOR are:

The individual is a collector of magazines and newspapers and the service coordinator is concerned that this could present a fire hazard in the future.

A cracked wall tile is slowly deteriorating and may pose a danger in the future.

The individual wears clothes that do not fit correctly.

One of the valued outcomes in the individual's ISP is that the individual keep his or her room neat and clean, yet the room is always messy.

Should any minor problem grow worse (e.g., the cracked wall tile falls making other tiles crack or fall) and cause concern for the person's health and safety, the service coordinator should include it on a subsequent SCOR.

The SCOR should not be used to document service or habilitation program deficiencies unless they directly relate to the person's health, safety or the home environment. However, the service coordinator should thoroughly document in the service coordination notes any service or habilitation program deficiencies even if they are unrelated to health, safety or the home environment, and the subsequent actions taken by the service coordinator to address the deficiencies.

**Frequency of Completion of the SCOR**

The SCOR must be completed at least twice a year, in non-consecutive calendar quarters, and whenever a serious problem is identified during a home visit.

Service coordinators who serve Willowbrook Class members should establish either a 1st and 3rd or 2nd and 4th quarter cycle for completing an individual's mandatory SCOR. An MSC working with a Willowbrook Class member for the first time must complete

the first SCOR within the first six months of working with the individual.

If a serious problem is identified, the service coordinator must complete a SCOR to report the problem each quarter until the problem is resolved. Once the problem is resolved, and if no other problems are observed, the service coordinator can return to filing a SCOR every other quarter. The service coordinator, however, should indicate how the problem was resolved in the monthly note.

Only one SCOR needs to be completed if the service coordinator visits more than one person at the same certified home. The names of all the individuals visited must be listed on the SCOR.

**Collaborative SCOR Visits for Willowbrook Class Members**

When the Consumer Advisory Board (CAB) represents or co-represents a Willowbrook Class member, the local CAB program associate should participate in a collaborative SCOR visit once annually with the service coordinator. This SCOR visit can occur when a team meeting is convened at the residence and both the service coordinator and CAB representative are present or at some other mutually agreed upon time.

The Service Coordination Observation Report is not completed for people who live with their family or on their own in a non-OPWDD Certified home. If a service coordinator observes a health, safety, or environmental problem in a person's private home, or if the individual or the family brings a problem to the service coordinator's attention, the service coordinator should discuss the problem with the individual and/or the family to determine an appropriate course of action. The service coordinator should review these concerns with his or her supervisor and take appropriate actions as necessary.

**Distribution of the SCOR**

If no problems are reported on a SCOR:

- The original SCOR is retained by the service coordinator in a separate file. A copy of the SCOR is kept in a separate file exclusively for SCORs at the residence, unless the person lives in a Family Care home.

- If the person lives in a Family Care home, the service coordinator sends a copy of the SCOR to the Family Care

liaison for the home who files the report in the home's certification file.

If problems are reported on a SCOR:

- The original SCOR is retained by the service coordinator in a separate file. A copy of the report is kept in a separate file exclusively for SCORs at the residence, unless the person lives in a Family Care home.
- If the person lives in a Family Care home, the service coordinator sends a copy of the SCOR to the Family Care liaison for the home who files the report in the home's certification file.
- A copy is given to the service coordinator's supervisor. The service coordinator's supervisor must send a copy of the report to the executive director of the voluntary agency operating the residence or to the DDSO Director for state-operated residences. For Family Care homes, a copy of the report must be sent to the DDSO/Agency's Family Care coordinator and to the Family Care liaison for the home.
- The service coordinator should notify his or her supervisor if the problem noted in the Service Coordination Observation Report is not resolved in a reasonable timeframe. The supervisor should contact the residential agency regarding the unresolved issue. If the issue remains unresolved, the supervisor should contact the DDSO regarding his or her concerns.

## APPENDIX 4 REFERENCE MATERIALS

Person Centered Planning

The Eight Hallmarks of Person Centered Planning (with 23 indicators)

MSC Contract