



**Office for People With
 Developmental Disabilities**

ADMINISTRATIVE DIRECTIVE

Transmittal:	Administrative Memorandum (ADM) 2017 - 01
To:	Executive Directors of Voluntary Provider Agencies Developmental Disabilities Regional Office Directors State Operations Office Directors Medicaid Service Coordinators and MSC Supervisors
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Date:	July 1, 2017
Subject:	Home and Community-Based Services (HCBS) Waiver and Non-Waiver Enrolled Respite Services
Suggested Distribution:	HCBS Waiver Providers Quality Improvement Staff Billing Department Staff Medicaid Service Coordinators (MSCs) and Supervisors Regional Office Front Door Staff Central Office Leadership Team Administrative Staff of Respite Services HCBS Waiver Coordinators
Contact:	Waiver Unit, Division of Person-Centered Supports peoplefirstwaiver@opwdd.ny.gov
Attachments:	Respite Documentation Record – Individual Summary

Related ADMs	Releases Cancelled	Regulatory Authority	MHL & Other Statutory Authority	Records Retention
ADM-2005-02	ADM-2005-02	14 NYCRR Parts 635 and 686	MHL §§13.07 and 13.09 (b)	6 Years from Date of Service: 18 NYCRR 504.3(a)

Purpose

The purpose of this Administrative Memorandum (ADM) is to describe the service requirement changes to Respite services effective **July 1, 2017** that delineate program standards or support a provider's claim for reimbursement. These requirements apply to Respite services delivered to individuals who are enrolled in OPWDD's Home and Community Based Services (HCBS) Waiver or to non-waiver enrolled (NWE) individuals. Respite services that are provided by "self-hired" staff as part of a person's self-directed budget are not addressed in this ADM. This memorandum does not affect individuals who receive Respite services through a Family Support Services (FSS) contract; FSS contracts for Respite services remain in effect.

Background

The regulatory basis for HCBS Respite is found in 14 NYCRR Sections 635-10.4, 635-10.5, and 686.15.

Respite services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief of the individual's unpaid primary caregiver (e.g., those persons who normally provide care for the individual).

Respite services can be provided in the home or out of the home, during the day, evening, or overnight. Respite can be delivered in the following locations: individual's home or place of residence; non-certified community location; certified residential setting where the individual does not permanently reside (i.e., Family Care Home; Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF/IIDD); Individualized Residential Alternative (IRA) or Community Residence (CR)); or Free-Standing Respite facility under the auspices of OPWDD. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences. Respite services may not be separately billed to Medicaid for individuals living in certified residences. A Family Care Home is a setting where Respite services can be provided, however, an individual receiving Residential Habilitation services in a Family Care Home is not eligible to receive HCBS Waiver Respite services.

Categories of Respite Services

Effective July 1, 2017, Respite services may be delivered and billed under the following categories:

1. **In-Home Respite Services** – Day or overnight services provided in a person's family home or in another non-certified/non-licensed home that is not the person's own family home. In-Home Respite activities may also include staff accompanying the person to community (non-certified) settings.
2. **Site-Based Respite Services** – Day or overnight services provided in a) a Free Standing Respite site (the operating certificate identifies a Respite opportunity in the home), including Systemic, Therapeutic Assessment, Resources and Treatment (START) Resource Centers; b) a Certified Residence; or c) a Community Setting (whether certified or not) that the provider owns, leases, or pays property costs or usage fees for a room, building or portion thereof (including, but not limited to, public library, school or hotel). Services may include daytime or overnight outings in a Community Setting and includes time spent on community trips that start or end at a Community Setting as identified above.

3. **Recreational Respite Services** – Services are provided with a focus on recreational and/or community integration activities and include any programs where routine travel to an outing or event may be involved. These services are provided in locations that are not owned, rented, or leased by the provider (e.g., a mall or movie theater).
4. **Camp Respite Services** – Services delivered at site-based locations that possess a permit under Subpart 7 of the NYS sanitary code.
5. **Intensive Respite** – Services for individuals with high behavioral and/or high medical needs that meet the qualifications for additional staffing supports due to such needs. Intensive Respite services are distinguished from other billing categories of Respite as they are determined by the individual's level of need, rather than the location of service. Individuals will be authorized to receive Intensive Respite services by OPWDD Regional Offices.

a) High Behavioral Needs

- i. Services provided to individuals with high behavioral needs that meet the qualifications for additional staffing supports and are overseen by 1) a Licensed Psychologist and/or a Licensed Clinical Social Worker (LCSW) as defined under New York State Education Law; or 2) a Behavioral Intervention Specialist (BIS) as defined in regulation by 14 NYCRR 633.16(b)(32); or 3) a START Clinical Team Member.
- ii. An individual receiving Intensive Respite services for individuals with high behavioral needs must have a Plan that is developed by the licensed professional, START Team Member, or BIS that instructs Respite staff on the implementation of Respite staff actions to address the individual's high behavioral needs.
- iii. Respite staff must be trained in the implementation of the Plan by the licensed professional, START Team Member, or BIS and the Plan must be reviewed by the licensed professional, START Team Member, or BIS every six (6) months at a minimum, or as needed based on the individual's changing needs or schedule for service use.
- iv. The agency delivering the Intensive Respite services for individuals with high behavioral needs directly employs or contracts with an agency or a licensed professional, START Team Member and/or BIS who is assigned to the Intensive Respite services program, directly oversees and/or provides Respite services and whose appropriate staffing costs are assigned to the Respite program for cost reporting purposes.

b) High Medical Needs

- i. Services provided to individuals with high medical needs that meet the qualifications for additional staffing supports and are overseen by licensed clinical professionals including, but not limited to: a Physician, Physician Assistant (PA);

Special Assistant; Registered Professional Nurse (RN); Nurse Practitioner; Clinical Nurse Specialist; and/or Licensed Practical Nurse.

- ii. An individual authorized for Intensive Respite with high medical needs must have a Plan of Nursing Services (PONS) that is developed by an RN. The PONS instructs Respite staff on the implementation of Respite staff actions to address the individual's high medical needs.
- iii. Respite staff must be trained in the implementation of the PONS by the RN. The PONS must be reviewed by the RN annually at a minimum, or as needed based on the individual's changing needs or schedule for service use.
- iv. The agency delivering the Intensive Respite services for individuals with high medical needs must directly employ or contract with an agency or with an RN who is assigned to the Intensive Respite services program. The RN must directly provide services described in the PONS or may delegate these tasks to Respite staff. In cases where PONS are delegated to Respite staff, the RN must oversee the care being provided by Respite staff. The term "oversee" in this context means that the RN must be available, either by telephone or in person, when the delegated tasks are being performed by Respite staff. The RN staffing costs are assigned to the Respite program for cost reporting purposes.

Authorization Processes

Site-Based, Recreational, In-Home and Camp Respite

The DDRO shall authorize units of Respite based upon a needs-based assessment of the individual. Authorized Respite units may be used for any of the following categories of Respite: Site-Based, Recreational, In-Home, and Camp Respite. It is the responsibility of the provider to ensure that the appropriate category of Respite is billed for the Respite service delivered.

Intensive Respite

OPWDD Regional Offices shall authorize units of Respite based upon an individual's documented behavioral support and/or medical support needs in order to maintain the health and safety of the individual or others while Respite is being provided. Intensive Respite services for individuals with high behavioral or high medical needs must have a Plan to address their behavior needs or a PONS created and implemented prior to delivery of Intensive Respite services. Provider agencies must meet the criteria described in the Categories and Service Limits sections of this ADM in order to deliver Intensive Respite services.

Billing and Service Limits

Billing

All categories of Respite services are billed in 15-minute increments (billing units), with a full 15 minutes of service required to bill a single unit (i.e., there is no "rounding up"). For each continuous period of service delivery (or "session"), the provider must also document the service start time and service stop time for each Respite "session." For example, where Respite service is provided to an individual from 3:00 p.m. to 4:30 p.m., the provider may claim six 15-minute billing units if all

other documentation requirements are met. Respite services require in-person or “face-to-face” service provision by Respite staff.

Respite services are not always provided for a continuous time period on a given day. For example, an individual may receive Respite services at a Free-Standing Respite Site from 9:00 a.m. to 10:00 a.m. and then leave to attend a Day Habilitation program. After the Day Habilitation service, the individual may again receive Respite services at the Free-Standing Respite Site from 3:00 p.m. to 5:00 p.m. that afternoon. In this case, the total billable units for Respite services for the day would be twelve 15-minute billing units (four billing units in the morning plus eight in the afternoon).

An individual may also receive multiple types of Respite services during any given day. For example, an individual may receive Respite Services at a Free-Standing Respite Site from 10:00 a.m. to 11:30 a.m. and then receive two hours of In-Home Respite services in the afternoon from 3:00 p.m. to 5:00 p.m. In this case, the total billable units for Site-Based Respite Services would be six 15-minute billing units and the total billable units for In-Home Respite Services would be eight 15-minute billing units. Respite service billing must be done in accordance with billing limitations specified in this ADM for each Respite category.

Service Limits

Respite services are authorized by OPWDD Developmental Disabilities Regional Offices (DDROs) via a needs based assessment. Authorized Respite units may be utilized as non-overnight hours, overnight hours, or a combination of thereof.

1. Non-Overnight Respite

- a) Non-overnight Respite services are those an individual receives for a portion of the day but not overnight.
- b) Billing for Site-Based, Recreational, Camp, and Intensive non-overnight Respite services is limited to no more than ten (10) hours of service provision per calendar day.
- c) In-Home non-overnight Respite services do not have a calendar day limit on service provision.

2. Overnight Respite

- a) Overnight Respite is defined as Respite services provided to a person on two (2) consecutive days when Respite staff are providing oversight to a person during nighttime hours.
- b) Overnight Respite services may be billed for the following Respite categories: In-Home, Site-Based, Camp, and Intensive.
- c) Overnight Respite billing for In-Home, Site-Based and Intensive Respite is limited to no more than forty-two (42) overnight stays in a one-hundred-eighty (180) day period across all overnight Respite categories per individual. Overnight Respite billing for Camp Respite is limited to fourteen (14) days per calendar year per individual. The fourteen (14) days of overnight Camp Respite apply against an individual’s overall forty-two (42) day in a one-hundred-eighty (180) day period limit.
- d) Billing for Overnight Respite services at the full hourly fee is limited to no more than forty-two (42) days in a one-hundred-eighty (180) day period per individual across all overnight Respite service categories (In-Home, Site-Based Camp and Intensive). After the forty-two (42) day limit has been reached, any continued

overnight billing will be limited to the regional average daily rate paid for Supervised IRA services on a Per Diem basis. The one-hundred-eighty (180) day periods are as follows:

- January 1 – June 30
 - July 1 – December 31
3. Intensive Respite services can be provided to individuals with high behavioral or medical needs in any Respite setting. As such, Intensive Respite services for individuals with high behavioral or high medical needs remain subject to the service limits in place for the other four billing categories of Respite. For example, a person who has high behavioral support needs is authorized for Intensive Respite and attends a Site-Based program. Provided the individual has Regional Office authorization and a Plan in place, the Respite agency bills Intensive Respite for the time he/she attends the Site-Based program. There is no billing under the Site-Based category for this situation.

Same Day Service Delivery for Respite and Other Services

1. Time spent receiving another Medicaid service cannot be counted toward Respite billable service time, except for services such as Supported Employment or Pathways to Employment where non-direct/non-face-to-face may be billable. In addition, Respite services cannot be duplicative or delivered at the same time as services otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973. For individuals who participate in educational services (including home schooling), Respite hours needed should be determined based upon an individual's daily schedule and activities.
2. The schedule for Respite service delivery for children and young adults who attend school must be outside of regular school hours. For students who are home schooled or receiving homebound instruction, Respite services can be delivered during traditional school hours, but the Respite services must be outside the scheduled time for educational instruction provided to the child.

Transportation

Effective with the date of this memorandum, to and from transportation time will be included in a provider's billable time for Respite services if a provider is responsible for directly providing or contracting with a vendor that provides transportation. Transportation time does not include staff travel time when staff are traveling to and from the service delivery location without the accompaniment of the individual receiving the Respite services. In instances where an individual travels from a Day Habilitation service to a Respite service, the travel time may be counted as Respite billable time **only when the following is true:**

1. Respite staff provides the transportation or the Respite provider contracts with a vendor to provide the transportation; and
2. These transportation costs are reported in the Respite providers' Consolidated Fiscal Report (CFR) associated with its Respite program and not associated with the Day Habilitation program.

If the Day Habilitation program provides the transportation to the Respite service, the time is not considered billable Respite time unless 1 and 2 above is followed. Unless 1 and 2 are followed, failure to accurately report transportation costs can lead to a disallowance, given that a Day Habilitation provider's to and from transportation costs are included in its Day Habilitation reimbursement.

Service Documentation

Service documentation must be contemporaneous with Respite service provision. Required service documentation elements are:

1. Individual's name, and if applicable, the Medicaid ID (CIN).
2. Identification of the category of waiver service provided, in this case, "Respite."
3. Identification of the category of Respite service, i.e. In-Home, Camp, Site-Based, Recreational, or Intensive Respite.
4. Name of the agency providing the Respite service.
5. The date the service was provided.
6. The start time and stop time for each continuous period of Respite service.
7. Verification of service provision by the Respite staff person who delivered the service (this is accomplished with a staff signature and title). Initials are permitted if a "key" is provided which identifies the title, signature, and full name associated with the staff initials.
8. The date the service was documented (the date must be "contemporaneous" with service provision).

Respite Documentation Record

It is the responsibility of the provider to ensure that the appropriate fee is billed for the category of Respite delivered. Therefore, providers must maintain service documentation that supports the category of Respite billed. This documentation must indicate the appropriate billing category (i.e., Site-Based, In-Home, Camp, Recreational or Intensive). A provider may develop such a checklist/documentation or use the Respite Documentation Record – Individual Summary checklist template attached to this ADM.

Individualized Service Plan (ISP)/Life Plan (LP)

The Respite provider must have a copy of the individual's current Individualized Service Plan (ISP) or Life Plan (LP) on file. The ISP/LP for individuals enrolled in the HCBS Waiver is developed by the individual's Medicaid Service Coordination (MSC) service coordinator, Plan of Care Support Services (PCSS) service coordinator or Managed Care Organization (MCO) case manager. The ISP/LP must include the following elements related to the Respite service:

1. Identification of Respite as the category of service.

2. Identification of the agency providing Respite service.
3. Specification of the Frequency is “hourly” or “hour.”
4. Specification of the Duration as “ongoing.”
5. Specification of an effective date that is on or before the first date of service for which the agency bills Respite services for the individual.

Respite services would be documented as follows:

<p>Name of Provider: Agency Name Type of Service: Respite Frequency: Hourly Duration: Ongoing Effective Date: Date prior to first day of Respite billing</p>

Since Respite is not a habilitation service under the HCBS waiver, a Habilitation Plan is not required.

Self-Direction

The requirements for self-directed Respite services delivered by self-hired staff are not described in this Memorandum. However, the requirements of this Memorandum do pertain to Agency Supported Self-Directed Respite services. An individual may choose to self-direct Agency Supported Respite services for In-Home Respite services and the Respite provider will bill eMedNY in accordance with the billing requirements described in this Memorandum. Please see the Self-Direction Guide for Providers for additional information.

Liability for Services

Respite services are covered by the Liability for Services regulations ([14 NYCRR Part 635-12](#)). An individual must have Medicaid coverage that will pay for his/her Respite services and be enrolled in the HCBS Waiver or pay for the cost of their services. Certain individuals may qualify for a limited exception. The limited exception means that persons can continue to receive Respite services without applying for Medicaid and the HCBS Waiver and without paying for their services. To qualify for the limited exception, an individual must meet the following criteria:

1. Receive Respite services;
2. Not live in a residence certified by OPWDD (Intermediate Care Facilities for individuals with developmental disabilities (ICF/IDD), Individualized Residential Alternatives (IRAs), Community Residences (CRs), or Family Care Homes;
3. Not receive any of the following OPWDD provided or certified services: Medicaid Service Coordination (MSC), Day Treatment, Community Habilitation, Day Habilitation, Prevocational Services, or Supported Employment services; and
4. Not have been enrolled in the HCBS Waiver at any time after March 14, 2010.

Information on the limited exception can be found in the OPWDD LIAB 10 Information about the Limited Exception notice available on the OPWDD website at the following link:
<https://opwdd.ny.gov/sites/default/files/documents/OPWDD-LIAB-10.pdf>

Activity Fees Associated with Respite Services

Eligible Activities:

Respite providers may arrange for special activities or outings as part of the Respite service delivery (i.e., Respite staff take the individual to a movie while providing Respite). In keeping with personal allowance guidance, it is appropriate that an individual or his or her family use personal resources for admission/entrance fees or Camp activity fees associated with such events, when the following criteria are met:

1. The expense supports the individual's community involvement and inclusion;
2. The individual willingly chooses to spend his/her money in this manner;
3. The individual directly benefits from the expenditure; and
4. Individual operating expenditures are not a routine/regular expectation of the program.

An individual receiving Respite services should not pay for a Respite-related activity unless all four criteria listed above are met. The expectation in those cases is that fees or costs associated with an activity would be incurred by the provider as part of the service. The HCBS Waiver does not allow charging individuals a "co-payment" for Waiver services or for establishing cost sharing arrangements, such as premiums or enrollment fees. In general, a co-payment is an amount that is charged to the participant each time he/she receives a service. A cost sharing arrangement requires the individual to make a fixed, periodic payment to the provider.

Records Retention

New York State regulations require each Medicaid provider to prepare records to demonstrate the provider's right to receive Medicaid payment for a service. These records must be prepared "contemporaneously" with the service and kept for six years. 18 NYCRR 504.3(a).

All documentation specified above must be retained for a period of at least six years from the date the service was delivered or when the service was billed, whichever is later.

Technical Assistance

For additional information on the requirements and standards described in this memorandum, contact the Division of Person-Centered Supports Waiver Unit at:
peoplefirstwaiver@opwdd.ny.gov.

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