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Office for People With Developmental Disabilities

Informational Session: Family Support Services (FSS) Reimbursement Updates

May 30, 2023

Purpose

- Ensure consistent messaging and clarify practices in the FSS Reimbursement Services ADM and FAQ resource

- Provide updated FSS documents and related guidance on new FSS Reimbursement forms in effect Spring 2023

Overview

- Family reimbursement through the FSS program is provided to help families by easing the expenses of providing care for family members with intellectual or developmental disabilities.

- Standard remains that Reimbursable FSS goods and services *must be*:
  - Related to the person's intellectual or developmental disability; ***and***
  - deemed appropriate and necessary to meet the needs of the person by the FSS provider

- Effective 7/1/2022, FSS Reimbursement practices were revised and clarified with an Administrative Directive Memorandum (ADM).

- ADM and FAQ documents specific to FSS Reimbursement were updated in 2023, with further clarification offered in response to stakeholder feedback.

Eligibility

To be eligible to receive/be enrolled in FSS, a person *must*:

1. Have established eligibility for OPWDD services; ***and***
2. Reside with one or more non-paid family member (i.e., biological, adoptive, or extended family or non-paid caregiver in the absence of biological, adoptive or extended family)

People who reside independently (outside of the home of a natural, unpaid caregiver), within OPWDD certified residential programs, or who reside in certified foster care settings remain ineligible to receive FSS services.

Care Management is **not** a requirement for receipt of FSS. The caregiver of an eligible person may apply to receive FSS. Established application process and program parameters apply.

Learning Curve

- OPWDD staff have streamlined the decision making and reconsideration process for reimbursement requests towards ensuring consistency and standardization statewide.

- Providers are encouraged to use the ADM and FAQ guidance to respond to the needs of those enrolled. ROs should be utilized for technical support and guidance, as needed.

- The provider remains responsible for communicating reimbursement decisions based on the ADM requirements.

Clarification to Family Support Services Reimbursement ADM

- FSS Reimbursement revised forms and amended guidance:
    - Revisions to FSS reimbursement application
    - Revisions to tracker and instructions
    - Clarifications within the FAQ document
    - Considerations for Allowable and Non-Allowable items
    - Updates and clarification on list of Allowable/Non-Allowable items

Revisions to FSS Reimbursement Application

OPWDD FSS Family reimbursement application has been updated to include/omit the following:

- Question 7a: “Is the Individual enrolled in Medicaid?”
- Question 7c reworded to: “Is anyone residing in your home receiving payment to provide care to the individual receiving services?”
- Question 9: Notice of Decision or other OPWDD Eligibility Document approved by DDRO (If current documentation is not on file with provider agency) has been removed from the checklist of required documents.

Revisions to FSS Reimbursement Tracker and Instructions

The OPWDD FSS Reimbursement tracker with instructions has been updated to include the following elements:

- Enrolled in Medicaid
- Enrolled in Waiver
- Reviewed by Committee
- Date of Reimbursement Request
- Reimbursement Item
- One Time or Ongoing
- If Ongoing, Provide Frequency
- Does Individual Live with Family and/or Caregiver
- Clinical Justification

Revisions to FSS Reimbursement Tracker and Instructions, continued

The OPWDD FSS Reimbursement tracker with instructions has been updated to include the following elements:

- Preservation of Family Unity
- Cost Effective Options Explored
- Provide Weblink to Item
- Alternative Funding Sources Explored
- Individual Connected with a CCO
- Item Listed in Life Plan with Connection to Disability and Why It's Needed
- Notes

FAQ Document

In response to stakeholder feedback and requests for additional clarification, OPWDD developed an FAQ document specific to the 7/2022 FSS Reimbursement ADM.

FAQ Highlights

Highlighted areas on the FAQ include clarification on:

- Life Plan Documentation
- Clinical Justifications– what is needed and for which items
- FSS Respite Reimbursement and Waiver status
- Funding flexibilities: partial reimbursements, direct purchase, and pro-rating (shared items)
- Emergency reimbursement criteria
- FSS criteria for Self Directing participants

Life Plan Documentation & CM Responsibilities

- For those that are enrolled in care management service, the FSS provider(s), identified by organizational name(s) and type of service(s) should be listed in in Section V of the Life Plan/Life Plan Addendum.

- **A brief justification or overview of service/item to be listed in Section I (Narrative) of the Life Plan/Life Plan Addendum is now *required.***

- Services/items listed and their accompanying statement should provide an underlying supporting need and correspond to each enrolled FSS service (inclusive of all provided through different or same FSS providers).

Life Plan Documentation & CM Responsibilities, continued

- Care Managers should ensure all Waiver and non-Waiver services are both current and accurately listed in Life Plan (including CDPAP/SDS).

- Care Managers are responsible for alerting providers in a timely manner of any status changes to services listed in the Life Plan which may impact FSS services (e.g., launch of an initial Self-Directed budget for people who are Self-Directing their services, aging out of school, withdrawing from site based programming, etc.)

- Required information in Sections I and V should be included in the Life Plan no later than the time of next scheduled Life Plan review or when requesting a new FSS service, whichever comes first.

Life Plan Documentation, Common Questions:

Q: Does the provider require copies of the Life Plans?

A: Yes. A copy of the Life Plan should be submitted along with all other required documentation (refer to ADM) with a completed application to the FSS provider(s) that the family has chosen (if the person is enrolled in a CCO).

On an ongoing basis-- but *no less than with each application submitted*— a copy of the most current, approved Life Plan/Life Plan addendum should be forwarded to the FSS provider(s) of record.

Life Plan Documentation, Common Questions:

Q: I was informed that the person can only have one agency listed now in the Life Plan under the provider's section. If this is so, how should this information be listed for people who access different services through multiple FSS providers (both in the Life Plan, and as appropriate, a SDS budget)?

A: In sections I and V of the person's Life Plan, as well as in the Self-Direction Budget (in the case of a person enrolled in Self-Direction), there is the possibility that multiple agencies would be listed should separate, non-duplicative types of goods and services be received. In these instances, there can be multiple listings documented in the Life Plan distinguishing all other identified FSS programs that the person uses. Each FSS service should have its own accompanying justification listed

Clinical Justification

- The family/caregiver must provide the FSS provider with a clinical justification that indicates a significant, definable, positive impact on the individual/family directly relating to health, safety and emotional well-being, normalization of life, accessibility to needed services, personal growth and/or development of the person.

- The clinical justification must be clinically indicated and substantiate the need for the item or service that is being requested.

- The clinical justification must be supported by a clinician and demonstrate a clear connection to the person’s developmental and/or intellectual disability.

Clinical Justification

- Clinical justification from clinician(s) working within their scope of practice including but not limited to physical therapist, occupational therapist, speech therapist, physician, registered nurse, is acceptable.

- The clinician must provide a signed letter dated within a year of request (on formal letterhead) that demonstrates the need based on the criteria listed above in this paragraph.

Impacts of Waiver Status on FSS Reimbursements:

- People who are enrolled in the HCBS Waiver must access Waiver Respite prior to applying for FSS Family Reimbursed respite.

- The person/family, along with their care manager (if applicable) must explore if Waiver Respite opportunities are available.

- If staffing is not available from any Waiver Respite providers, individuals/families can then apply for FSS family reimbursed respite.

Clarifying Guidance for Self-Directing and CDPAP Enrolled Participants

- The FSS ADM was intended to avoid duplication in service provision and to allow for equitable access to limited FSS resources in alignment with the prioritization of applications section of the ADM (page 7).

- Guidance has evolved for applicants of FSS Reimbursement who are enrolled in OPWDD's Self-Directed Services or NYS DOH's Consumer Directed Personal Assistance Program (CDPAP) based on the gaps and allowances within those programs.

Clarifying Guidance for Self-Directing Participants

- FSS reimbursement is allowable ***only prior*** to the approval of the person's initial Self-Direction budget or under the special circumstances specific to Self-Direction as described in section P of the ADM or question 8 of the FAQ.

- The Self-Direction budget is responsible to cover items/services once budget approval occurs through Family Reimbursed Respite (FRR), Individual Directed Goods and Services (IDGS), or Other Than Personal Services (OTPS).

- The person's budget must include FSS prior to reimbursement application submission.

Clarifying Guidance for CDPAP Enrolled Participants

- **Paid Caregivers are not eligible for Family Reimbursement.**

- Family/caregivers who themselves provide paid services to a person they live with through the NYS DOH's Consumer Directed Personal Assistance Program (CDPAP) ***are not eligible*** for FSS family reimbursement.

- When a person receives CDPAP **only** from one or more staff who live outside of their home, their family ***is eligible*** to apply for FSS family reimbursement.

Considerations for Allowable and Non-Allowable Deliverables

- FSS should always be utilized as a short term, time-limited resource when alternative funding sources have been exhausted.
- FSS is a complement and *not* a supplement to other available programs, services, and funding mechanisms.
- Items/services requested must be directly related to the person's disability.
- Routine expenses one would incur in caring for a loved one without a disability or raising a child remains the [fiscal] responsibility of the caregiver.
- An application submission is not a guarantee that funds will be awarded.

Allowable Items (Current as of 4/2023):

- Recreation Activity/Program/Equipment– including, but not exclusive to:
  - Integrated, community-based activity fees/ supplies
  - Instrumental and music lessons/fees (e.g., guitar lessons, piano lessons)
  - Braille bingo cards, playing cards and dominoes
  - Cooking classes (not resulting in certification)
  - Theatre classes/workshops
  - Museum membership
  - Art classes; Crafts
  - Gym Membership; Fitness classes
  - Swim lessons
  - Sports lessons/fees (e.g.: soccer, baseball, bowling)
  - Martial arts lessons (e.g.: karate, Tae Kwon Do)
  - Dance/ballet lessons
  - Hippotherapy/horseback riding lessons

Allowable Items (Current as of 4/2023): continued:

- Sensory items/activities (including, but not exclusive to):
  - Balance chair, bean bag chair
  - Indoor swing
  - Mini trampoline (single user)
  - Climber
  - Fidget items/sensory toys
  - Mats (positioning, wedge, floor)
- Items/Services that are not covered or available through other means and are Committee reviewed/approved
- Respite
- Camp (in compliance with ADM)
- Electronic devices (in compliance with ADM)
- Supplements approved by a clinician and outlined in the individual's treatment plan
- Legal fees related to guardianship/special needs trusts

Allowable Items (Current as of 4/2023), continued:

- Clothing as a necessity or if there are specific needs related to the intellectual/ developmental disability (I/DD) as clinically indicated (i.e., included in the Life Plan or with other appropriate documentation requested by the DDRO); and

- Other items as deemed by DDRO appropriate & reimbursable

Non-Allowable Items (Current as of 4/2023):

Healthcare/Personal care items (*including, but not limited to*):

- Items covered by Medicaid or healthcare insurer, including incontinence/medical supplies & prescription medications
- Exercise equipment
- Personal training, life coach services

Household Expenses (*including, but not limited to*):

- Appliances, large and small (washer/dryer, blender, AC)
- Furniture/furnishings (mattress
- Home repairs and Maintenance items
- Food storage containers, water bottle

Travel/Transportation (*including, but not limited to*):

- Vehicles (e.g., cars, motorcycles), bikes, trikes, scooters
- Automotive repairs, batteries, fuel
- Hotel/lodging, mileage and travel costs

Non-Allowable Items, continued (Current as of 4/2023):

Fiscal Expenses (*including, but not limited to*):

- Real property costs incl. tax bills
- Finance charges
- Sales tax, Shipping fees

Duplicative Expenses/Otherwise Covered (*including, but not limited to*):

- *Upgrades* to HCBS Waiver funded items/services
- Items/services related to Waiver program participation
- Equipment repair/replacement

Non-Allowable Items, continued (Current as of 4/2023):

Educational Based Services/Goods (*including, but not limited to*):

- College courses/Certification programs
- Homeschool supplies
- After-school and tutoring programs

Miscellaneous Items/Services (*including, but not limited to*):

- Regular and ongoing subscription plans (incl. cell phone plans)
- GPS Trackers/devices; video or audio monitoring devices
- Luxury items (e.g., swimming pools, hot tubs)

Partial Reimbursements

- As a 100% state paid service, any goods or services must be *cost effective* -- meaning whenever a comparable item is available at a lesser cost, the lesser cost item must be purchased or utilized.

- Partial reimbursement for goods and services is at the discretion of the provider.

Direct Purchase

- Direct purchase as an option for expenses which are needed without delay – as outlined in the ADM
- Providers must provide this option to families.
- The caregiver must submit an explanation of hardship describing why the family cannot pay for the service/item first with the request.

Direct Purchase

- An attestation of household income, household demographics, and fiscal obligations may be required by the provider.
- Funding is not guaranteed and would need to adhere to the same guidelines and standards as reimbursements.
- If item sold/returned, or service is not received, the caregiver must notify and reimburse cost to FSS provider.

Shared Items

- Items to be shared by others in the household (e.g., toiletries, food) must directly relate to the needs of a person with an intellectual or developmental disability and must be pro-rated based on the number of residents in the house.

Emergency Reimbursement

- Supports available through natural or community resources, and typically funded through other mechanisms, may be allowed on a short-term basis as a result of a crisis or because the person or family is in great need of specialized assistance, with appropriate supporting justification and approval (e.g., subsidies for housing, utilities, or food, durable medical goods).
- Family Reimbursement is not intended to cover chronic, ongoing crisis situations.
- Emergency reimbursements may be awarded once per lifetime per family for each type of emergency.

Emergency Reimbursement

- Emergency requests must include all information that is required for general reimbursement requests.
- Additionally, emergency requests must include:
    - Documentation substantiating the need (e.g., eviction notice, letter of justification from Care Managers, verification of service by exterminator)
    - Description of how the request addresses an immediate, short-term crisis that impacts the health and safety of the individual and
    - a plan to prevent reoccurrence of the crisis
- The application must also reflect emergency reimbursement need by indicating “yes” to the question in section five (5) of the application.
- Please note, emergency request funding is separate from the $3,000 statewide cap for Family Reimbursement.

Emergency Reimbursement

- When an FSS provider receives an emergency reimbursement request, they must contact the Regional Office immediately.
- The provider must submit the Family Reimbursements Tracker (see attachment C) and designate this as an emergency expenditure.
- The completed family reimbursement application must also be submitted.

Reconsideration Process

- As outlined in ADM-2022-02**R** (page 6), FSS providers must develop reconsideration processes for people/ families who would like their application to be reconsidered in the event that their application is denied, in whole or in part.

Reconsideration Process, continued

The reconsideration processes ***must*** include:

- Notification that the family or individual has fifteen (15) days from receipt of the FSS provider's written denial to request reconsideration of the denial;
- the opportunity for the family or individual to present additional documentation/justification to the FSS provider; ***and***
- the opportunity for the family or individual to engage in informal dispute resolution with the provider to discuss concerns about the denial.

The FSS provider must give written notice to the individual/family and care manager about the result of the reconsideration process.

Reconsideration Process

- If the FSS provider upholds the denial after the reconsideration process, the notice must state that the individual/family can appeal the decision to the DDRO no later than seven (7) days from the receipt of the written notice. Contact information for the DDRO appeal must be included in the notice.

- If the requested item/service is denied by FSS provider, reconsideration occurs at the provider level or at Regional Office level. Individual/family will have 15 days from date of notice to appeal decision.

- If the item/service is denied by OPWDD *due to an item not being on the allowable list*, reconsideration occurs at the OPWDD Central Office level.

Reconsideration Process – Notifying the Regional Field Office

- In addition to the original denial letter issued by FSS providers, if the FSS provider upholds a denial after informal dispute resolution, the Regional Field Office must be included on the upholding denial notification to the family for awareness of the potential incoming reconsideration process.

- This notification must be sent to the respective Regional Field Offices.

Reconsideration Process – Notifying the Regional Field Office

Regional Field Office Email Addresses

- Region 1 – region1fss@opwdd.ny.gov
- Region 2 – region2fss@opwdd.ny.gov
- Region 3 – region3fss@opwdd.ny.gov
- Region 4 – region4fss@opwdd.ny.gov
- Region 5 – region5fss@opwdd.ny.gov

Oversight

- Providers must establish a system for monitoring and verifying goods and services are used for their intended purpose.

- Providers must investigate any suspected fraud or misuse of FSS reimbursement. Through the time that the investigation is completed, payments should be suspended.

- If fraud is suspected, the provider must contact the Regional Field Office and follow the process as outlined in the ADM.

Resources

https://opwdd.ny.gov/regulations-guidance/adm-2022-02-family-support-services-fss-reimbursement-guidelines

Contact

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