NEW YORK STATE OF OPPORTUNITY. Office for People With Developmental Disabilities

Memorandum

TO: Care Coordination Organizations
CEOs of Voluntary Provider Agencies
Developmental Disabilities State Operations Offices (DDSOO) Directors
Developmental Disabilities Regional Offices (DDRO) Directors
Provider Associations
Willowbrook Consumer Advisory Board

FROM: Katherine Marlay, Deputy Commissioner
Division of Policy and Program Development

DATE: September 26, 2018 (updated August 19, 2019 with revisions underlined)

SUBJECT: Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual Updates

The purpose of this memorandum is to respond to operational challenges identified by CCO/HHs in the delivery of Care Management services that began on July 1, 2018. The contents of the enclosed attachments detail new and amended policies effective immediately. The CCO/HH Provider Policy Guidance and Manual (Version 2018-1) will be revised to reflect this guidance at a later date. These modifications will offer CCO/HHs more flexibility in the coordination of Care Management services. In addition, to ensure the successful implementation of CCO/HH Care Management services, CCO/HH policy requires the completion and submission of ongoing CCO/HH reporting as described in Attachment 1.

This September 26, 2018 memorandum is being updated to comport with policy revisions described in OPWDD Administrative Directive 2018 ADM-06 R, revised on May 9, 2019 and available at: https://opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda/2018-06 These revisions are underlined below and are effective retroactive to July 1, 2018.

Completion of the Comprehensive Assessment and Life Plan Development

As outlined in Attachment 2, the timeframes for completion of the Comprehensive Assessment and the development and finalization of the Life Plan have been extended for **new** individuals (individuals who have not received Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) prior to this transition) that have enrolled in a CCO/HH during the first quarter of implementation. Additionally, to ensure that a Care Manager has made contact with the individual/family, the CCO/HH Care Manager Checklist (Attachment 2a) must be completed for all enrollees (new or transitioning), within thirty (30) days of enrollment. These updates will facilitate a smooth and successful transition of individuals receiving CCO/HH services. Section 1.8, of the CCO/HH Provider Policy Guidance and Manual, entitled *Additional CCO/HH Standards and Requirements*, will be amended to reflect these changes.

Care Manager Caseloads and Transition of Individuals in Tier 4

The timeframe for CCO/HHs to comply with the Tier 4 caseload requirements has been extended from ninety (90) days to six (6) months as outlined in Attachment 2. This provision includes individuals transitioning between tiers and individuals who have been classified as Tier 4 since July 1, 2018. Section 4.1*,* of the CCO/HH Provider Policy Guidance and Manual*,* entitled *General Requirements for CCO/HH Claim Submission* will be modified to reflect these changes. The extension for meeting compliance requirements in no way changes the obligation to provide needed Care Management services based on an individual's presenting needs. **This extension does not apply to members of the Willowbrook Class, who must receive a direct 1:20 ratio on the first day they receive Care Management services as per the Willowbrook Permanent Injunction.**

CCO/HH Staffing Policies Supporting Individuals in Tier 4

To meet the changing and complex needs of those who are in an OPWDD defined Tier 4 reimbursement category, CCO/HHs may utilize different models of Care Management to affect successful transitions, continuity of care and improved outcomes. As specified in Attachment 3, CCO/HHs have the option to adopt staffing strategies, such as a mixed caseload and/or team approach, to support Tier 4 caseload compliance. Any or all of the models defined can be used by the CCO/HH to meet the Care Management staffing needs of the individuals they serve. CCO/HHs must identify in the applicable CCO/HH policies procedures, which of the identified models(s) they will use. CCO/HH policy updates related to caseload management must be submitted to OPWDD for review and approval within sixty (60) days of the issuance of this memo. If accepted, the CCO/HH must agree to complete specified reporting requirements as outlined in Attachment 1. The CCO/HH Provider Policy Guidance and Manual will be revised to include a new section entitled *Guidance for Supporting Individuals in Tier 4.*

Attachment 1: CCO/HH Reporting Requirements

To track the progress of the CCO/HH Care Management policy requirements, OPWDD and DOH require the submission of monthly reports on the data elements noted below. A spreadsheet will be provided to capture the information and facilitate consistent monthly reporting.

Data Required and Frequency:

The following data requirements are to be provided to your Central Office CCO Liaison on a monthly basis:

1. Total number of enrollments beginning July 1, 2018
   a. Total number of Tier 4 enrollments

2. Total number and percentage of completed Comprehensive Assessments (see policy)
   a. Total number and percentage of completed Comprehensive Assessments for Tier 4 individuals

3. Total number and percentage of completed Life Plans
   a. Total number and percentage of completed Life Plans for Tier 4 individuals

4. Total number and percentage of individuals meeting the Tier 4 ratio requirements

5. Intake, Pre-enrollment, and Enrollment (as specified on spreadsheet provided by OPWDD).

6. Care Management Staffing (as specified on spreadsheet provided by OPWDD)

7. Number of Health Home Enrollees whose consents have been uploaded to CCO electronic health record system

8. Any other data required by DOH and/or OPWDD.

Attachment 2: Facilitating the CCO/HH Transition – Policy Updates

This document defines new and amended CCO/HH policies effective immediately. The CCO/HH Provider Policy Guidance and Manual (Version 2018-1) will be revised to reflect this guidance at a later date. Recent CCO/HH policy updates include:

1. Completion of the CCO/HH Care Manager Checklist (Attachment 2a) for all individuals (new or transitioning) to ensure that a Care Manager or designee of the Care Manager has:
    a. Contacted the individual/ family within thirty (30) days of enrollment
    b. Discussed the individual's choice to enroll in the CCO/HH and what that choice means
    c. Assessed any immediate needs for Care Management supports and service planning. Immediate needs must be addressed by the planning team through a coordination of efforts with OPWDD DDROs and the individual's service providers;

2. Extension of the timeframe to conduct the Comprehensive Assessment and develop and finalize the Life Plan for new individuals that have enrolled during the first quarter of implementation.

3. Modification of caseload requirements to extend the timeframe for CCO/HHs to comply with Tier 4 caseload requirements from ninety (90) days to six (6) months. This provision includes individuals transitioning between tiers and individuals who have been classified as Tier 4 since July 1, 2018.

	Completion of Checklist	**Finalization of the Life Plan**[1]
New individual enrolled after the 1st quarter of launch (October 1, 2018 forward)	30 days	90 days from enrollment in CCO/HH or HCBS Waiver whichever comes first
New individual enrolled during the 1st quarter of launch (July 1, 2018 through Sept 31, 2018)	30 days	120 days from enrollment
Individuals who transitioned from MSC/PCSS on July 1, 2018[2]	No later than October 31, 2018	Annual review date (no later than December 31, 2019)

[1] A Life Plan is finalized when it is signed by the Care Manager and the individual receiving services and/or his/her representative. Providers responsible for delivering services documented in Sections II III and IV of the Life Plan must acknowledge and agree to provide the provider-assigned goals, supports, and safeguards associated with those services, per the finalized plan. The service provider's acknowledgement and agreement may be done via signature, email, or other method agreed upon between the Care Manager and the service provider.

[2] Per a revision to the June 8, 2018, memo, "It is the expectation that July, August, September, and October ISP reviews will continue to be conducted on schedule. With the permission of the individual, and as long as the individual's care needs are generally stable, the Care Manager may delay the annual review for up to six (6) months. However, the "semi-annual" review must be conducted in July, August, September, or October in lieu of the annual review meeting. During this period, the ISP would continue to be in place. A note in the Care Coordination record must reflect the rationale for the revised time frame.

	Completion of Checklist	Finalization of the Life Plan
Individuals in Tier 4 who transitioned from MSC/PCSS on July 1, 2018	No later than October 31, 2018	No later than May 31, 2019
Members of the Willowbrook Class	N/A	No later than December 31, 2019
Life Plan Reviews	N/A	No later than 45 days from the review meeting the Life Plan will be signed by the Care Manager and the individual receiving services and/or his/her representative [1]
Individual transitioning to a different CCO/HH	A new checklist must be completed within 30 days of enrollment into the new CCO/HH	Annual review date

[1] Providers responsible for delivering services documented in Sections II III and IV of the Life Plan must acknowledge and agree to provide the provider-assigned goals, supports, and safeguards associated with those services, per the finalized plan. The service provider's acknowledgement and agreement may be done via signature, email, or other method agreed upon between the Care Manager and the service provider.

Policy update regarding the completion of the CCO/HH Care Manager Checklist for all individuals (new or transitioning)

Care Managers, or a designee of the Care Manager, whose responsibility is to educate individuals and their families on CCO/HH services (i.e., CCO/HH Intake staff member), will be required to complete the CCO/HH Care Manager Checklist (Attachment 2a). This checklist must be completed to initiate and bill for CCO/HH services and done in partnership with the individual and their family/designated representative. The checklist assists with identifying and understanding the individual/family's current service needs and educates the individual/family on CCO/HH services. The checklist must be completed face-to-face or via telephone within thirty (30) days of CCO/HH enrollment, except where noted above for individuals who transitioned from MSC/PCSS on July 1, 2018. Care Managers (or their designee) also have the option of completing the checklist at the time the CCO/HH consent forms are reviewed and signed by the individual/family. The process of completing the checklist is essential to the successful delivery of the Health Home core services and will also identify any additional service needs of the individual. Individuals may change CCO/HHs at any time and a new checklist will need to be completed within thirty (30) days of enrollment into the new CCO/HH.

Once complete, the checklist must be signed and dated by the person who completed the checklist tasks. Additionally, it is required that the Care Manager sign and date the checklist whether they completed it independently or it was completed by their designee. It is best practice to have the signature of the individual or their involved family member/designated representative, but it is not required.

Comprehensive Assessment and Life Plan Development

For individuals who have transitioned from a MSC provider to a CCO/HH, the individual's Individualized Service Plan (ISP) will remain current until the initial comprehensive person-centered planning meeting is held to establish the individual's Life Plan. In addition to obtaining the current ISP and any other available assessments or supporting documentation, the Care Manager must also complete the following activities for everyone on their caseload if the information is available:

- Obtain or request any relevant plans or person-centered planning meeting information from other systems (i.e., Individual Education Plan (IEP), 504 Plan, discharge plans developed by hospitals, nursing homes, correctional facilities, assessments which may include, but are not limited to: clinical assessments and/or State approved functional needs assessments).
- Obtain available OPWDD assessment information, including the DDP2 and CAS summaries, from the OPWDD IT system (CHOICES).
- Confirm and identify the members of the individual's care planning team, in which the primary DD providers (i.e., residential, day, and community habilitation providers) are mandatory members.
- Confirm and identify all providers responsible for providing care to the individual. Those providers may include but are not limited to: medical, behavioral health, DD, LTSS and social and community services providers.
- Schedule the date, time and location of the Life Plan review meeting and identify the care planning team members who will be participating.

The team must be comprised of the individual and/or their family/designated representative, the Care Manager, DD and other service providers as requested by the individual and/or their family/designated representative.

Attachment 2a: CCO/HH Care Manager Checklist

Individual's Name: _____
Date of Birth (month/day/year): _____ TABS ID: _____

Care Managers, or a designee of the Care Manager whose responsibility is to educate individuals and their families on CCO/HH services (i.e., CCO/HH Intake staff member) will be required to complete the CCO/HH Care Manager Checklist. This checklist must be completed to initiate and bill for CCO/HH services and done in partnership with the individual and their family/designated representative. This checklist assists with identifying and understanding the individual/family's current service needs and educates the individual/family on CCO/HH services. The checklist must be completed face-to-face or via telephone within thirty (30) days of CCO/HH enrollment, except for individuals who transitioned from MSC/PCSS on July 1, 2018. Care Managers (or their designee) also have the option of completing the checklist at the time the CCO/HH consent forms are reviewed and signed by the individual/family. This process is essential to the successful delivery of the Health Home core services and will also identify any additional service needs of the individual. Individuals may change CCO/HHs at any time and a new checklist will need to be completed within thirty (30) days of enrollment into the new CCO/HH.

Upon completion of each task, this checklist must be signed and dated by the person who completed the tasks. Additionally, it is required that the Care Manager sign and date the checklist whether they completed it independently or it was completed by their designee. It is best practice to have the signature of the individual or their involved family member/designated representative, but it is not required.

Enrollment in CCO/HH is effective: _____
(month/day/year)

<u>Step One:</u> Information Gathering

Upon enrollment into the CCO/HH Care Manager must complete the following steps for everyone on their case load, if the information is available:

- ☐ Obtain or request any relevant plans or person-centered planning meeting information from other systems (i.e., Individualized Education Plan (IEP), 504 Plan, discharge plans developed by hospitals, nursing homes, correctional facilities, assessments which may include are but not limited to: clinical assessments and/or State approved functional needs assessments).
- ☐ Obtain available OPWDD assessment information, including the DDP2 and CAS summaries, from the OPWDD IT system (CHOICES).
- ☐ Confirm and identify the members of the individual's care planning team in which the primary DD providers (i.e. residential, day, and community habilitation providers) are mandatory members.
- ☐ Confirm and identify all providers responsible for providing care to the individual. These providers include but are not limited to: medical, behavioral health, DD, LTSS and social and community services providers.
- ☐ Schedule the date, time and location of the Life Plan review meeting and the care planning team members who will be participating.

Date of Person-Centered-Planning Meeting: Click or tap to enter a date.

Individual's Name: _____

Step Two: CCO/HHs are required to provide the following six Health Home Core Services.

The tasks referenced below are examples of core service activities that must be reviewed during the initial CCO/HH enrollment period. Care Managers are responsible for identifying the individual/family's service needs and educating the individual/family on CCO/HH services.

Comprehensive Care Management

- ☐ Inform individual and their family of the Care Manager's responsibility to create, document, execute and update the individualized, person-centered Life Plan.
- ☐ Identify the individual's current service needs, providers, supports, goals, and engagement activities.

Care Coordination and Health Promotion

- ☐ Educate individual and their family on engagement and decision-making to promote independent living, as well as education on wellness promotion and prevention programs.
- ☐ Coordinate and arrange for the provision of current and additional needed services and ensure treatment adherence.

Comprehensive Transitional Care (note: CCO/HH services may be billed to eMedNY within thirty (30) days of discharge from a hospital or institutional setting).

- ☐ Notify individual and their family of the established networks with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings.
- ☐ Is the individual currently residing in a health facility? (i.e. hospital or residential/rehabilitation setting? ☐ Yes ☐ No
  If yes, are the appropriate procedures currently in place to ensure timely access to follow-up care post discharge? ☐ Yes ☐ No

Individual and Family

- ☐ Educate individual and their family on support and self-help resources to increase knowledge, engagement, self-management and to improve adherence to prescribed treatment.
  Currently, does the individual and family require additional education and support services? ☐ Yes ☐ No

Referral to Community and Social Supports

- ☐ Advise individual and their family of available community-based resources and explain the Care Manager's role in managing appropriate referrals, access, engagement, follow-up and coordination.
  Currently, does individual require additional community-based resource support? ☐ Yes ☐ No

Use of Health Information Technology (HIT) to Link Services

- ☐ Inform individual and their family of the purpose and utilization of HIT.
- ☐ Has the individual signed a consent to share personal information? ☐ Yes ☐ No

X _____ _____

Care Manager's Signature Date

X _____ _____

Care Manager Designee's Signature Date

X _____ _____

Individual/Family's Signature Date

Attachment 3: Tools for Caseload Management

Care Management Models That Meet Enhanced Caseload Ratio Requirements

Care Managers who have even one (1) member of the Willowbrook Class on their caseload must provide a direct 1:20 ratio, with the exception of those Class Members who reside in an Intermediate Care Facility (ICF) where it must be a 1:20 equivalent ratio. Members of the Willowbrook Class who reside in an ICF, receive Willowbrook Case Services (WCS) from the Care Manager. The "Model 1: Tier 4 Caseload" would be used for Care Managers who have a member of the Willowbrook Class on their caseload.

To meet the changing and complex needs of those who are in an OPWDD defined Tier 4 reimbursement category, CCO/HHs may utilize different models of Care Management to affect successful transitions, continuity of care and improved outcomes. CCO/HHs have the option to adopt any of the following models of Care Management offered below. To ensure individuals with enhanced needs on a given caseload receive the required level of service, certain parameters will apply.

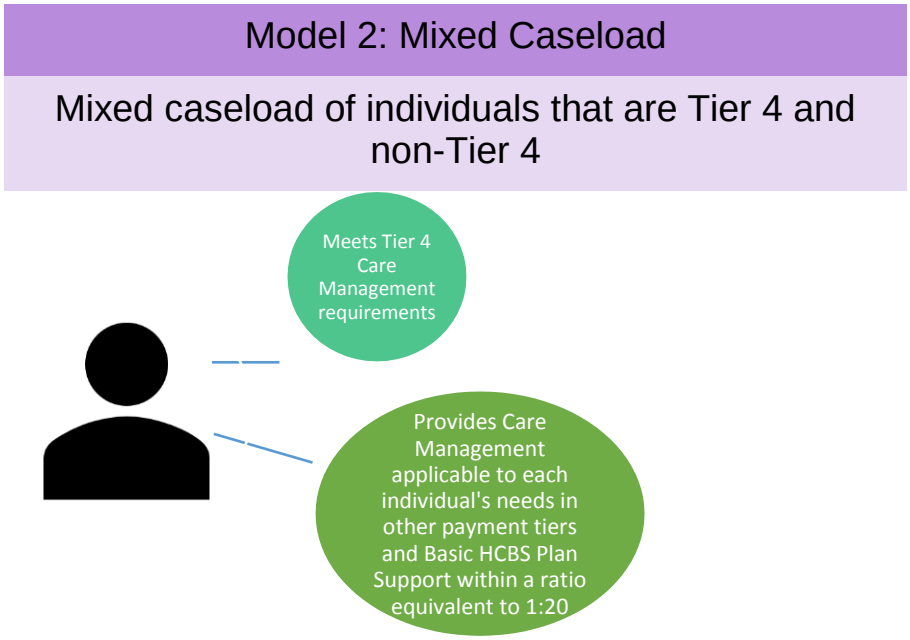
Direct Assignment of Care Manager (CM) at 1:20 ratio:

In this model the assignment to meet the required 1:20 ratio is direct in that there is one Care Manager who provides Care Management to twenty (20) individuals or less.

Model 1: Tier 4 Caseload
20≤ individuals served by 1 Care Manager

Mixed Caseload:

For the purposes of caseload stratification and resource management; a caseload mix of individuals in the Tier 4 payment tier and other tiers is allowable if and only if the equivalent Care Manager to individual ratio is 1:20 individuals or less. This means the weighted equivalent is twenty (20). This stratification allows for having more than twenty (20) individuals on a caseload, but keeping within the 1:20 ratio. Caseload sizes should always allow for adequate time for providing Care Management as outlined in this guidance to individuals with more complex needs, while allowing for thoughtful consideration of the Care Coordination needs of individuals who have been identified as not having more complex needs.



Example: One suggested approach for formulating a mixed caseload while factoring in varied levels of need is a weighted point system. Under this model, caseload capacity is determined by point accumulation as opposed to a traditional model, where capacity is based on a fixed number of individuals. Each individual is assigned a point value based on the individual's category as determined by the CCO/HH.

The table below outlines potential categories and values a CCO/HH could consider when using a mixed caseload approach for caseloads that include payment Tier 4 individuals:

Category	Point Value
Payment Tier 4	1
Other payment Tiers 1-3	Less than 1 as determined by the CCO/HH
Basic HCBS Plan Support	Less than 1 as determined by the CCO/HH

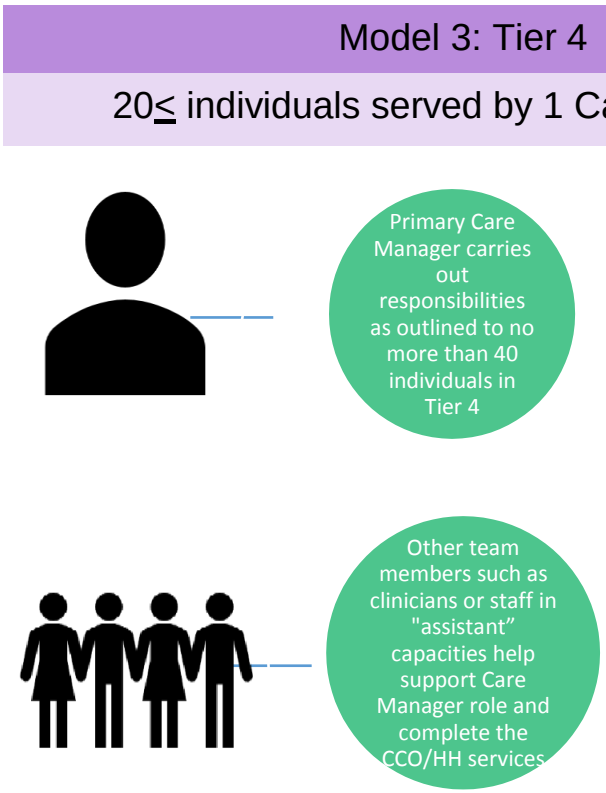
Team Approach:

A CCO/HH may choose to use a team approach to serve a caseload consisting of individuals in the Tier 4 reimbursement category. The team could consist of clinicians with designated time to support the Care Management role or staff in "assistant" capacities who help complete the CCO/HH services but are not required to meet the Care Manager qualifications and would assist under the supervision of Care Managers. However, use of this approach mandates the following requirements are met:

The team caseload must maintain the ratio of twenty (20) individuals per each FTE on the team. For every forty (40) Tier 4 individuals, the team must have at least one qualified Care Manager, as outlined and defined in the CCO/HH Provider Policy Guidance and Manual.

- The qualified Care Manager will be identified as the primary Care Manager and will be responsible for:
    - conducting the Comprehensive Assessment Process
    - developing the Life Plan, and
    - providing oversight regarding coordination of interventions in accordance with the Life Plan

- Any and all other Care Management needs and functions (not specified in the bullets immediately above) can be completed by the qualified Care Manager or clinicians with designated time to support the Care Management role or staff in "assistant" capacities.



Additional Requirements

- The CCO/HHs must identify the Care Management model(s) that they will be utilizing and define their related policies within their CCO/HH Policy Manuals. The policies must clearly define the weighting and team approaches that will be used with a significant level of detail so that a review of compliance to the defined standards can be undertaken.
- OPWDD must review and approve the policies defining the proposed model(s) prior to finalization and implementation.
- For members of the Willowbrook Class in CCO/HHs, all requirements of the Permanent Injunction apply. Weighting for equivalent caseloads is only allowable for Class Members who receive Willowbrook Case Services (WCS).