ADMINISTRATIVE DIRECTIVE

Transmittal: 18-ADM-06

To: Executive Directors of Voluntary Provider Agencies
Developmental Disabilities Regional Offices and State Operations Offices
Care Managers and Care Coordination Organizations (CCO) CEOs

Issuing OPWDD Office: Division of Person-Centered Supports

Date: June 26, 2018

Subject: Transition to People First Care Coordination

Suggested Distribution: OPWDD Providers

Contact: Division of Person-Centered Supports
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Attachments: None

Related ADMs/INFs

Releases Cancelled

Regulatory Authority

MHL & Other Statutory Authority

Records Retention
Purpose:

It is recognized that several existing regulations, policies, administrative memoranda (ADM) and Memorandum of Understanding (MOU) contain language that needs to be updated to current agency terminology as the Office for People With Developmental Disabilities (OPWDD) transitions to a new model of care management, through the use of Care Coordination Organizations (CCOs). The purpose of this ADM is to identify the language and service documentation requirements necessary in the near term to support the continuation of habilitative and other services during this transition.

Discussion:

Transition to Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support Services

Effective July 1, 2018, New York State will initiate the transition of the State’s system of services for individuals with intellectual and/or developmental disabilities (“I/DD” or “individual(s)”) from Plan of Care Support Services (PCSS) and State Plan Medicaid Service Coordination (MSC) to Health Home Care Management and Basic Home and Community-Based Services (HCBS) Plan Support services.

Service Documentation Requirements During the Transition Period

There will be a one-year transition period from July 1, 2018 through June 30, 2019 (“transition period”). During this transition period, both Individualized Service Plans (ISPs) and/or Life Plans may be in effect throughout the OPWDD service system.

An individual’s ISP, created prior to July 1, 2018, will remain in effect until that individual’s Life Plan is developed and implemented. An individual’s ISP must be converted into a Life Plan pursuant to the requirements in the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual. While the annual plan review date will typically correspond to the date of transition to the Life Plan, there may be instances where the dates do not correspond. However, all ISPs must be transitioned to Life Plans on or before June 30, 2019, as outlined in the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

Once an individual’s Life Plan has been developed, finalized, and signed/approved by all required parties, per the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual, the Life Plan becomes the active plan of care document. Beginning on July 1, 2018, Life Plans, as opposed to ISPs, will be created for individuals who are new to the OPWDD system, in accordance with the Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

During the one-year transition period to CCOs, the term “Life Plan” will be implied to replace any references to the ISP in any MOU, ADM, policy, or regulation, except with respect to specific billing requirements for ISP documentation for any remaining service claims. After an individual’s ISP transitions to a Life Plan, the previously required ISP documentation will no longer be applicable to support service claims. Instead, service claims must be supported by a
copy of the individual’s Life Plan covering the time period of the claim. CCOs are responsible for creating, updating, and maintaining Life Plans. The Life Plan must be completed per the requirements in the *Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual*.

The Life Plan will be the active document to define an individual's person-centered goals/valued outcomes and safeguard needs. When an individual’s ISP transitions to a Life Plan, his/her goals/valued outcomes and safeguards will be integrated into the Life Plan. Attaching Habilitation Plans to the Life Plan will not be required, as these components will become embedded within the Life Plan itself. Section IV [four] of the Life Plan identifies HCBS and State Plan services that have been authorized for the individual.

Under an ISP, individuals’ goals were carried out via a Habilitation Plan, which was created by the Habilitation provider. For individuals with a Life Plan; however, the identified goals/valued outcomes are carried out via a Staff Action Plan created by the Habilitation provider. Additional guidance about Staff Action Plan requirements will be issued by OPWDD.

Effective July 1, 2018, the term “Staff Action Plan” is implied to replace any reference to a Habilitation Plan in any existing policy, regulation, ADM or MOU, for individuals who have a Life Plan as the controlling active plan of care. For individuals who continue to have an ISP as the controlling active plan of care, Habilitation Plans remain in place and Habilitation providers must continue to follow the guidance regarding Habilitation Plans as prescribed in ADM# 2012-01 until the individual's Staff Action Plan is developed and finalized.

An Individual Plan of Protection (IPOP) is a compilation of all supports and services needed for an individual to remain safe, healthy and comfortable across all settings. For individuals who have an ISP as the controlling active plan of care and receive Individualized Residential Alternative (IRA) Residential Habilitation services, there is a requirement for an IPOP. For individuals who have a Life Plan as the controlling plan of care, the IPOP and safeguards will be integrated into Section III [three] of an individual’s Life Plan. The individual’s goals/valued outcomes and safeguards will be implemented via a Staff Action Plan. Providers may develop internal guidance documents about the implementation of specific/detailed protective oversight measures within residential and day programs. Those materials must align with the overarching protections stated in Section III [three] Individual Safeguards/Individual Plan of Protection (IPOP) of the individual’s Life Plan.

**Transition from Medicaid Service Coordinator to Care Manager**

Effective July 1, 2018, the person coordinating an individual’s services and supports and developing his/her Life Plan will be called a Care Manager. All references to a Medicaid Service Coordinator in existing policy, regulation, ADM and/or MOU will be replaced by/intended to mean Care Manager beginning July 1, 2018.

**Life Plan Specification of Duration, Effective Date, and Frequency for HCBS Waiver Services**
CCOs are responsible for creating, updating, and maintaining Life Plans. The Life Plan must be completed pursuant to the requirements in Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual.

A Life Plan identifies a date range that is in effect based upon its twice-annual review. The authorized HCBS Waiver services identified in the Life Plan are “in effect” during this period unless otherwise noted in an addendum. The effective date for the HCBS Waiver service is the effective date (i.e. review date) of the Life Plan identified in the effective date column of Section IV [four]. The duration of the HCBS Waiver service is identified in the Life Plan through the comment column in Section IV [four]. The frequency of the HCBS Waiver service is identified in the Life Plan through the unit column in Section IV [four].

Additionally, 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.” 18 NYCRR 504.3(a).

Records Retention

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 questions regarding this memorandum, please contact the Division of Person-Centered Supports at: care.coordination@opwdd.ny.gov.

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