



**Office for People With
Developmental Disabilities**

ADMINISTRATIVE DIRECTIVE

Transmittal:	2018-ADM-06R
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
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Subject:	Transition to People First Care Coordination
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Contact:	Division of Person-Centered Supports care.coordination@opwdd.ny.gov
Attachments:	None

Related ADMs/INFs	Releases Cancelled	Regulatory Authority	MHL & Other Statutory Authority	Records Retention
2018-09R, 2017-03, 2017-02, 2017-01, 2016-03, 2016-01, 2015-07, 2015-06, 2015-05, 2015-04, 2015-02, 2015-01, 2014-04, 2014-02, 2014-01, 2013-03, 2012-04, 2012-02, 2012-01, 2011-01, 2010-02, 2009-03, 2006-04, 2006-01, and 2002-01	2018-06	14 NYCRR 633.12	MHL §§ 13.01, 13.07	Six (6) years

PURPOSE:

Effective July 1, 2018, OPWDD issued Administrative Memorandum #2018-06, entitled “Transition to People First Care,” to update existing regulations, policies, administrative memoranda (ADMs) and Memoranda of Understanding (MOUs) as the Office for People With Developmental Disabilities (OPWDD) transitions its care management service to the Care Coordination service. This ADM, ADM #2018-06R replaces ADM #2018-06 to make certain clarifying revisions. Those revisions are underlined below and are effective retroactive to July 1, 2018.

DISCUSSION:

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

There will be a one-and-a-half-year transition period from July 1, 2018 through December 31, 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.

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 “MSC” in existing policy, regulation, or ADM are replaced by/intended to mean Care Manager. The term “Life Plan” replaces any references to an ISP in any ADM, policy or regulation, except with respect to specific billing requirements for ISP documentation for any claims for services provided during the time period an ISP was in effect.

B. Life Plans & Staff Action Plans

1. Creating a Life Plan

CCOs are responsible for creating, updating, and maintaining Life Plans. An individual’s ISP, created prior to July 1, 2018, will remain in effect until a Life Plan is developed and finalized. An individual’s ISP must be converted into a Life Plan by a Care Manager pursuant to the requirements in the *Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual* (“CCO/HH Manual”). **No later than December 31, 2019 all ISPs, including those for Tier 4 individuals, must be transitioned to finalized Life Plans.** After an individual’s ISP is replaced with a Life Plan, ISP

documentation is not acceptable to support service claims. Instead, service claims must be supported by a copy of the individual's Life Plan for the time period of the claim.

As of July 1, 2018, individuals new to the OPWDD system (i.e., on or after July 1, 2018), will have Life Plans developed and finalized in accordance with the *CCO/HH Manual*. Finalized Life Plans for newly enrolled CCO members (i.e., members enrolled after 10/1/2018) are due no later than 90 days after CCO enrollment or HCBS waiver enrollment, whichever comes first.

Additional information available at:

https://opwdd.ny.gov/sites/default/files/documents/FINAL_CCO_Policy_%20Update_%20Memorandum_%20and_%20Attachments_%209%2026%2018.pdf

Once an individual's Life Plan has been developed and finalized per the *CCO/HH Manual*, the Life Plan becomes the active plan of care document.

2. Finalizing a Life Plan

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.

Service providers are responsible for reviewing the finalized, acknowledged and agreed to Life Plan. Providers may occasionally find inaccuracies in the finalized, acknowledged and agreed to Life Plan. Providers should demonstrate due diligence in working with the Care Manager, CCOs, OPWDD and/or others to correct the Life Plan as soon as possible. Service providers should document their timely efforts to correct any errors in the Life Plan. Examples of this documentation may include notes in the individual's monthly summary, e-mails, phone calls, etc.

When an individual's ISP transitions to a finalized Life Plan, his/her goals/valued outcomes and safeguards will be integrated into the Life Plan. Habilitation Plans are not attached to the Life Plan, as the goals/valued outcomes and safeguard needs components are in the Life Plan itself.

Section IV [four] of the Life Plan is required to identify all HCBS and State Plan services that have been authorized for the individual.

3. New Services Prior to Life Plan Finalization

When HCBS waiver services are needed prior to the finalization of a Life Plan, there must be sufficient documentation to support service authorization for provider service billing. Sufficient documentation prior to Life Plan finalization includes: (1) the OPWDD Developmental Disabilities Regional Office (DDRO) approved Request for Service Authorization (RSA); and (2) the acceptable supporting information justifying the need for services as outlined in the January 7, 2019 Memorandum titled *Care Coordination Organizations Policy Update: Service Authorizations Post July 1, 2018*. (Available at: https://opwdd.ny.gov/sites/default/files/documents/Care%20Coordination%20Organization%20Policy%20Update_%20Service%20Authorizations%20Post%20July%201%202018.pdf).

4. Life Plan Section IV: Specification of Duration, Effective Date, and Frequency for HCBS Waiver Services

A Life Plan identifies a “from-to” date range. For the initial Life Plan, the effective dates for each HCBS waiver service is the same as the “from-to” dates of the initial Life Plan and is identified in the effective date field of Section IV [four]. The Life Plan, and the services described in the Life Plan, remains in effect until a new Life Plan is finalized. If a new Life Plan is not finalized in the expected timeframe, the services do not expire (i.e., the service remains authorized by the DDRO for the individual). A failure to finalize or review a Life Plan within the required timeframes may result in billing disallowances in a fiscal audit.

For individuals who currently have ISPs and are transitioning to the Life Plan, the effective dates of the HCBS Waiver services should be listed as the first effective date of the Life Plan (i.e., the “from” date which is the date of the Life Plan meeting), not the date previously outlined in the individual’s ISP. For example, if an individual’s ISP lists Community Habilitation as an HCBS Waiver service with an effective date of 9/13/17 and the individual’s Life Plan meeting is on 2/15/19, then the effective date for Community Habilitation in the Life Plan should read 2/15/19.

When services are newly added to the individual's Life Plan after the initial Life Plan is finalized, the effective date of each new service should correspond to the Life Plan review date on which the new service was added to the Life Plan. For example, The Life Plan was finalized on 2/1/19. The individual requests a new service, and a Life Plan review meeting is held on 5/15/19 to discuss this request. Day Habilitation is added to the individual's Life Plan during the Life Plan review meeting. The effective date for Day Habilitation is 5/15/19.

The duration of the HCBS Waiver service is identified in the Life Plan in Section IV [four] in either the effective date column or comments column (and either "ongoing" or "ongoing as authorized" is acceptable where applicable). The frequency of the HCBS Waiver service is identified in the Life Plan through the unit column in Section IV [four]. Information on the required billing documentation standards, including frequency and duration of HCBS waiver services, for Section IV [four] of the Life Plan can be found in the ADM for that specific service (i.e., Supported Employment, Community Habilitation, etc.).

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).

5. Staff Action Plans

Under an ISP, individuals' goals were carried out via a Habilitation Plan, which was created by the Habilitation provider. Under a Life Plan, the identified goals/valued outcomes are identified within the individual's Life Plan and are carried out via a Staff Action Plan created by the Habilitation provider. Staff Action Plan requirements are contained in ADM #2018-09R (available at: https://opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda).

Effective July 1, 2018, the term "Staff Action Plan" is implied to replace any reference to a Habilitation Plan in any existing policy, regulation or ADM, except with respect to specific billing requirements for Habilitation Plan documentation for any service claims for services provided during the time-period a Habilitation Plan was in effect.

6. Dispute Resolution During The Life Planning Process

All parties are encouraged to work collaboratively and well in advance of the required time-period for Life Plan finalization. If the individual, service provider(s), and/or the individual's care planning team disagree about the details of the Life Plan, the Care Manager must work throughout the life planning process to facilitate resolution by implementing the dispute resolution process developed by the CCO, as required in the CCO/HH Manual, as well as the person-centered planning process. Care Managers should employ their training and use of their own clinical resources to facilitate consensus and appropriate resolution of any disagreements between the parties. As needed, the Care Manager may also reach out to the OPWDD Regional Office for technical assistance.

In the unlikely event that the dispute resolution process has been exhausted by the Care Manager and a resolution still has not been reached regarding elements of a Life Plan within the required time-period for finalization, the following should occur:

- i. At the Life Plan Meeting(s):
 - a. If the disputed element represents a **change** to a previously approved goal in a prior finalized ISP or Life Plan, the Care Manager makes a note in the "Summary of IDT Meeting" section of the Life Plan that there is a dispute regarding that specific goal, including a narrative description of the nature of the dispute; or
 - b. If the disputed element represents a **new** goal, as opposed to a change to a previously existing one, the Care Manager removes the disputed element from the body of the Life Plan altogether, moving it into the "Summary of IDT Meeting" section, including a narrative regarding the nature of the dispute.

Example A: During the life planning process, the individual or her advocate requests the ability to participate in a certain type of community inclusion activity but the provider who would be supporting that service asserts that the request is not clinically appropriate. In the event the Care Manager is unable to facilitate a resolution of this dispute, he would move the community inclusion goal altogether out of the Life Plan and into the "Summary of IDT Meeting" Section.

Example B: During the life planning process, the individual or her advocate requests that additional staffing be included for a pre-existing community inclusion activity but the provider who would be supporting this service asserts that the request is not clinically appropriate. In the event the Care Manager is unable to facilitate a resolution of this dispute, he would leave the prior existing community inclusion goal in the Life Plan unchanged and include a narrative in the “Summary of IDT Meeting” Section regarding the nature of the staffing dispute.

- ii. Within 45-days of the Life Plan meeting, the Care Manager and the individual and/or his/her representative sign the Life Plan. With these signatures, the Life Plan is considered final. Any disputed elements remain in the “Summary of IDT Meeting” section and the remainder of the Life Plan is ready for implementation.
- iii. The providers acknowledge the plan and agree to deliver the Provider-assigned goals, supports, and safeguards associated with their services, per the undisputed goals in the finalized plan (including the prior version of currently disputed goals). 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. A Life Plan must be acknowledged, even with element(s) in dispute but disagreements will be noted.
- iv. Staff action plans are developed and signed by the habilitation staff and forwarded to the Care Manager via the CCO’s portal or another agreed upon mechanism for prompt communication. In addition to Care Managers, the Staff Action Plans should also be provided to: the individual and his/her representative and any other parties agreed to by the person and his/her representative.
- v. Once the Life Plan and corresponding Staff Action Plans are finalized, if an element remains in dispute and no agreement has been facilitated by the Care Manager, then the individual, his or her representative, or a provider may initiate due process proceedings pursuant to 14 NYCRR 633.12 as an objection to a plan of services.

During the pending due process proceeding, all other elements in the finalized Life Plan and Staff Action Plans shall be implemented.

C. Suspension of Certain Billing Standards During the Transition Period

Notwithstanding the adjusted or suspended standards below, CCOs and providers must arrange for necessary services and care for all enrolled individuals.

1. Suspended Life Plan and Service Billing Standards

For Life Plans finalized on or before December 31, 2019 (i.e., the transition period), OPWDD is suspending service documentation requirements for documenting the Waiver service name, frequency, duration, and effective date in the Life Plan. Instead, only the name of the service provider and the service name must be identified in the Life Plan. Additionally, for Support Brokerage services, the name of the Fiscal Intermediary (FI) must be identified, but the name of the Support Broker/Agency that is paid by the FI does not need to be included in the Life Plan.

If the service provider or service being provided is not listed in the pre-populated choices embedded in the Life Plan development system, the most relevant choice available should be selected (e.g., “IRA” is acceptable in place of Residential Habilitation, “Supported Work” is acceptable in place of Supported Employment, etc.). However, Care Managers should identify the correct service provider name and service name in the comments section of the Life Plan to support provider billing claims.

All Life Plans created or amended after the transition period must comply with all regulatory and policy standards.

2. Suspended Staff Action Plan Billing Standards

During the transition period, certain Staff Action Plan billing standards in ADM #2018-09R are **ONLY** waived for individuals who have ISPs transitioning to Life Plans. All non-waived billing standards remain effective for all Staff Action Plans. Waived billing standards in ADM #2018-09R only include:

- “The initial Staff Action Plan must be in place no later than 60 days of the start of the individual’s habilitation service, or the Life Plan review date, whichever comes first;” and
- “Evidence demonstrating the Staff Action Plan was distributed no later than 60 days after: the start of the habilitation services; the life plan review date; or the development of a revised/updated Staff Action Plan, whichever comes first (which may include, but is not limited to: a monthly

narrative note; a HITS upload; or e-mail).”

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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