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

Memorandum

To: Executive Directors of Care Coordination Organizations

From: Katherine Bishop
Director
Program Development and Implementation

Date: January 7, 2019

Subject: **Care Coordination Organization Policy Update: SERVICE AUTHORIZATIONS POST JULY 1, 2018 ***

POLICY BACKGROUND

The 2011 New York State Executive budget provided for the establishment of a model for person-centered integrated care coordination and Care Management services called Health Homes. Authorization for the establishment of Health Homes was included in the Affordable Care Act - (P.L. 111-148 & P.L.111-152), Section 2703 (SSA 1945b) and the NYS Social Services Law Section 365-l entitled "State option to provide Health Homes for members with chronic conditions under the Medicaid State Plan." The Centers for Medicare and Medicaid Services' (CMS) approval of the Care Coordination Organizations/Health Home (CCO/HH) SPA (#17-0025) on April 9, 2018, authorizes the enrollment of individuals with developmental disabilities into Health Homes, and the State will begin to expand and tailor the Health Home Care Management program to serve individuals with intellectual and developmental disabilities (I/DD). CCO/HHs have been established - in accordance with the statutory laws outlined above.

Medicaid program policy concerning the CCO/HHs may be found at the New York State Department of Health (NYSDOH) website:
https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx. This policy will be updated periodically based on programmatic need as described in clarification memoranda that are provided to CCO/HHs by the Office for People With Developmental Disabilities (OPWDD) and DOH. These memoranda can be found at the following website: https://opwdd.ny.gov/providers_staff/care_coordination_organizations/providers/cco-manual

MEMORANDUM

This memorandum addresses the post July 1, 2018 status of the Preliminary Individual Service Plan (PISP) previously issued by OPWDD's Front Door, and requirements for Requests for Service Authorizations (RSA) when: (1) an individual has a PISP that was developed prior to the implementation of Care Coordination Organizations (CCOs); or (2) services are immediately needed for an individual, but the individual's Life Plan has not been developed. Furthermore, service authorizations for OPWDD Home and Community Based Services (HCBS) waiver services after July 1, 2018 are based on

information provided by an individual's care manager, including information drawn from the development of the individual's Life Plan. The PISP previously used as a basis for service authorizations is no longer produced.

Preliminary Individual Service Plan After July 1, 2018
Prior to July 1, 2018, the Front Door issued PISPs for individuals applying for OPWDD HCBS waiver services. The PISPs defined the services an individual needed prior to the development of the Individualized Service Plan (ISP). The PISP was used by Medicaid Service Coordinators (MSCs) when submitting a -RSA to OPWDD's Front Door on behalf of an individual.

PISPs issued earlier than April 1, 2018 must be reviewed by the care manager and supported by more recent, available information outlined in this document. PISPs developed between April 1, 2018 and June 30, 2018 are still in effect and are valid for up to six months beyond their issue date. These PISPs may be used to justify a Request for Service Authorization submitted to the Front Door.

As of July 1, 2018, PISPs are no longer issued by OPWDD. The process to follow for service authorization when a PISP is no longer valid is described in Section II, "Post July 1, 2018 Process and Standards," below.

Pre-Life Plan Service Authorization
The processes below must be followed when an individual is leaving a nonqualifying setting and moving into an Individualized Residential Alternative (IRA). This includes conversion of an Intermediate Care Facility (ICF) to an IRA, or when individuals apply for/enroll in the HCBS waiver prior to CCO enrollment.

Providers should not notice a significant change in procedures.

I. ***Previous Process and Standards for Individuals Leaving Non-Qualifying Settings***:

A. Individuals leaving nonqualifying settings could move into an IRA prior to being enrolled in MSC.

B. Individuals were required to be enrolled in Medicaid and the HCBS waiver.

C. Pre-July 1, 2018, PISPs were issued, but PISPs were not used to support billing requirements. Billing was based on delivery of services.

D. A PISP did not outline valued outcomes or goals. Valued outcomes were developed as the ISP was created and goals as habilitation plans were developed.

E. The MSC had 60 days from the time of waiver enrollment or enrollment into MSC, whichever occurred first, to create an ISP.

F. The service provider developed the initial habilitation plan, which was forwarded to the service coordinator within 60 days of the start of the delivery of service.

G. Services were documented in daily service documentation notes and monthly summary notes.

II. Post July 1, 2018 Process and Standards

A. Individuals leaving nonqualified settings and enrolling in an IRA must:
   1. Meet eligibility and level of care requirements,
   2. Be enrolled in Medicaid,
   3. Be enrolled in the HCBS waiver, and
   4. Be approved for a certified residential opportunity by OPWDD.

B. PISPs are no longer issued. However, PISPs created between April 1, 2018 and June 30, 2018 may be used by care managers to develop and provide justification for a RSA to be submitted to OPWDD's Front Door.

C. Care managers must provide updated information and justification of service authorization requests for an individual if a preliminary Life Plan is not available and the individual has a PISP dated prior to April 1, 2018. Care managers may use other documents to develop and provide justification for a RSA. Other acceptable documentation may include, but is not limited to:
   1. Documents from the waiver application and/or Level of Care Eligibility Determination, including psychological or psycho-social reports;
   2. Individualized Education Plans (IEP) and 504 plans;
   3. Discharge plans developed by hospitals, nursing homes, correctional facilities;
   4. Assessments (e.g., clinical assessment(s), Coordinated Assessment System (CAS) summary, I Am tool);
   5. In-process Life Plans;
   6. Service planning packets developed during ICF to IRA conversions; and
   7. Preliminary Adult Service Plans (PASPs) developed by a provider planning for an individual leaving a residential school.

   Note: Additional information is required to support an individual's request to live in a certified residential setting. Additional clinical information must be provided to OPWDD to justify the need for a certified residential setting and for a Staff Action Plan to be developed. The care manager must work with the Regional Office Certified Residential Opportunities (CRO) staff if an individual wants to move into a certified living setting.

D. Care managers submitting a RSA must provide a brief justification for the individual's need for each service. The justification must be outlined on the appropriate section of the RSA form, which must include a reference to the

specific document where more detail can be found (e.g., the psycho-social, IEP). The RSA and the referenced documents must be uploaded into CHOICES for OPWDD Front Door review and action. If CHOICES cannot be accessed by the care manager, the care manager should contact the district Front Door and discuss the best means of communication.

III. Other Individuals Needing Waiver Services Prior to Enrollment in a CCO

A. Some individuals are in time-sensitive situations and need waiver services authorized prior to enrollment in a CCO. These individuals may apply for enrollment in the waiver prior to meeting all CCO eligibility requirements and being enrolled in a CCO. The CCO enrollment start date is the first of the following month after submission of the CCO-1 enrollment form (CCO enrollment is effective the first of the following month after submission of the CCO-1). The CCO and DDRO must work together through the Front Door process to ensure that all required eligibility documents are provided.

B. The IAM and/or Life Plan are the preferred documents for service authorization justification in these instances. If the IAM and/or Life Plan are not provided, the care manager must submit appropriate justification, as described above in Section II C. 1-7. The CCO must manually create an individual's record in the Health Information Technology (HIT) Coordinate system, which requires the individual's birthdate and Tracking and Billing System (TABS) ID from the DDRO.

C. The I AM and Life Plan may be shared with the Front Door as justification for a RSA.

IV. Billing for Services

A. When HCBS waiver services are needed prior to the completion of a Life Plan, an RSA approved by the Regional Office, along with the acceptable supporting information justifying the need for such services is sufficient documentation to support service authorization for service billing purposes. HCBS waiver providers must continue to follow the HCBS waiver service documentation and payment/billing standards, requirements, and limits described in the applicable OPWDD Administrative Memorandum (ADM) and OPWDD regulation for the HCBS waiver service being provided to the individual. OPWDD ADMs are available on the OPWDD website at: https://opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda. Finalized Life Plans must identify all authorized services and must be in place consistent with the time lines established in Care Coordination Organization/Health Home (CCO/HH) Policy Manual

B. As defined in ADM #2018-09, initial Staff Action Plans must be in place no later than 60 days from the start of the habilitation service. The individual's Life Plan drives the development of the Staff Action Plan and must be used by the habilitation provider to develop the Staff Action Plan. Therefore,

habilitation providers must collaborate with CCOs in order to develop the initial Staff Action Plan within the required timeframe upon completion of the individual's Life Plan.

V. Medicaid Approval Including Parental Deeming

A. Parental deeming cases requested prior to July 1, 2018 may use PISPs developed between April 1, 2018 and June 30, 2018 for service authorization.

B. For individuals in parental deeming cases with PISPs created prior to April 1, 2018, care managers must provide updated documents (*see **Post July 1, 2018 Process and Standards***, D. 1-7) to justify service requests.

C. Medicaid Service Coordination cannot be backdated.
   1. When an individual's Medicaid approval has a retroactive date prior to July 1, 2018, (s)he will need to work with the CCO to complete enrollment in the CCO. Please refer to the Frequently Asked Questions document for additional information. This may be found at: https://opwdd.ny.gov/providers_staff/care_coordination_organizations/provider_faq.
   2. When an individual's Medicaid approval has a retroactive date of July 1, 2018 or later, (s)he will need to work with the CCO to complete CCO enrollment. CCO enrollment cannot be backdated, and enrollment might not match the Medicaid approval date.

cc: Developmental Disabilities State Operations Offices (DDSOOs) Directors
Developmental Disabilities Regional Offices (DDROs) Directors
Executive Directors of Voluntary Provider Agencies
Provider Associations

** Update to September 6, 2018 Service Authorizations Post July 1, 2018 Memorandum sent by Abiba Kindo, Deputy Commissioner*