

# Care Coordination Organization/ Health Home (CCO/HH) Provider Policy Guidance and Manual

New York State Department of Health  
(NYSDOH) New York State Office for People  
With Developmental Disabilities (OPWDD)

The purpose of this Manual is to provide Medicaid policy and comprehensive guidance to providers participating in the New York State Health Home program known as Care Coordination Organization/Health Homes (CCO/HHs) serving individuals with intellectual and developmental disabilities (I/DD).

Please note, every effort is being made to keep this manual current and the information provided is subject to change (i.e., upon release of the Staff Action Plan Administrative Memorandum (ADM)).

Policies for Health Homes serving adults and children can be found at the following link: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/policy/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm)

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## Preface

Beginning July 1, 2018, New York State will initiate the transformation of OPWDD's system of services for individuals with intellectual and/or developmental disabilities (I/DD) to better integrate services, promote the better use of resources to meet growing and changing needs and become truly person-centered. As part of this transformation, the New York State Department of Health (NYSDOH) in collaboration with New York State Office for People With Developmental Disabilities (OPWDD) expanded the Health Home program to serve individuals with I/DD through the creation of Care Coordination Organization/Health Homes (CCO/HHs).

The purpose of this Manual is to provide Medicaid policy and comprehensive guidance to CCO/HH providers. Policy statements and requirements governing the CCO/HH Program are included. The Manual is formatted to incorporate changes as additional information and periodic clarifications are necessary.

Before rendering services to an individual, providers are responsible for familiarizing themselves with all Medicaid and OPWDD procedures and regulations, currently in effect and those issued going forward, for the CCO/HH Program. The CCO/HH Program is an optional service under the New York State Medicaid State Plan.

Be advised that the NYSDOH publishes a monthly newsletter, the Medicaid Update, which contains information on Medicaid programs, policy and billing. It is sent to all active enrolled providers. New providers should be familiar with current and past issues of the Medicaid Update to be current on policy and procedures.

Note: Although every effort has been made to keep this policy manual updated, the information provided is subject to change. Medicaid program policy concerning the CCO/HH initiative may be found at the NYSDOH website listed below.

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/)

## Statutory Authority and Overview of Health Homes

### Patient Protection and Affordable Care Act

The goal of Health Homes is to improve care and health outcomes, lower Medicaid costs, and reduce preventable hospitalizations, emergency room visits, and unnecessary care for Medicaid members, including individuals with I/DD. NYSDOH and OPWDD are working to align the OPWDD service system with the major reform initiatives of the Federal and State governments. Part of this reform is the establishment of CCO/HHs which are Health Homes tailored to meet the needs of individuals with I/DD.

Health Homes are an option afforded to States under the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), enacted on March 30, 2010, together known as the Affordable Care Act (ACA). Section 2703, allows states under the State Plan option or through a Waiver, the authority to implement Health Homes effective January 1, 2011. It is under the authority of the ACA, in addition to New York's State Plan and other Federal and State requirements, that CCO/HHs will provide comprehensive person-centered Care Management and planning to individuals with I/DD.

The purpose of Health Homes is to provide the opportunity to States to address and receive additional Federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), developmental disability and long-term services and supports for persons with chronic illness. States approved to implement Health Homes will be eligible for 90 percent Federal match for health home services for the first eight (8) fiscal quarters that the SPA is in effect.

### State Medicaid Director Letter: Health Homes for Members with Chronic Conditions

State Medicaid Director Letter (SMDL), #10-024, Health Homes for Members with Chronic Conditions, provides preliminary guidance to States on the implementation of Section 2703 of the ACA, entitled "State Option to Provide Health Homes for Members with Chronic Conditions."

A link to the State Medicaid Director's letter has been provided below for additional information:

<http://downloads.cms.gov/cmsgov/archiveddownloads/SMDL/downloads/SMD10024.pdf>

The authority to implement Health Homes is included in Section 1945 of the Social Security Act and in NYS Social Services Law Section 365-I and all other applicable State and Federal responsibilities for those Health Home providers that may hold specific license(s) and/or certificate(s) apart from their Health Home provider

designation. Upon issuance of final Federal regulations, New York State will need to comply with regulatory requirements, which may include amending the Health Home SPAs.

The Health Home Program was one of seventy-nine (79) recommendations endorsed by Governor Andrew Cuomo's Medicaid Redesign Team (MRT) which was charged with finding ways to reduce costs and improve the quality and efficiency of care within the New York State Medicaid program.

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 ACA (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."

On February 3, 2012, the US Department of Health and Human Services (HHS), CMS approved New York State's first SPA #11-56, Health Home SPA for individuals with Chronic Conditions, Phase 1 of the Health Home Program with an effective date of January 1, 2012. On December 4, 2012 CMS approved two additional Health Home SPAs for Phase 2 (SPA #12-10) and Phase 3 (SPA #12-11) with effective dates of April 1, 2012 and July 1, 2012 respectively. The combined approval of these three (3) SPAs allowed for statewide implementation of the Health Home Program.

CMS' approval of the 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 I/DD. These individuals will be served by CCO/HHs that have been developed in accordance with the statutory laws outlined above.

For links to approved SPAs for all Health Home programs, please visit: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/med\\_spas.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/med_spas.htm)

A compilation of the Social Security Laws on the State option to provide Coordinated Care through a Health Home for individuals with chronic conditions can be found at this link: [http://www.ssa.gov/OP\\_Home/ssact/title19/1945.htm#ftn490](http://www.ssa.gov/OP_Home/ssact/title19/1945.htm#ftn490)

## **Conversion of Medicaid Service Coordination (MSC) to CCO/HH Care Management**

Effective July 1, 2018, OPWDD will transition Care Management, both Medicaid Service Coordination (MSC) and Home and Community Based Services (HCBS) Waiver Plan of Care Support Services (PCSS) to the Health Home model of care. Health Home Care Management for individuals with I/DD will be provided by CCO/HHs. This effort is the

first part of OPWDD's transformation of the State's system of services for individuals with I/DD, which will also include implementing a proposed 1115 MRT Waiver to initiate the transition to Managed Care for individuals with I/DD.

Information about OPWDD's transition to CCO/HHs and the service system transformation can be found in the link below:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/)

## **Section I: Introduction to CCO/HH Service Model**

### **1.1 Overview of the CCO/HH Model for Individuals with I/DD**

The expansion, tailoring, and implementation of New York's Health Home Care Management model to serve individuals with I/DD is designed to bring more choice and flexibility to the provision of comprehensive Care Management and assessment and, ultimately, other services. The CCO/HH model and its requirements will provide the strong stable person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD.

CCO/HHs work with individuals with I/DD and their families to bring together health care and developmental disability service providers to develop an integrated, Life Plan that includes developmental disability, medical, behavioral health, community and social supports, and other services. CCO/HHs will assist individuals and/or their family/representatives with accessing services that support healthy, well-rounded and fulfilling lives. The coordination of an individual's care is done through a dedicated Care Manager who oversees and coordinates access to all services. With the consent of the individual and/or their family/representative, health records will be shared among providers to ensure the individual receives unduplicated supports and services.

### **1.2 Federal Health Home Population Criteria**

Health Home services are provided to a subset of the Medicaid population with complex chronic health and/or behavioral health needs whose care is often fragmented, uncoordinated, and duplicative. This population includes categorically and medically needy beneficiaries served by Medicaid Managed Care Plans (MMCP) or Fee-For-Service (FFS) and Medicare/Medicaid dually eligible beneficiaries who meet Health Home criteria. Individuals served in a Health Home must have:

- Two or more chronic conditions (e.g., Substance Use Disorder, Asthma, Diabetes) OR

- One single qualifying chronic condition:
  - HIV/AIDS or
  - Serious Mental Illness (SMI) (Adults) or
  - Serious Emotional Disturbance (SED) or Complex Trauma (Children)

The chronic conditions described in Section 1945(h)(2) of the Social Security Act include, but are not limited to, the following:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- Overweight as evidenced by a body mass index (BMI) of 25
- HIV/AIDS
- Other Chronic Conditions

Effective July 1, 2018, the Health Home eligibility criteria is being expanded to include the following categories of Developmental Disability chronic conditions:

- 1) Intellectual Disability
- 2) Cerebral Palsy
- 3) Epilepsy
- 4) Neurological Impairment
- 5) Familial Dysautonomia
- 6) Prader-Willi Syndrome
- 7) Autism

These conditions shall be considered single qualifying chronic conditions for enrollment in a CCO/HH for adults and children. In order to be eligible for enrollment in a CCO/HH, Medicaid-enrolled individuals will need to present with a diagnosis of one of the above conditions, meet ICF Level of Care eligibility determination criteria, and be determined by OPWDD or its designee to meet the criteria in Section 1.03 (22) of the Mental Hygiene Law, as shown below:

**Developmental Disability Definition:**

Developmental disability means the disability of an individual which:

- (a) (1) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi Syndrome or autism;
- (2) is attributable to any other condition of a person found to be closely



- related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person; or
- (3) is attributable to dyslexia resulting from a disability described in subparagraph one (1) or two (2) of this paragraph;
- (b) originated before such person attains age twenty-two (22);
- (c) has continued or can be expected to continue indefinitely; and
- (d) constitutes a substantial handicap to such person's ability to function normally in society."

Additional information on CCO/HHs and the expansion of the Health Home eligibility criteria to include Developmental Disability as a chronic condition is contained in the CCO/HH SPA.

### 1.3 Federal Core Health Home Services

Section 1945(h)(4) of the Social Security Act defines Health Home services as "comprehensive and timely high-quality services" and includes the six (6) core services to be provided by designated CCO/HH providers. Under the provisions of the Health Home State Plan and the State Plan Standards and Requirements for CCO/HHs, CCO/HHs are expected to deliver at minimum, at least one (1) of the core services in a manner that meets the person-centered needs and Valued Outcomes of individuals with I/DD. The goal of CCO/HH core services is to ensure access to appropriate services, improve health outcomes, reduce preventable hospitalizations and emergency room visits, promote use of Health Information Technology (HIT), and avoid unnecessary care.

#### Core Services include:

1. Comprehensive Care Management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
4. Individual and family support, which includes authorized representatives;
5. Referral to community and social support services if relevant; and
6. The use of HIT to link services, as feasible and appropriate.

CCO/HH providers will be required to maintain written documentation that clearly demonstrates how these core requirements are being met.

Further information on the six (6) core services is available at this link:

[http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/provider\\_qualification\\_standards.htm](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/provider_qualification_standards.htm)

## 1.4 Person-Centered Planning Process

Person-centered planning is a process directed by the individual that helps us learn how they want to live and describes what supports are needed to help them move toward a life they consider meaningful and productive. The planning process empowers the individual by building on their abilities and skills, promoting a quality lifestyle that supports the individual in finding ways to contribute to their community. Other factors which impact the individual's life, such as health and wellness, are also considered during the planning process. Knowing and exploring opportunities to use the individual's skills and abilities helps to set a direction while providing positive motivation, and increasing the likelihood of achieving the desired outcomes that are most important to the individual receiving supports.

The person-centered planning regulation can be found at the following link:

<https://opwdd.ny.gov/sites/default/files/documents/person-centered-planning-text.pdf>

Person-centered planning applies to:

- (1) OPWDD funded HCBS Medicaid Waiver services; and
- (2) OPWDD funded service coordination services, known as Basic HCBS Plan Support provided to individuals who receive OPWDD funded HCBS Medicaid Waiver services; and
- (3) the service planning process for all HCBS Medicaid Waiver services funded by OPWDD

### Person-Centered Planning Process

A person-centered planning process is a process in which, to the maximum extent possible, an individual directs the planning of their services and makes informed choices about the services and supports that they receive. The planning process guides the delivery of services and supports to an individual in a way that leads to outcomes or results in areas of the individual's life that are most important to them (e.g., health, relationships, work, and home).

The person-centered planning process involves parties chosen by the individual, often known as the individual's Circle of Support. The parties chosen by the individual participate in the process as needed, and as defined by the individual, except to the extent that decision-making authority is conferred on another by State law.

The parties chosen by the individual assist the individual in decision-making by, among other things, explaining issues to be decided, answering the individual's questions, encouraging the individual to actively participate in decision-making and, when necessary, assisting the individual with communicating their preferences.

The person-centered planning process requires that:

- (i) supports and services are based on the individual's interests, preferences, strengths, capacities, and needs;
- (ii) supports and services are designed to empower the individual by fostering skills to achieve desired personal relationships, community participation, dignity, and respect; and
- (iii) the individual is satisfied with activities, supports, and services.

Person-centered planning is a collaborative and recurring process between the individual and the service provider. The planning process is used at the time the Life Plan is developed and during subsequent reviews of the Plan.

A person-centered planning process is required for developing the Life Plan including the HCBS Waiver service habilitation plan, with the individual and parties chosen by the individual.

The person-centered planning process involves:

- (1) providing necessary information and support to ensure that the individual, to the maximum extent possible, directs the process and is enabled to make informed choices and decisions;
- (2) scheduling times and locations of convenience to the individual;
- (3) taking into account the cultural considerations of the individual by providing information in plain language and in a manner, that is accessible to and understood by the individual and parties chosen by the individual;
- (4) providing a method for the individual to request updates to the Life Plan as needed; and
- (5) developing strategies that address conflicts or disagreements in the process, including clear conflict of interest guidelines for individuals, and communicating such strategies to the individual who is receiving services as appropriate.

### **The Life Plan**

The Life Plan is created using the person-centered planning process described above. The Life Plan is also known as the person-centered plan of care.

The individual's Care Manager must develop a Life Plan with the individual. The Life Plan must include and document the following:

- (1) the individual's goals and desired outcomes;
- (2) the individual's strengths and preferences;
- (3) the individual's clinical and support needs as identified through an assessment of functional and health-related needs;
- (4) the necessary and appropriate services and supports (paid and unpaid) that are based on the individual's preferences and needs (as identified through an assessment of functional and health-related needs) and that will assist the individual to achieve their identified goals;
- (5) the services that the individual elects to self-direct;
- (6) the providers of those services and supports specified in (4) and (5) of this subdivision;
- (7) if an individual resides in a certified residential setting, document that the residence was chosen by the individual, and document the alternative residential settings considered by the individual, including alternative residential settings that are available to individuals without disabilities (Note: The setting chosen by the individual is integrated in, and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community having the same degree of access to the community as individuals not receiving services. The individual may choose service and support options that are available to individuals without disabilities for his or her residence and other areas of his or her life.);
- (8) the risk factors and measures in place to minimize risk, including individual specific back-up plans and strategies when needed; and
- (9) the individual and/or entity responsible for monitoring the Life Plan.

The Care Manager must develop the Life Plan in a way that is understandable to the individual and parties chosen by the individual. At a minimum, the Life Plan must be written in plain language and in a manner, that is accessible to the individual, to the extent possible, and parties chosen by the individual. The Life Plan must be finalized and agreed to with the individual's written informed consent and signed by the provider(s) responsible for implementing the Life Plan. The Care Manager must distribute the Life Plan to the individual and parties involved in the implementation of the plan.

The individual, parties chosen by the individual, the service provider, and Care Manager must review the Life Plan and the Care Manager must revise such plan if necessary, as follows:

- (1) at least semi-annually;
- (2) when the capabilities, capacities, or preferences of the individual have changed and warrant a review;
- (3) at the request of the individual and/or parties chosen by the individual;
- (4) when it is determined that the existing plan (or portions of the plan) is/are ineffective; and
- (5) upon reassessment of the individual's functional need.

### **Documentation of Rights Modifications**

This section only applies to HCBS Medicaid Waiver services in settings certified by OPWDD.

Modifications to the rights must be supported by a specific assessed need and justified in the individual's Life Plan:

- (1) Each individual's residence is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the applicable landlord/tenant law. For a residence to which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement for each individual that provides for eviction processes and appeals comparable to those provided under the applicable landlord tenant law.
- (2) Each individual has privacy in his or her sleeping or living unit:
  - (i) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
  - (ii) The individual sharing a unit has a choice of roommates in that setting.
  - (iii) The individual has freedom to furnish and decorate his or her sleeping or living unit within the lease or other agreement.
- (3) Each individual has the freedom and support to control his or her own schedules and activities, and has access to food at any time.

- (4) Each individual is able to have visitors of his or her choosing at any time.

The Care Manager must ensure documentation of the following in the individual's Life Plan:

- (1) a specific and individualized assessed need underlying the reason for the modification;
- (2) the positive interventions and supports used prior to any modifications;
- (3) less intrusive methods of meeting the need that were tried but did not work;
- (4) a clear description of the condition that is directly proportionate to the specific assessed need;
- (5) a regular collection and review of data to measure the ongoing effectiveness of the modification;
- (6) established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- (7) an assurance that interventions and supports will cause no harm to the individual; and
- (8) the informed consent of the individual.

In the event that a rights modification affects another individual receiving services in the setting who does not require a rights modification, the Care Manager must ensure documentation of the following in such individual's Life Plan:

- (1) the impact that the rights modification has on the individual;
- (2) the efforts taken to lessen the impact on the individual; and
- (3) the informed consent of the individual.

### **Notice of the Person-Centered Planning Process and Life Plan**

The Care Manager must give notice of the individual's right to a person-centered planning process and of the right to object to services, to the individual and the person upon whom decision-making authority is conferred by State law if any, in the following manner:

- (1) for individuals who did not have an Individualized Service Plan (ISP) in place on November 1, 2015, the Care Manager must give written notice prior to the

initiation of the person-centered planning process and development of the Life Plan; or

(2) for individuals who had an ISP in place on November 1, 2015, the Care Manager must give written notice at the time of the individual's next ISP review.

Such information must be conveyed in plain language and in a manner, that is accessible to and understood by the parties specified in subdivision (a) of 14 New York Codes, Rules, and Regulations (NYCRR) Part 636 which can be found at the following link:

<https://opwdd.ny.gov/sites/default/files/documents/person-centered-planning-text.pdf>

### **Additional Care Manager Responsibilities**

CCO/HH Care Managers are expected to assist individuals with maintaining benefits such as Social Security, Supplemental Security Income (SSI), Medicaid and Medicare coverage and/or Food Stamps.

Care Manager responsibilities also include:

- Monitoring benefits for individuals whose representative payee is the agency operating their certified residence.
- Assisting individuals with their benefits, when the individual does not have a representative payee or when the non-residential representative payee requests assistance.

## **1.5 Federal CCO/HH Provider Functional Requirements**

The CCO/HH model of service delivery supports the provision of timely, comprehensive, high-quality Health Home services that operate under a whole-person approach to care that integrates medical, behavioral health, developmental disability services, and other needed supports and social services. The whole-person approach to care must address the clinical and non-clinical care needs of the individual.

As described in the CMS SMDL #10-024 and Section 1945(b) of the Social Security Act, designated CCO/HH providers are required to address the following Health Home functional components listed below.

1. Provide quality-driven, cost-effective, culturally appropriate, and person-centered CCO/HH services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to mental health and substance abuse services;
5. Coordinate and provide access to comprehensive Care Management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered Life Plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use Health Information Technology (HIT) to link services, facilitate communication between members of the individuals care planning team and the individual and/or their family/representative, provide feedback to practices, as feasible and appropriate;
11. Establish a continuous quality improvement program, collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Additional information regarding Federal CCO/HH Provider Functional Requirements can be found at the following link:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hhidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf)

## 1.6 New York State Provider Qualification Standards for CCO/HHs

To ensure that CCO/HHs meet the Federal Health Home model of service delivery in addition to the State standards and requirements, “CCO/HH Provider Qualification Standards” were developed. These standards set the ground work for ensuring that individuals enrolled in CCO/HHs receive appropriate and timely access to medical, developmental disability, behavioral health, social services, and long-term care supports and services in a coordinated, person-centered and integrated manner. CCO/HHs will be closely monitored to ensure that the CCO/HH Provider Qualification Standards are being met.

Information on these standards can be found at the following links:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hhidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf)



## 1.7 Health Home Standards and Requirements for CCO/HHs, Care Management Providers and Managed Care Organizations

### State Plan Standards and Requirements for CCO/HHs

As specified in the CCO/HH SPA, CCO/HHs must provide the following core services and have policies and procedures in place to ensure Care Management services meet the following requirements.

#### 1. Comprehensive Care Management

**1a.** A comprehensive health assessment that identifies medical, mental health, chemical dependency, developmental disability and social service needs.

**1b.** The individual's Life Plan integrates the continuum of medical, behavioral health services, rehabilitative, long term care, developmental disability and social service needs and clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability providers, Care Manager and other providers directly involved in the individual's care.

**1c.** The individual and their family/representative and those chosen by the individual should play a central and active role in the development and execution of their Life Plan. Parties should agree with the goals, interventions, and time frames contained in the Life Plan.

**1d.** The individual's Life Plan clearly identifies primary, specialty, behavioral health, developmental disability, and community networks and supports that address their needs.

**1e.** The individual's Life Plan clearly identifies family members and other supports involved in their services. Family and other supports are included in the Life Plan and execution of care as requested by the individual.

**1f.** The individual's Life Plan clearly identifies goals and timeframes for improving their health and health care status, independence and community integration, and the interventions that will produce this effect.

**1g.** The individual's Life Plan must include outreach and engagement activities that will support engaging the individual in care and promoting continuity of care.

**1h.** The individual's Life Plan includes periodic reassessment of their needs and clearly identifies the individual's progress in meeting goals and changes in the Life Plan based on changes in need.

## 2. Care Coordination and Health Promotion

**2a.** The CCO/HH provider is accountable for engaging and retaining the individual in coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating the individual's needs, including prevention, wellness, medical, specialist and behavioral health treatment, care transitions, developmental disability, long term services and supports, and social and community services where appropriate through the creation of an individualized Life Plan.

**2b.** The CCO/HH will assign individuals a dedicated Care Manager who is responsible for coordinating all aspects of their care and overall management of the Life Plan. The CCO/HH Care Manager is clearly identified in the individual's record. The individual cannot be enrolled in more than one (1) Care Management program funded by the Medicaid program.

**2c.** The CCO/HH provider must describe the relationship and communication between the dedicated Care Manager and the treating clinicians to ensure that the Care Manager can discuss with clinicians on an as needed basis, changes in the individual's condition that may necessitate treatment change (i.e., written orders and/or prescriptions).

**2d.** The CCO/HH must define how it will document care decisions when conflicting treatment is being recommended or provided.

**2e.** The CCO/HH has policies, procedures and an accountability structure (contractual agreements) to support effective collaborations between primary care, specialists, behavioral health and developmental disability providers, referrals, follow-up and consultations that clearly define roles and responsibilities.

**2f.** The CCO/HH supports continuity of care and health promotion through the development of a treatment relationship with the individual and their Interdisciplinary Team (IDT), known as the care planning team.

**2g.** The CCO/HH supports care coordination and facilitates collaboration through follow-up consultations the establishment of regular case review meetings (i.e. Life Plan review), including all members of the care planning team on a schedule determined by the CCO/HH and the individual. At a minimum, the schedule for the Life Plan review will, in most cases, follow the individual's established schedule for annual care planning meetings, which requires the plan is reviewed at least twice each year. The CCO/HH provider has the option of utilizing technology conferencing tools including audio, video and /or web deployed solutions when security protocols and precautions are in place to protect PHI (Personal Health Information).

**2h.** The CCO/HH ensures twenty-four (24) hour/seven (7) days a week availability to a Care Manager to provide information and emergency consultation services.

**2i.** The CCO/HH will ensure timely access to appointments for individuals to medical and behavioral health care services within their CCO/HH provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

**2j.** The CCO/HH promotes evidence based wellness and prevention by linking individuals with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on the individuals needs and preferences.

**2k.** The CCO/HH has a system to track outcomes and initiate changes in care, as necessary, to address the individual's needs.

### **3. Comprehensive Transitional Care**

**3a.** The CCO/HH has a system in place with hospitals and residential/rehabilitation facilities in their network to provide the CCO/HH prompt notification of an individual's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

**3b.** The CCO/HH has policies and procedures in place to support individuals experiencing transitions from school to adult services, life changes (employment, retirement, other life events), or when an individual is electing to transition to a new CCO/HH provider or to a new Care Manager within the same CCO/HH.

**3c.** The CCO/HH has policies and procedures in place with local practitioners, health facilities including emergency rooms, hospitals, and residential/habilitation providers and community-based services to help ensure coordinated, safe transitions in care for individuals who require transfers in the site of care.

**3d.** The CCO/HH utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the individual and/or their family/representative, and local supports.

**3e.** The CCO/HH has a systematic follow-up protocol in place to ensure timely access to follow-up care post discharge that includes at a minimum, receipt of a summary care record from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, Care Manager verification with outpatient providers that the individual attended the appointment, and a plan to outreach and re-engage the individual in care if the appointment was missed.

#### 4. Individual and Family Support

- 4a. The individualized Life Plan reflects the individual's and their family/representative's preferences, education and support for self-direction, self-help, and other resources as appropriate.
- 4b. The individualized Life Plan is accessible to the individual and their family/representative and is based on the individual's preference of either electronically and/or via mail.
- 4c. The CCO/HH provider utilizes peer supports, support groups and self-care programs to increase the individual's and their family/representative's knowledge of their disease, engagement and self-management capabilities, and improves adherence to prescribed treatment.
- 4d. The CCO/HH discusses advance directives with individuals and their family/representative.
- 4e. The CCO/HH communicates and shares information with individuals and their family/representatives with appropriate consideration for language, literacy and cultural preferences.
- 4f. The CCO/HH gives the individual, and if they agree, their family/representative access to the Life Plan and options for accessing clinical information.

#### 5. Referral to Community and Social Supports

- 5a. The CCO/HH identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.
- 5b. The CCO/HH has policies, procedures and an accountability structure (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.
- 5c. The Life Plan should include community-based and other social support services as well as healthcare, long term supports and services and developmental disability services that respond to the individual's needs and preferences and contribute to achieving the individual's goals.

#### 6. Use of HIT to Link Services

CCO/HHs are required to meet the following HIT standards in the delivery of the CCO/HH core services. CCO/HHs are required to meet the "Final Standards" within six (6) months of program initiation.

**These standards require:**

- Use of a Certified Electronic Health Record (EHR) for select care team members
- Participation in a Regional Health Information Organization/Qualified Entity (RHIO/QE) for select health care delivery organizations
- Provision of access to a singular electronic care plan for any care team member/organization consented to by the CCO/HH patient
- Use of electronic clinical decision support amongst direct care providers

**Initial Standards**

**6a.** CCO/HH has structured information systems, policies, procedures and practices to electronically create, document, execute, and update a Life Plan for every CCO/HH enrollee.

**6b.** CCO/HH has a systematic process to follow-up on tests, treatments, services and referrals, which is incorporated into the individual's Life Plan.

**6c.** CCO/HH has an electronic record system which allows the individual's health information and Life Plan to be accessible to the care planning team and which allows for population management and identification of gaps in care including preventive services.

**6d.** CCO/HH makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.

In addition, as of the initial date of operation:

- The CCO/HH must ensure the Life Plan employs the Care Coordination Data Definitions (CCDD). The CCDD establishes data standards between OPWDD and comprehensive care coordination providers. These standards allow care coordination providers to share necessary Life Plan data with OPWDD. The current CCDD is a continually evolving document and will progressively advance as the CCO/HH program evolves and is implemented and the I/DD population transitions to Managed Care.

Additional information on the current CCDD can be found at the following link:  
[https://opwdd.ny.gov/sites/default/files/documents/CareCoordinationDataDefinitions6-29\\_2.pdf](https://opwdd.ny.gov/sites/default/files/documents/CareCoordinationDataDefinitions6-29_2.pdf)

- The CCO/HH must use systems provided by the State to verify OPWDD and CCO/HH eligibility, enroll and track CCO/HH enrollments, capture the individual's consent, conduct comprehensive assessments, calculate CCO/HH rate tiers and generate CCO/HH enrollment rosters.

- CCO/HHs will be required to provide a Care Management solution and access to State systems. The State is now assessing the feasibility of modifying the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) for CCO/HHs. Currently, it is anticipated that following an initial start-up of CCO/HHs and a transition period, CCO/HHs will be required to use the MAPP HHTS to track CCO/HH enrollments as indicated in the “Preliminary Assessment of System Uses and Requirements” table in Part 1 of the CCO/HH Application located at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hhidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf)

- CCO/HHs must provide the capability for individuals and/or their family/representative, providers, and the State to access, via a secure web-based portal, the Life Plan and to view or upload documents and input information to the Life Plan, including but not limited to, clinical notes, progress notes and other related documentation.
- CCO/HH has a billing system that allows for timely claims submission to the State’s Medicaid Management Information System (MMIS) and payment to Care Managers.
- CCO/HH IT capability to develop and produce reports, where applicable and as described in Section 14 - Performance Management and Quality Metrics of the CCO/HH Application.
- CCO/HH IT capability must maintain interoperability with other defined State systems using NYS ITS approved protocols.
- CCO/HH IT capability must provide access for individuals and their family/representative to the Life Plan and other related documentation via a secure portal that includes digital signature and bi-directional communications functionality for the approval and management of the Life Plan between the individual and the CCO/HH.
- CCO/HH IT capability must capture the individual’s consent, electronically share changes to demographics and service adds, edits, and deletions as prescribed by OPWDD.

## Final Standards

**6e.** CCO/HHs have structured interoperable information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a Life Plan as defined by OPWDD for every CCO/HH enrollee.

**6f.** CCO/HHs use a health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the individual's health information and Life Plan to be accessible to the care planning team.

**6g.** CCO/HHs will be required to comply with the current and future version of the Statewide Policy Guidance which includes common information policies, standards and technical approaches governing health information exchange.

The Statewide Policy Guidance can be found at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_home/policy/shinny.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_home/policy/shinny.htm)

**6h.** CCO/HHs must commit to joining RHIO/QEs for data exchange and includes a commitment to share information with all providers participating in a Life Plan. RHIOs/QE (Qualified Entities provide policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

**6i.** CCO/HHs will support the use of evidence based clinical decision-making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance, as well as supporting the enrollees personal life goals and valued outcomes.

In addition, CCO/HHs must adhere to all State and Federal legal, statutory, and regulatory requirements.

## **1.8 Additional CCO/HH Standards and Requirements**

This section includes additional standards and requirements that CCO/HHs will be responsible for implementing and monitoring, including:

- a) Minimum Standards and Requirements for CCO/HH Life Plans
- b) Comprehensive Assessment Requirements
- c) Requirements for Monitoring and Implementing the Life Plan
- d) Requirements for Care Planning Meetings
- e) CCO/HH Care Manager Qualifications and Requirements
- f) Requirements for Willowbrook Class Members
- g) Advisory Body

### **a. Minimum Standards and Requirements for CCO/HH Life Plans:**

In delivering the six (6) core services, including the provision of an integrated and electronic Life Plan, CCO/HHs must, at a minimum, include the elements of OPWDD's Life Plan for all integrated services and providers, including OPWDD HCBS. The current regulatory requirements of OPWDD regulations governing person-centered planning are consistent with, and reflected in, the person-centered planning process requirements of the CCO/HH model. In addition to those requirements, other

information and requirements deemed necessary by the CCO/HH may also be included.

Additional information on the person-centered planning process can be found in Section 1.4 of this manual or at:

[https://opwdd.ny.gov/opwdd\\_services\\_supports/person\\_centered\\_planning](https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning)

In completing the Life Plan, CCO/HH Care Managers will be required to adhere to the core services, CCO/HH requirements and standards, include all integrated services in the Life Plan (physical, developmental disability, behavioral, HCBS and other community and social supports), and satisfy the HIT standards for preparing, implementing and monitoring the electronic Life Plan. The minimum standards and requirements for the Life Plan must meet the CMS care planning requirements for providing HCBS services authorized under the 1115 Waiver.

The CCO/HH Life Plan represents a comprehensive document created as the result of a person-centered planning process directed by the individual, with assistance, as needed, from a representative identified by the individual and/or family/representative and in collaboration with the care coordination team. The Life Plan is an understandable and personal plan for implementing decisions made during the planning process and includes all services and habilitation plan components. The individual and/or their family/representative are at the center of all planning. The Life Plan must be finalized and agreed to with the individual's written informed consent.

For individuals who are transitioning from MSC or PCSS to CCO/HH services, at the beginning of CCO/HH service delivery, there will be a schedule for the transition of the individual's ISP to the Life Plan. For all other individuals who are newly entering OPWDD services and CCO/HH services, the development of the Life Plan will proceed according to the schedule outlined in this section.

For all new CCO/HH enrollees, within sixty (60) days of an individual being enrolled in a CCO/HH, the Care Manager shall conduct a face-to-face meeting with the individual and their family/representative to perform a comprehensive assessment, convene the care planning team and the development of the Life Plan using a person-centered planning process.

As described in more detail below, at a minimum, the Life Plan must include:

- Description of the individual;
- Desired quality of life, health, and functional outcomes; including incorporating information derived from a robust person-centered planning process and assessments (inclusive of the state sanctioned assessment);
- Observable/measurable action steps to achieve outcomes that will be taken by the individual, paid and unpaid service providers, and others who will support the individual;



- Pertinent demographic information regarding the individual;
- Safeguard description and supports needed to reduce the likelihood of harm including a detailed back up plan for situations in which regularly scheduled paid or unpaid supports are unavailable or do not arrive and evacuation in an emergency;
- Employment status;
- Services, including developmental disability, physical, behavioral health, and HCBS long term services and supports the individual will receive;
- Relevant information pertaining to behavioral support that is needed;
- Relevant information regarding physical health conditions and treatment;
- Frequency of planned Care Manager contacts needed; and
- Steps that must be taken by the individual in the event of an emergency
- Reasonable accommodations needed

## **Demographics and Profile**

### Identifying Information

This section of the Life Plan captures information about the individual, including their full name, Medicaid number or CIN number, address, the CCO/HH in which the individual is enrolled, name of lead CCO/HH Care Manager and Care Management Agency (CMA), initial Life Plan date, and Life Plan review dates.

This section should also track information specific to the individual's employment, including employment status, employment setting, hours worked, and average wage.

### **Profile Information**

This section of the Life Plan captures the individual's home, work, relationships, health, and educational profile. Each of these sections includes question and answer fields as well as free text to provide a person-centered narrative that captures personal history and appropriate contextual information, as well as a description of skills, abilities, aspirations, needs, interests, things that make the person happy, challenges, pre-school and school age services etc., learned during the person-centered planning process, a record review, and any assessments completed.

The profile should describe the individual and their current interests, needs, and wants. It assists those helping the individual provide supports and services with an

understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action. The profile is not a static history of the person, it should be updated regularly to accurately reflect the individual's changing needs and goals.

### Outcomes and Support Strategies

This section of the Life Plan must capture the following information: goal description, Valued Outcomes, action steps, responsible party, service type, timeframe for action steps, special considerations (if applicable), and Personal Outcome Measures (POMS). Evidence of achievement will be reflected in monthly notes from assigned providers. Specifically, requirements of this section include, but are not limited to:

- **Goal Description:** A free text section that must include the specific details around the individual's goals and/or Valued Outcomes.
- **Valued Outcome:** Valued Outcomes are the individual's chosen life goals and are the driving force behind the services and supports the individual receives. The Valued Outcomes should simply state what the individual wants to achieve. List the individual's valued outcomes that derive from the profile and planning process. There must be at least one (1) Valued Outcome for each HCBS Waiver service the individual will be receiving. The Waiver service is "authorized" only where the service relates to at least one (1) of the individual's Valued Outcomes.
- Valued Outcomes within the Life Plan must link to one of the twenty-one (21) defined Council on Quality and Leadership (CQL) POMS Measures.

Additional information on CQL and POMS Measures can be found at the following link:

[https://opwdd.ny.gov/opwdd\\_services\\_supports/person\\_centered\\_planning/personal-outcome-measures](https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning/personal-outcome-measures)

- **Action Steps/Objectives:** The specific supports and services related to each goal and/or Valued Outcome. Objectives are the measurable (i.e. observable) action steps that are aimed at achieving the Valued Outcome. Action steps should be written so that they can be measured and evaluated. Action steps will lead to the specific approaches, activities and services that are provided.
- **Responsible Party:** Identify the individual(s) who will be responsible for implementing and documenting progress toward the goal, which needs to relate to authorized-funded services, natural supports, and community resources.
- **Service Type:** This includes natural supports, Residential Habilitation,

Day Habilitation, Community Habilitation, Supported Employment, Pre-Vocational Services, Respite, Adaptive Devices, Environmental Modifications, Family Education and Training (FET), Fiscal Intermediary Services, Broker Services, Community Transition Services, Intensive Behavioral Services, and health and long-term care services, etc.

- Timeframe for Each Action Step: Indicate the date the goal is anticipated to be achieved.
- Special Considerations: If applicable this is a free text area to provide information regarding health and safety concerns that may need to be considered in assisting the individual to achieve their Valued Outcome. There may be instances where an individual receiving services chooses not to follow specific medical or treatment advice, information relative to decisions of this nature should be included within this section.
- POMS: Identify the POM that best fits with the goal and Valued Outcome as determined by the individual, Care Manager and/or the care coordination team.

### **Individual Safeguards/Individual Plan of Protection (IPOP)**

This section of the Life Plan focuses on the development of supports to assist the individual in maintaining desired personal safety. Supports that help achieve safety and reduce risk should support the individual's health, needs, and interests.

Safeguards are actions to be taken to prevent risk and to promote good health. Support staff, as appropriate, must have knowledge of the individual's health and safety support needs and the planned actions to meet those needs. All required safeguard domains identified in the CCDDs need to be actively assessed and addressed in the Life Plan, if needed.

When developing safeguards, the Care Manager must evaluate, with the individual and/or their family/representative, whether there are opportunities that the individual wants to engage in that could be determined as risky. This involves analysis of the perceived risk based on the ability to provide support in addressing risks, not on the individual's ability.

To evaluate risk and the individual's responsibility and ability to calculate the risk, the following factors should be considered:

- Weighing the benefits to the individual and the rights of the individual against the risk
- Ways to empower the individual to improve their ability to make informed decisions through education and self-advocacy skills
- Evaluate possible resources and environmental adaptations

that can allow the individual to take the risk, but mitigate potential hazards

### **HCBS Waiver and Medicaid State Plan Authorized Services**

This section of the Life Plan includes a listing of all HCBS Waiver and State Plan services that have been authorized for the individual. CCO/HHs will be required to ensure that these services have been authorized by the appropriate entity (i.e., OPWDD's Developmental Disability Regional Offices (DDRO) or Local Department of Social Services (LDSS)). For each HCBS service, the Waiver service provider, the service type, frequency of support of service, duration of the support of service, and the effective dates must be identified.

The 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 and must be manually entered in 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). Information on the duration and frequency of the HCBS Waiver service can be found in the applicable ADM found at the following link:

[https://opwdd.ny.gov/opwdd\\_regulations\\_guidance/adm\\_memoranda](https://opwdd.ny.gov/opwdd_regulations_guidance/adm_memoranda).

### **All Supports and Services; Funded and Natural/Community Resources**

This section is meant to identify the services, supports, and caregivers in an individual's life, along with the proper contact information. The Medicaid funded services identified above, this section will include contact information for the appropriate representative associated with those services. In addition, other service providers outside of Waiver and State Plan services should be listed in this section, along with the type of service provided and current contact information. All Additionally, all-natural supports and community resources that help the individual be a valued member of their community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations, should be listed with contact information, as appropriate.

This section of the Life Plan should contain people, places, or organizational affiliations that are a resource to the individual by providing supports, such as family/representatives, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. This information should include the name of the individual, place or organization as well as a contact number and address of each.

Examples of services to be reflected in the integrated and comprehensive Life Plan include but are not limited to: Primary Care Physician, Dentist, Psychologist, Podiatrist,

Psychiatrist, NYSTART (Crisis Prevention and Response Services), Dermatologist, Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR) and HCBS Waiver Services. Each of these services received by the individual must also include the name, contact number and address of the service provider and anyone that will participate in IDT meetings.

### **b. Comprehensive Assessment Requirements**

As required by the comprehensive Care Management core service, CCO/HH enrollees must be comprehensively assessed, using one or more tools, to identify developmental disability, medical, mental health, behavioral health, chemical dependency, social and emotional needs. The comprehensive assessment must be completed within sixty (60) days of enrollment into the CCO/HH. CCO/HHs are required to ensure that the comprehensive Life Plan includes all services identified by the assessments.

In addition to the CCO/HH's comprehensive assessment tool(s), Care Managers must assess every individual using the Developmental Disabilities Profile 2 (DDP2). The DDP2 must be conducted at least annually, or more frequently if the individual experiences a significant change by the CCO/HH Care Manager.

Once fully implemented, the CCO/HH will be required to transition from the DDP2 to the Coordinated Assessment System (CAS) and adhere to the above timeframe for completion. The CAS is housed in the State's Uniform Assessment System-New York (UAS-NY). The CCO/HH will be required to ensure CCO/HH Care Managers complete the State required CAS training and adhere to the person-centered administration protocols.

When the CAS is initially performed, and administered by OPWDD, the CCO/HH will coordinate and facilitate the inclusion of the individual's legal guardian(s) and/or actively involved family members/representatives. When the CCO/HH administers subsequent updates to the CAS, the CCO/HH provider must ensure Care Managers have met the State-defined CAS qualifications and training requirements and adhere to the person-centered administration protocols. Upon completion of the CAS, either by OPWDD or the CCO/HH, the CCO/HH must review the CAS with the individual and their family/representative as part of the person-centered planning process utilized for the development of the Life Plan.

### **c. Requirements for Monitoring and Implementing the Life Plan**

The Life Plan is a comprehensive, person-centered plan of care. It integrates the continuum of physical/medical, behavioral health services, rehabilitative, long-term care, developmental disability and social service needs, including pre-school and school-age services for children. The plan also clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability service providers, School Districts, the Care Manager and other providers directly involved in the individual's services. The Life Plan is subject to

continuous updating and monitoring by the Care Manager as CCO/HH services are delivered each month. Changes and updates to the Life Plan must include changes in assessment data and health status, including, but not limited to, the coordination of service changes, medication administration, or support services following hospitalization discharge or other sites of care change. It is the Care Managers responsibility to communicate with the physician's office as needed to ensure that the Life Plan comports with the physician's assessment of the individual's needs. The Life Plan should be comprehensively reviewed to ensure: results/effects of the delivered supports and services are to the satisfaction of the individual and/or family/representative; functional/clinical status; and quality of life outcomes. The results of these assessments should be used to determine whether any changes are needed to the Life Plan and whether the individual's supports and services are effectuating desired outcomes and results.

#### **d. Requirements for Care Planning Meetings**

The CCO/HH enrollee shall lead the planning process. The Care Manager must ensure that members of the care planning team are chosen by the individual. The Care Manager shall also ensure that all Life Plan reviews and updates use a person-centered planning process that provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. The individual's cultural background shall be recognized and valued in the planning process. If support for

the planning process is needed from a language translator or a sign language interpreter, then such support must be arranged by the CCO/HH.

- i. All person-centered planning meetings, Life Plan updates and/or review meetings must occur at times and locations of convenience to the individual.
- ii. No less than annually, a person-centered planning review meeting must occur face-to-face, and all members of the care planning team must participate. Members of the care planning team, other than the individual and the Care Manager, have the option of utilizing technology conferencing tools including audio, video, and/or web-deployed solutions when security protocols and precautions are in place to protect PHI.
- iii. Review and updates of the Life Plan must also occur when the individual or their family/representative requests that information be changed or added and/or when the need for supports and services change. The Life Plan should change as the individual changes. A planning meeting should be arranged to include people chosen by the individual including family members and others as determined by individual and occur in a timely response to the request to hold a

meeting.

- iv. The Life Plan will be considered approved when it is agreed to with the individual and their family/representative's written informed consent and the Care Manager has signed the plan.
- v. The Care Manager shall sign and date the Life Plan, along with any updates. The Care Manager shall ensure that the individual and their family/representative reviews, signs and dates the Life Plan, as well as any significant updates. The individual and their family/representatives must be informed by the CCO/HH of the method in which they can request updates to the Life Plan as needed or wanted.

#### **e. CCO/HH Care Manager Qualifications and Requirements**

CCO/HH Care Managers must meet the following qualifications:

- a) A Bachelor's degree with two (2) years of relevant experience, OR
- b) A License as a Registered Nurse (RN) with two (2) years of relevant experience, which can include any employment experience and is not limited to case management/service coordination duties, OR
- c) A Master's degree with one (1) year of relevant experience.
- d) Current MSC Service Coordinators are "grandfathered" to facilitate continuity for the person receiving coordination. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC Agency or CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.

CCO/HH Care Manager qualifications will be waived for existing MSC Service Coordinators who apply to serve as Care Managers in CCO/HHs. CCO/HHs will be required to provide core services training for current MSC Service Coordinators that transition to the CCO/HH program and do not meet the minimum education and experience requirements. Such training shall be provided by the CCO/HH within six (6) months of contracting with an MSC Service Coordinator. Based on the previous experience and training of existing MSC Service Coordinators, it is anticipated that most MSC Service Coordinators will transition to CCO/HH Care Manager roles.

To ensure a smooth transition, during the first year of operations CCO/HH Care Managers, with appropriate firewalls and supervisory structures in place, may provide CCO/HH Care Management services and through a contract with a CCO/HH as a CMA, if the CCO/HH chooses. CCO/HHs will be responsible for developing an infrastructure that supports the effective delivery of person-centered Care Management services and will need to define the supervisory structure and qualifications that will support that infrastructure. After one (1) year of operation, all Care Managers (including former MSC

Service Coordinators) providing Care Management under a designated CCO/HH must be directly employed by the CCO/HH and may not provide HCBS, except for agencies that are operated by a Federally Recognized Tribe.

CCO/HHs are required to ensure that all Care Managers are qualified to provide and meet the standards and requirements of CCO/HH Care Management and deliver the six (6) core CCO/HH services. All CCO/HHs must ensure Care Managers are trained in the Skill Building areas identified on page 28-29 of the CCO/HH Application and can employ the skills aligned with each area in the delivery of CCO/HH Care Management.

More information on Skill Building areas can be found at the following link:  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hidd_application_part_1.pdf)

The State will provide CCO/HHs with further guidance on standards for meeting these requirements and CCO/HHs will be required to submit their training plans to the State. The State will also provide additional information on requirements for Care Manager and supervisor criminal background checks.

## **CCO/HH Background Check Policy**

### **Purpose**

The purpose of this policy is to establish procedures for conducting the required background checks for CCO/HH Care Managers and other applicable CCO/HH employees. The 2018-19 Enacted New York State Budget includes new statutory requirements related to criminal history record checks, mandated reporter requirements, and Statewide Central Register (SCR) Database checks.

CCO/HH Care Managers and other applicable CCO/HH employees must cooperate with three (3) required clearances:

- Staff Exclusion List (SEL) through the NYS Justice Center
  - NYS Social Services Law 495
- Criminal History Record Check (CHRC) through NYSDOH
  - NYS Public Health Law Article 28-E
- Statewide Central Register Database Check (SCR) through OCFS
  - NYS Social Service Law 424-a



In addition, CCO/HH Care Managers and other applicable CCO/HH employees are required to be mandated reporters of child abuse and maltreatment, per NYS Social Services Law 413.

The employer of record is the agency responsible for completing the required background checks. CCO/HHs are responsible for ensuring that the CMAs they subcontract with have complied with all of the necessary background check requirements.

### **Staff Exclusion List (SEL) through NYS Justice Center**

The SEL is a Statewide Register maintained by the NYS Justice Center. The SEL contains the names of people found responsible for serious or repeated acts of abuse and neglect, and people on the SEL are prohibited from being hired by OPWDD providers. The SEL is required for all newly hired staff that will have regular and substantial contact with individuals in CCO/HHs. The SEL should be completed prior to all other required background checks for practical purposes. If a prospective employee is on the SEL, that prospective employee cannot be hired to work with individuals in the OPWDD service system, including CCO/HHs, and therefore this eliminates the need for other background checks to be performed.

- The SEL check is free and is required for all prospective CCO/HH Care Managers and other applicable CCO/HH employees who require a SCR Database Check. The SEL check is not transferrable from agency to agency.

### **The SEL Check Process:**

- CCO/HHs are responsible for establishing an account and meeting any additional requirements to ensure completion of the SEL checks with the NYS Justice Center.
- Authorized person(s) are the staff at each agency that can request SEL checks online and receive results via email.
- CCO/HHs are required to retain documentation of the result for each SEL check.

### **Criminal History Record Check (CHRC) through NYS Department of Health**

Effective April 1, 2018, Article 28-E of the Public Health Law requires a CHRC be conducted for all prospective direct care employees, including CCO/HH Care Managers and other applicable CCO/HH employees. CHRCs are fingerprint-based, national FBI criminal history record checks. The CHRC must be completed for staff who will provide direct care or supervision, which includes all direct hire and contracted CCO/HH Care Managers. Care Managers who previously had Criminal Background Checks (CBC) completed through the NYS Justice Center are required to have the CHRC because the

previously conducted checks do not transfer and the CBC does not meet the requirements of the CHRC.

In addition, CCO/HHs must submit to the State, a plan for ensuring that all CHRCs are submitted no later than January 1, 2019. This plan must include sub-contracted staff, if applicable. CCO/HHs are required to submit this plan no later than July 15, 2018 to the following mailboxes: [care.coordination@opwdd.ny.gov](mailto:care.coordination@opwdd.ny.gov), [OPWDD.SM.CCOProjectManagement@opwdd.ny.gov](mailto:OPWDD.SM.CCOProjectManagement@opwdd.ny.gov) and [hhidd@health.ny.gov](mailto:hhidd@health.ny.gov).

The following titles are only exempt from the CHRC requirements if they are operating within their title:

- Professionals licensed under Title 8 of the NYS Education Law
- Licensed nursing home administrators, security guards, volunteers and students enrolled in a program leading to a professional license under Title 8 are not subject to the CHRC

An employee is operating within their title if their license was specifically required for their position. If a Title 8 licensee is not operating within their title, they are still subject to the CHRC.

### **The CHRC Process:**

Employers of covered persons are responsible for requesting and processing the checks.

- CCO/HHs must ensure appropriate direct observation and evaluation of the *temporary employees*, effective April 1, 2019.
- Temporary employees are those whose CHRCs are pending.
- Effective April 1, 2019, temporary employees will not be able to provide direct care without supervision by an employee whose check has been successfully completed or by exempt staff.
- If an employee is later employed by another agency that requires a CHRC, the CHRC process will be expedited once the direct employer (CCO/HH) submits their request for a CHRC. If the applicant has already been evaluated by DOH/CHRC, the direct employer will not receive a Live-Scan Request Letter. However, they will receive a letter of determination concerning employment eligibility. There is no additional fee in this situation and the expedited checks are typically processed in one (1) to two (2) weeks.
- Total cost of CHRC is \$99.00. The employer of record is responsible for the cost. These costs are statutorily prohibited from being passed on to the employee. However, a CCO/HH may reimburse an agency for the cost of contract staff.

- There are some crimes which will statutorily disqualify a person from obtaining employment pursuant to Executive Law 845-b (5)(a). There are also discretionary crimes which may be disqualifying for employment depending on an analysis of Correction Law Article 23-A. The agency will receive CHRC Legal Determination Letters which are based on legal review of NYS and FBI criminal histories.
- Sample notification letters that are favorable to the applicant and which are sent **only** to the health care provider include the following:
  1. **Programmatic non-ident** letter issued when both the Department of Criminal Justice Services (DCJS) and FBI report the applicant has no criminal history at all.
  2. **Legal no conviction/no hit** letter issued following receipt of a criminal history record indicating charges or convictions by the DCJS or the FBI which upon investigation and legal determination are not reportable convictions for any felony or misdemeanor (for example violations, infractions, sealed records, family court, military non-judicial punishment).
  3. **DOH non-denial (a)** letter issued when an applicant has submitted, in advance of an initial attorney review, sufficient rehabilitation materials to attenuate a presumptively disqualifying conviction.
  4. **DOH non-denial (b)** letter issued following initial attorney review of an applicant's record and legal determination made finding no direct relationship or unreasonable risk to the granting of employment eligibility regarding that criminal history (for example, a 1999 Class U misdemeanor DWI).
  5. **Open charges/not held in abeyance** letter issued when the applicant has a pending minor misdemeanor matter which does not relate to the proposed employment in a health care setting or creates an unreasonable risk to patients or where the applicant has received an adjournment in contemplation of dismissal with respect to an open charge.
  6. **Final non-denial (a)** letter issued following the issuance of a pending denial letter where the applicant has submitted sufficient rehabilitation materials to attenuate a statutorily disqualifying conviction.

7. **Final non-denial (b)** letter issued following the issuance of a pending denial letter where the applicant has submitted sufficient rehabilitation materials to attenuate a discretionarily disqualifying conviction.

Note, Letters #2 through #5 above are issued after the criminal history check is perfected and a comparative law analysis performed, and do not require an applicant response, leaving the final hiring decision with the health care provider. Letters #6 and #7 communicate favorable final decisions rendered after the applicant submits rehabilitation information. These are issued following an attorney review of the applicant's complete rehabilitation submission and a thorough DOH investigation concerning the circumstances of a crime.

- Sample notification letters that are unfavorable to the applicant and which are sent to both the health care provider and the applicant include the following:
  8. **Pending denial to provider/pending denial to employee** letters issued following attorney review of a perfected rap sheet where the applicant has misdemeanor and/or felony convictions which, upon legal review, contain either a statutorily or discretionarily disqualifying conviction and requesting the submission of rehabilitation documentation from the applicant.
  9. **Final denial (a)** letter to provider/employee issued following the issuance of a pending denial letter where the applicant has not submitted sufficient rehabilitation materials to attenuate a statutorily disqualifying conviction.
  10. **Final denial (b)** letter to provider/employee issued following the issuance of a pending denial letter where the applicant has not submitted sufficient rehabilitation materials to attenuate a discretionarily disqualifying conviction.
  11. **Hold in abeyance** letter to provider/employee issued when the applicant has a pending felony, or a pending misdemeanor which relates to the proposed employment in a health care setting or creates an unreasonable risk to individuals enrolled in CCO/HHs.

In addition, following the DOH issuance of a pending denial letter to the provider and employee, a favorable final employment eligibility determination can also be made by DOH attorneys in the form of a final non-denial (a) or final non-denial (b) letter (letters 6 and 7) as referenced above.

12. A 12<sup>th</sup> type of letter, referred to as a **Charge notification-after hire letter**, concerning a subsequent arrest, is sent only to the health care employer. When subsequent arrests involve particularly egregious circumstances, DOH attorneys may also telephone the employer to read the charges to

that employer, thereby allowing the employer to make a timely risk management decision concerning ongoing employment

- Results of CHRCs must be kept confidential unless provided to an authorized party. Access to results must be restricted to the employee, the provider and/or the provider's authorized designee, others involved in the hiring decision, and the Department of Labor. Criminal history information must remain strictly confidential and be kept in a separate area that only authorized persons have access to.

### **Statewide Central Register Database Check (SCR) through NYS OFCS**

The Statewide Central Register (SCR) maintains a database of records of child abuse and maltreatment reports. The purpose of the database check is to find out if a prospective employee of a CCO/HH is a confirmed subject of an indicated report of child abuse or maltreatment. The SCR Database Check is required for those employees that will have regular and substantial contact with enrollees, which includes but is not limited to CCO/HH Care Managers.

SCR Database checks will be required for prospective employees hired on or after July 2, 2018 that will have the potential for regular and substantial contact with individuals served by CCO/HHs, and those agencies that are providing Care Management via contracts. SCR Database checks are not transferable and are prohibited from being re-disclosed. The cost of the SCR Database check is \$25.00 and may be paid by either the employer or the employee. The payment must be submitted when the SCR Database Check request is submitted.

#### **The SCR Database Process/Results:**

- If the prospective employee is not found to be a confirmed subject of an indicated report, CCO/HH will receive notification that the SCR has no record of the applicant being an indicated subject of a report of child abuse or maltreatment.
- If the prospective employee is found to be the subject of an indicated report, the SCR is required to send a letter informing the applicant of their due process rights. The applicant is given ninety (90) days to respond back to the SCR in writing that they want to exercise their due process rights through an administrative review and fair hearing process. If the SCR does not hear back from the applicant within that timeframe, the SCR will then notify the CCO/HH that the SCR has a record of the applicant being an indicated subject of a report.
  - If a CCO/HH is notified that the SCR has a record of an applicant being an indicated subject of a report, the notification will not contain any details related to the report of abuse or maltreatment.

- An indicated SCR report is not an automatic exclusion from employment.
- The CCO/HH can request that the prospective employee sign an authorization for release of information allowing the CCO/HH to request of and obtain a copy of the indicated SCR report. After reviewing the records, it is the CCO/HHs discretion as to whether they hire or do not hire the prospective employee.

### **Mandated Reporter Requirements**

CCO/HH Care Managers and other applicable CCO/HH employees are mandated to report suspected child abuse or maltreatment. Reports of suspected child abuse or maltreatment are to be made immediately by telephone, to the mandated reporter line at 1-800-635-1522. The mandated reporter line is available 24 hours a day, 7 days a week. This line is dedicated to mandated reporters. Please do not provide this number to the public, who can report child abuse or maltreatment by calling 1-800-342-3720. In addition to the report made by phone, the mandated reporter must complete a written form (form LDSS 2221A) and submit it, within 48 hours, to the child protective services of which the child resides.

The Office of Child and Family Services offers free training online for mandated reporters that can be completed at any time of day, any day of the week. Upon completion of the online training, participants will electronically receive a certificate of attendance. There are no costs associated with this requirement.

### **f. Requirements for Willowbrook Class Members**

CCO/HHs are required to provide the six (6) core services and must have policies and procedures in place to ensure Care Management services meet the requirements described in this policy. These standards and requirements govern the provision of Health Home Care Management to Willowbrook Class Members who enroll in CCO/HHs.

#### 1) Overview of the Willowbrook Case

- A. OPWDD is responsible for ensuring certain entitlements under the Willowbrook Permanent Injunction, including protection from harm and high quality, community-based integrated services, to be provided in the least restrictive setting and regardless of any Willowbrook Class Member's inability or failure to pay a fee or a Willowbrook Class Member's ineligibility for Medicaid. Information can be found on the Willowbrook class action litigation, filed in 1972, including New York State's expectations for delivery of services to Willowbrook class members, at the following web site: [https://opwdd.ny.gov/opwdd\\_resources/Willowbrook\\_class/](https://opwdd.ny.gov/opwdd_resources/Willowbrook_class/).

B. Willowbrook Class Members are entitled to Active Representation by the Consumer Advisory Board (CAB). The CAB, acting in loco parentis, must provide all necessary and appropriate representation and advocacy services to Willowbrook Class Members with no actively involved families for as long as any such Class Member shall live. The CAB must also safeguard the individual and legal rights of all members of the Willowbrook Class, whether or not the CAB represents the individual Class Member. See Permanent Injunction at ¶ 7.

C. CCO/HH Care Managers are critical to successful implementation of the Willowbrook entitlements for services and shall engage in advocacy to protect and uphold the rights and entitlements of the Class Members in CCO/HHs, residential, day and/or work programs, and in all spheres of the Class Member's life. These rights and entitlements are established by Federal law and regulations and by Class Membership under the Willowbrook Permanent Injunction. Responsibilities specific to Care Management functions can be found in Appendix I of the Permanent Injunction.

2) CCO/HH Requirements when providing comprehensive Care Management to Willowbrook Class Members

A. All CCO/HH entities and Care Managers providing services to Willowbrook Class Members must be fully familiar with their obligations under the Permanent Injunction.

See the Willowbrook Permanent Injunction, available at:

[https://opwdd.ny.gov/opwdd\\_resources/willowbrook\\_class/willowbrook\\_permanent\\_injunction](https://opwdd.ny.gov/opwdd_resources/willowbrook_class/willowbrook_permanent_injunction)

The Overview of Services for Willowbrook Class Members is available at:

[https://opwdd.ny.gov/sites/default/files/documents/overview\\_of\\_services\\_for\\_willowbrook\\_class\\_members\\_7.pdf](https://opwdd.ny.gov/sites/default/files/documents/overview_of_services_for_willowbrook_class_members_7.pdf)

B. CCO/HH entities shall deliver Health Home core services in a manner that comports with the following provisions:

- i. CCO/HH will identify the individual's status as a Willowbrook Class Member in its electronic care planning data system.
- ii. All Willowbrook Class Member's Active Representation (Appendix H of the Permanent Injunction) status will be reflected in the electronic care planning data system and this status must be reviewed and updated on at least a semi-annual review basis or more frequently as needed. The Care Manager will ensure

that Active Representation is being reviewed on an ongoing basis and make referrals to the CAB as mandated when necessary.

- iii. A copy of the Willowbrook Class Member's Notice of Rights will be retained in the Class Member's record in the electronic care planning data system. This Notice of Rights will be provided to all service providers that deliver services to the Willowbrook Class Member.
- iv. The names and contact information for the parties involved in the Willowbrook case (Plaintiff's Counsel for the Willowbrook Class: the New York Civil Liberties Union and New York Lawyers for Public Interest, the Executive Director of the CAB, and the Independent Evaluator in the case of Willowbrook Class Members who remain on Attachment 1 to the Permanent Injunction), in addition the OPWDD Administrative Liaison, the OPWDD Office of Counsel, and the OPWDD Statewide Willowbrook Liaison, shall be identified in the electronic care planning data system. The appropriate representatives shall receive copies of all notices or other communications, including but not limited to due process notices, incident reports and death notices, as dictated by the Willowbrook Permanent Injunction and OPWDD guidance and Administrative Directives on these matters.
- v. CCO/HHs shall immediately report to the Willowbrook parties listed above: the hospitalization of a Willowbrook Class Member, the placement of a Willowbrook Class Members in a Skilled Nursing Facility or change in other residential placements and/or day program settings, in accordance with appropriate due process notifications as per OPWDD's Community Placement Procedures and/or Permanent Injunction.
- vi. CCO/HH services provided to Willowbrook Class Members must comply with requirements for reporting, investigation, implementation of preventative actions, and other needed follow-up on incidents which pose a risk to the health and safety of the Class Member's as per the Permanent Injunction, and as described in CCO/HH policy guidance. This includes provision of required Willowbrook Incident Notifications.

C. Care Management for all Willowbrook Class Members shall be provided CCO/HHs with the following requirements:



- i. Care Managers shall be a Qualified Intellectual Developmental Professional (QIDP) as that term currently is defined in federal rules 42 CFR 483.430.
- ii. Care Managers shall lead the Interdisciplinary Team.
- iii. Care Managers shall fulfill the role as defined in Appendix I of the Willowbrook Permanent Injunction.
- iv. Care Manager's caseload shall be no greater than a 1:20 ratio.
- v. Care Managers shall have at least a monthly face-to-face contact with each Willowbrook Class Member on the Care Manager's caseload. The Care Manager shall prepare monthly case notes that conform with service coordination requirements.
- vi. Care Manager's shall participate in Willowbrook-specific Care Management Training provided by OPWDD, as well as all other required Care Coordination Training.
- vii. Care Managers shall make every effort to ensure that all appropriate parties, including the Class Member, the correspondent, the Mental Hygiene Legal Services (MHLS) and the CAB are invited and in attendance at all care planning meetings.
- viii. Care Managers must prepare sections two (2) and three (3) of the Life Plan to comport with the requirements of a Care Manager Activity Plan ("CMAP"): The CMAP must be reviewed and updated at least every six months. New activities that the individual with developmental disabilities would like to occur may be added at any time. This review should be documented in the Care Management notes.
  1. The CMAP should be integrated into the Individual's Life Plan;
  2. The CMAP must describe certain short-term care management activities that will effectuate the goals that are most important to the person.
  3. The CMAP must track activities to achieve valued outcomes or other objectives
- ix. Care Managers must prepare the "Care Manager Observation Report" ("CMOR")
  1. The CMOR is required for Willowbrook Class Members who receive Care Management and live in an OPWDD certified residence, including Family Care homes, IRAs, SOICFs, VOICFs, CRs;

2. The CMOR is NOT required for Willowbrook Class Members who live in nursing facilities or non-certified OPWDD residences;
  3. The CMOR shall be completed at a minimum one (1) time in a six (6) month period, (i.e., twice a year; but shall be completed any time the Care Manager observes a significant issue in the home related to health, safety or the environment; and
  4. Care Managers will participate in a collaborative CMOR visit with the local CAB program associate once annually when CAB is involved on behalf of the Class Member.
  5. Care Manager should always have a form when they make a visit to a home where a CMOR is required.
- x. CCO/HH Care Managers shall ensure that no Willowbrook Class Member will be subjected to any aversive conditioning and/or behavioral research or experimentation without approval (see Behavior Modification, ¶ 13, Appendix J).

#### **g. Advisory Body**

CCO/HHs are required to form a representative counsel made up of individuals receiving services and their family/representatives. This Advisory Body will review CCO/HH outcomes and advise CCO/HH leadership regarding policies and CCO/HH operations.

### **1.9 Other Federal and State CCO/HH Requirements**

In addition to the six (6) core services and the CCO/HH standards and requirements contained in Section 1.8, CCO/HHs must also have policies and procedures in place to satisfy each of the requirements below.

1. CCO/HHs will provide core services tailored to meet the needs of individuals with I/DD, as described in this Policy.
2. CCO/HHs must have processes in place to ensure the following:
  - i. Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
  - ii. Language access (written translation and spoken

- interpretation) capability, including language adaptations for non-verbal individuals;
- iii. 24 hour 7 days a week telephone access to a Care Manager;
  - iv. Crisis intervention;
  - v. Links to acute and outpatient medical, mental health and substance abuse services;
  - vi. Links to community based social support services-including housing;
  - vii. Consent for program enrollment and for sharing of information and treatment; and
  - viii. CCO/HHs are required to attest that all notices and informational materials provided to individuals, will be provided in a manner and format that can be easily understood. CCO/HHs must have a mechanism to help individuals understand the requirements and benefits of their Life Plan.
3. CCO/HHs will, to the extent required, collect data and report on specific quality measures required by the State and/or CMS, including those defined in Part I of the CCO/HH Application under “Performance Management and Quality Metrics.” Part 1 of the CCO/HH Application is available at the following link:  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hhidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf)
  4. CCO/HH have approached the providers listed in Part 1 of the CCO/HH Application and obtained the providers’ commitment to be part of the CCO/HH network. Formal evidence of this commitment will be required prior to designation. Contractual agreements must be in place with all organizations for which there is a financial arrangement prior to the first request for reimbursement when partnerships involve a financial arrangement.
  5. Payments which are subject to State mandated rates and other transitional provisions and rates implemented by the State will be made at rates which are not less than those mandated rates. CCO/HHs must have billing systems in place for submitting timely billable information to eMedNY via the 837EDI, and be prepared to modify 837i submission to MMCPs. CCO/HHs must have both an MMIS and National Provider Identification (NPI) number to ensure timely remittance and payment.
  6. CCO/HHs must submit a written attestation that the services specified above will be provided in accordance with the CCO/HH functional components referenced in the CMS SMDL, #10-024.

7. CCO's are required to adhere to all Willowbrook permanent injunction requirements including the requirement to notify the parties of any hospitalization, placement in a Skilled Nursing Facility or change in residential facility.

### **1.10 Standards and Requirements for Managed Care Organizations (MCO) Related to the Provision of CCO/HH Services**

1. MCOs must include information in the CCO/HH Welcome Letter that encourages potentially eligible individuals to enroll in a CCO/HH by including a brief summary of the services and benefits provided by the CCO/HH.
2. MCOs must inform their provider network about CCO/HHs and how they can benefit eligible individuals.
3. After enrollment in the CCO/HH, MCOs must share current claims data and demographic information, including information received from New York Medicaid Choice (NYMC), with CCO/HHs as long as the MCO is included on the consent form.
4. MCOs must identify a single point of contact and establish communication protocols with CCO/HHs single point of contact.
5. MCOs must have policies and procedures in place to inform and assist CCO/HHs in responding when critical events occur, including when an individual 1) has presented at a hospital emergency room/emergency department (ER/ED) and was not admitted 2) is admitted to an inpatient hospital or 3) is in crisis. MCOs will be involved in the discharge planning process and make timely determinations on any requests for authorization (if applicable and as per the MMMC model contract).
6. MCOs must have policies and procedures in place that provide for timely and effective communications between the MCO and Care Managers when an individual receives services at an ER/RD, Comprehensive Psychiatric Emergency Program (CPEP), Crisis Respite, residential addiction program or inpatient setting, to ensure the individual is safely transitioned to a subsequent setting when such services are no longer necessary. Such policies and procedures shall ensure that individuals have timely access to follow-up care post-discharge and that the individual's Life Plan is updated as necessary.
7. MCOs will review Life Plans for consistency with assessment results and known individual health needs, and make coverage and medical necessity

determinations for services included in plans of care within timeframes established in the MMMC Model Contract.

8. MCOs and CCO/HHs must establish clear lines of responsibility to ensure services are not duplicated.
9. MCOs will ensure that CCO/HHs offer individuals choice of providers that include providers not part of the CCO/HH.
10. When an individual requests withdrawal from CCO/HH enrollment and enrolls in Basic HCBS Plan Support, the MCO shall require through the CCO/HH Agreement, that the CCO/HH cooperate with the entity assuming such responsibilities and transfer all relevant records and materials necessary for the continuation of Basic HCBS Plan Support.
11. CCO/HHs must ensure when referring an individual enrolled in a MMCP to specific providers that the CCO/HH refers them to a provider within the MMCP's provider network.

## Section II: Requirements for CCO/HH Participation

### 2.1 CCO/HH Application

The initial implementation and approval of the State Plan for Health Homes by CMS in 2012 envisioned that Health Homes would initially serve adults, expand to serve children (2016), and then expand to serve individuals with I/DD. NYSDOH and OPWDD are working to expand and tailor the Health Home Care Management Program to serve individuals with I/DD. OPWDD's vision is that CCO/HHs will serve as important regional leaders in the development of specialized Managed Care options for individuals with I/DD.

The State has designated CCO/HHs to serve regional areas that are defined and in alignment with OPWDD DDROs. Those regions are defined as follows:

**Region 1** – Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates

**Region 2** – Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, St. Lawrence, Tioga, Tompkins

**Region 3**- Albany, Columbia, Dutchess, Fulton, Greene, Montgomery, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester

**Region 4 – Bronx, Kings, Queens, New York, Richmond**

**Region 5 – Suffolk, Nassau**

The State's goal is to provide CCO/HH services Statewide, including a choice of CCO/HH in a region wherever possible. CCO/HH Applicants identified the OPWDD region(s) they intend to operate in and were required to apply for designation in all counties in an OPWDD region. Applicants could request designation to serve part of an OPWDD region on an exception basis, provided the counties are contiguous and that approval of the CCO/HH coverage area supports the State's goal of Statewide coverage and choice of CCO/HH.

Successful CCO/HH Applicants demonstrated the capacity to provide Health Home Care Management and deliver the six (6) core services to individuals who live in all counties within the area the CCO/HH they are approved to operate in. Successful CCO/HH Applicants were required to demonstrate the capacity to serve 10,000 enrollees. Applicants with a capacity to serve at least 5,000 enrollees were considered for designation; however, such Applicants were also required to share a financial plan for review and consideration.

A list of the designated CCO/HHs can be found at:

<https://opwdd.ny.gov/news-and-publications/press-release/new-york-provides-people-developmental-disabilities-improved-way>

During specific designated application periods, and as directed NYSDOH and OPWDD, organizations applied to participate in the CCO/HH program. Enrollment periods for additional CCO/HHs will be determined by the State as needed. If the State determines that there is a need for additional CCO/HHs, specific instructions for completing a Medicaid CCO/HH provider application will be posted to the NYSDOH Health Home website.

The State has designated CCO/HHs statewide in the five (5) OPWDD regions. These CCO/HHs have been designated for an initial period of three (3) years from the effective date of the respective CCO/HH SPA.

After the initial three (3) year period of designation, NYSDOH and OPWDD will collaboratively review each CCO/HHs performance to determine if the CCO/HH will be re-designated. State re-designation of CCO/HH will be determined based on the needs of the State, compliance with Federal and State program requirements designed to meet the CCO/HH goals of decreased inappropriate inpatient admissions and emergency department visits, and improved health outcomes of individuals with I/DD. Performance on process and quality metrics, effective engagement, retention rates and satisfaction of CCO/HH enrollees will be considered.

CCO/HH providers are expected to develop and maintain a network of partnerships with cross-system service providers to meet the requirements of the CCO/HH Care

Management model and support effective Care Management and coordination for all CCO/HH enrollees.

## 2.2 Application Instructions for CCO/HHs

CCO/HH Applications were reviewed and approved by a team of State staff from NYSDOH and OPWDD. The State evaluated the comprehensiveness of the CCO/HH Applicant's partner network (including the inclusion of qualified Care Managers and current MSC Service Coordinators and providers' with expertise in providing physical, behavioral health and community supports services to individuals with I/DD); the demonstrated ability to meet the standards and requirements of CCO/HH (including the delivery of the six (6) core services); and the demonstrated ability to promote inclusion and cultural competence by establishing sufficient partnerships with entities serving various cultural groups in the region in which the CCO/HH is designated to operate.

Successful Applicants received designation letters, indicating their status as a designated CCO/HH and identifying any contingencies to the designation. Designated CCO/HHs are required to provide the State with a response, within an appropriate timeframe, including an acceptable plan that addresses the contingencies identified in the designation letter to the satisfaction of the State in order to become officially designated.

## 2.3 Designated CCO/HH Disenrollment

If a CCO/HH elects to discontinue provision of CCO/HH services, a six (6) month advance notice is required to NYSDOH and OPWDD. CCO/HH services may not be discontinued without a NYSDOH and OPWDD approved closure/services cessation plan, which includes proper procedures for clinically appropriate enrollee transition.

## 2.4 CCO/HH Provider Eligibility and Enrollment in the NYS Medicaid Program

Designated CCO/HH providers must be or apply to become a New York State Medicaid enrolled provider with a Category of Service (COS) 0265 (Case Management). In order to be enrolled (or be eligible for enrollment) in the State's Medicaid program the CCO/HH providers must agree to comply with all Medicaid program requirements. CCO/HH providers can either directly provide, or subcontract the provision of CCO/HH services for one (1) year ending 6/30/19. The CCO/HH provider is responsible for all CCO/HH program requirements, including services performed by the subcontractor(s).

A Medicaid provider enrollment application for CCO/HHs can be obtained at: <http://www.emedny.org/info/providerenrollment/index.aspx>. Once located, scroll to the bottom of the page and select the "Health Homes" link.

Completed applications should be sent to eMedNY at the address provided in the application instructions.

Questions regarding the provider enrollment applications should be directed to eMedNY at 1-800-343-9000.

Note: Designated CCO/HH providers that may hold specific license(s) and/or certificate(s), such as Article 28 of the Public Health Law, and/or Article(s) 16, 31, and 32 of the Mental Hygiene Law may have additional requirements established by the respective governing bodies.

For additional information, refer to the NYSDOH Health Home website at the link below: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/)

## 2.5 CCO/HH Network Partner Development

Designated CCO/HHs must provide NYSDOH and OPWDD with an updated network partner list upon designation and as the list changes. CCO/HHs are required to complete a Medicaid Data Use Agreement (DUA) and their CMA network partners are required to complete a Business Associate Agreement (BAA) in order to receive and share information from the CCO/HH.

## 2.6 Medicaid Data Use Agreement (DUA)

CCO/HHs must request the DUA directly from the NYSDOH Office of Health Insurance Programs, Division of Operations and Systems, Security and Privacy Bureau. CCO/HHs must submit completed DUAs to the Security and Privacy Bureau and receive acceptance, in order to obtain Medicaid Confidential Data (MCD) for CCO/HH enrollees from NYSDOH/OPWDD. Completed DUA applications should be sent to: [doh.sm.Medicaid.Data.Exchange@health.ny.gov](mailto:doh.sm.Medicaid.Data.Exchange@health.ny.gov)

The purpose of the DUA is to establish a legally binding agreement between the Requesting Organization (Requestor) and NYSDOH by defining the terms and conditions of the MCD release, should NYSDOH accept the Requestor's Agreement. An additional purpose of the DUA is to assure NYSDOH that the Requestor will maintain the security of MCD that NYSDOH releases to the Requestor.

The DUA must be completed and accepted prior to the State's release of the individual's information, which is considered MCD and PHI. In addition, the DUA, when accepted by NYSDOH, forms an agreement between the CCO/HH and NYSDOH and OPWDD as to the terms and conditions under which the release of data will be made. MCD/PHI includes all information about an individual as well as enrollment information and eligibility data. CCO/HH CMA partners and any contractors that will receive MCD are required to complete a BAA.

The DUA/BAA must be approved in order for the CCO/HH to share an individual's information with the CMA network partners. The BAA requires a signature from an individual authorized to bind the organization to legal agreements. A Medicaid provider



that may be involved in the treatment of an individual and who is NOT providing Care Management services to them prior to consent for CCO/HH services is NOT required to complete the DUA/BAA, as their privacy and confidentiality issues are covered under their regular provider packet with Medicaid.

## **2.7 Use of Medicaid Enrolled Providers for Provision of Care Management Services**

Network partners providing Care Management services should be NYS Medicaid enrolled providers for category of service (COS) 0265 (Health Home Care Management) with a MMIS provider identification number. A MMIS number is required to communicate CCO/HH billing, and process and quality metrics between NYSDOH, MCPs, and CCO/HHs.

## **2.8 Use of Network Partners that are Non-Medicaid Enrolled Providers**

CCO/HHs and contracted network CMAs are encouraged to use Medicaid enrolled providers but the State understands that CCO/HHs may not always have the option to do so. In those instances, CCO/HHs may contract with non-Medicaid providers to deliver CCO/HH services. The contracted services may include, but are not limited to, peer counseling, nutrition, vocational or housing supports. In these instances, it is up to the entities involved to form partnership and payment agreements to reimburse providers commensurate with the level of services provided. The State expects that CCO/HHs will be responsible for monitoring the appropriateness, timeliness and quality of services provided by these non-Medicaid providers. If these providers are paid from the CCO/HH per member per month (PMPM) fee, the CCO/HH must ensure that all payment agreements include the following:

- If applicable, the non-Medicaid provider must certify that information submitted in support of services is accurate, complete and truthful and certify that they will not submit false claims for payment;
- If applicable, the non-Medicaid provider must agree to comply with laws designed to prevent fraud and abuse;
- If applicable, the non-Medicaid provider must agree to report to the CCO/HH any incidents, suspected fraud, waste, or abuse or criminal acts;
- If applicable, the non-Medicaid provider agrees to be bound by the confidentiality provisions (2.9 of the Administrative Health Homes Services Agreement); and
- If applicable, the non-Medicaid provider must certify that none of its owners, employees or contractors is an “ineligible person.” Ineligible person means an individual or entity who (1) is ineligible to participate in Federal health

care programs, (2) has been convicted of a criminal offense subject to Office of Inspector General's (OIG) mandatory exclusion authority described in Section 1128(a) of the Social Security Act, or (3) is currently ineligible to participate in State medical assistance programs, including Medicaid or New York Child Health Plus (CHIP), or State procurement or non-procurement programs as determined by a State governmental authority.

Model language for these agreements and references to the applicable laws and statutes can be found in Sections 6.18, 6.19, and 6.20 of the Administrative Health Home Services Agreement being used for CCO/HHs and MMCPs to use for the delivery of CCO/HH services. It is available on the NYSDOH Health Home website at: [http://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/docs/administrative\\_health\\_home\\_services\\_agreement.pdf](http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/administrative_health_home_services_agreement.pdf)

DOH and OPWDD will be drafting approved model language for the CCO/HH and MMCP transition.

## 2.9 Changes to Originally Approved CCO/HH Application

CCO/HHs must adhere to the CCO/HH provider qualification and standards, functional requirements, and guidelines as outlined by CMS, in SMDL#10-024, Health Homes for Enrollees with Chronic Conditions. If a CCO/HH intends on making changes to their originally approved CCO/HH Application and designation letter, then a Health Home Notification of Change Form attesting to the applicable revision(s) must be completed, signed by the CCO/HH CEO/Executive Director, and submitted to both NYSDOH and OPWDD for review. Submitting a completed Health Home Notification of Change Form will allow NYSDOH to update the CCO/HH file, provide any needed guidance regarding provider enrollment and advise on any requirements that may result from changes in the partner network (i.e. including amendments to DUA Applications and CCO/HH Consent Forms).

Changes to the CCO/HH infrastructure/organization may include, but are not limited to, the following:

- CCO/HH Name,
- Billing Agent,
- DUA, and
- Partner Network

Changes to the CCO/HH partner network need to be reported by using the Health Home Notification of Change Form outlined above only if the change:

- (a) will result in the CCO/HHs inability to offer the full range of CCO/HH services as submitted in the initial application, or
- (b) will impact the CCO/HHs ability to remain in compliance with CCO/HH

standards and guidelines as outlined by the CMS, in the SMDL #10-024, Health Homes for Enrollees with Chronic Conditions, or

(c) was a result of a failure of a partner to meet expectations, or

(d) includes changes or additions of CMAs, or other partners receiving an individual's demographic data prior to obtaining the CCO/HH consent; this may require either an application to amend the existing DUA or the need to file a new DUA.

A copy of the Health Home Notification of Change Form can be found at the following link: [https://www.health.ny.gov/health\\_care/...health\\_homes/.../change\\_notification.docx](https://www.health.ny.gov/health_care/...health_homes/.../change_notification.docx)

The Health Home Notification of Change Form and questions concerning it may be submitted electronically to the Health Home mailbox at this link: [hhidd@health.ny.gov](mailto:hhidd@health.ny.gov)

To email Health Homes, visit the NYSDOH Health Home Website and click on the tab "Email Health Homes" or go directly to: [https://apps.health.ny.gov/pubdoh/health\\_care/medicaid/program/medicaid\\_health\\_homes/emailHealthHome.action](https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action)

Questions may also be directed to the NYSDOH Health Home program at (518) 473-5569.

## Section III: Rate Setting Methodology

### 3.1 CCO/HH Rates and Tiering

CCO/HH providers that meet State and Federal standards will be paid a PMPM Care Management fee that is based on region, assessment data, residential status and other functional indicators. A unit of service will be defined as a billable unit per service month. To be reimbursed for a billable unit of service per month, CCO/HH providers must, at a minimum, provide active Care Management by providing at a minimum, at least one (1) of the core services per month. Once an individual has been assigned a Care Manager and is enrolled in the CCO/HH program, the active Care Management PMPM may be billed. Care Managers must document all services the individual receives in their Life Plan.

The Care Management PMPM will include four (4) rate tiers that are calculated via information stored in OPWDD's internal Tracking and Billing System (TABS). The rate tier of an individual is determined by region, the acuity/functional capability status of the individual, the intensity of care coordination required to serve the individual, whether the individual lives in their own or family home, in a community living setting, has lived or currently lives in a certified residential setting and whether they are a member of a 'special group status' (i.e., self-directing individuals, START participants, and

Willowbrook Class Members). OPWDD will calculate and transmit corresponding tier levels for CCO/HH enrollees on the first of each month. This information will be sent via secure file transfer and identify information that will allow the CCO/HH to bill at the appropriate reimbursement level.

For individuals new to the OPWDD service delivery system, the tiered Care Management PMPM for the first month of enrollment in the CCO/HH is adjusted to include costs related to preparing an initial Life Plan; an initial Medicaid application, if needed; and gathering documentation and records to support the individual's I/DD diagnosis and ICF Level of Care eligibility determination. The PMPM rate tiers are calculated based on total costs relating to the Care Manager (salary, fringe benefits, non-personal services, capital and administration costs) and, for each tier, caseload assumptions. The State will periodically review the CCO/HH payments in conjunction with Department of Labor salary data to ensure that the CCO/HH rates are sufficient to ensure quality services.

At the onset of CCO/HHs on July 1, 2018, the acuity will be derived from an algorithm using the DDP2 data. The State has developed a new state approved assessment tool known as the CAS. Upon statewide implementation of the CAS, it will be used to calculate and determine the individual's rate tier.

#### **Additional Information Regarding the Rate Setting Methodology for CCO/HH**

The CCO/HH PMPM levels were predicated upon the following:

1. Cost: Not-for-profit provider cost data related to the existing Medicaid Service Coordination program was utilized to establish baseline funding needs, with adjustments to compensation to promote consistent salary levels with CCO/HH reimbursement standards for existing eligible populations.
2. Acuity: Everyone enrolled in the CCO/HH will be assigned to one (1) of four (4) tiers based on a variety of factors, including special group status, health and behavioral health scores and living setting. Each tier supports increasingly intense staffing ratios. The fees also assume varying levels of direct clinical expertise to support the comprehensive approach to Care Management the CCO/HH contemplates, while operating outside of a Managed Care environment.

Three (3) components are used to assign a rate tier (i.e., a care coordination need/intensity level). These include the DDP2 Health Score, the DDP2 Behavior Score, and special group status membership. The Health and Behavior scores are assigned a point value depending on where these scores fall on the continuum of possible scores (see Table 1 and Table 2 below).

**Table 1: Health Score Care Coordination Need Score**

Health Score Range*	Point Score
Under 1.24 SD	0
1.25 – 2.49 SD	0.5
2.5 SD and Above	1.25

**Table 2: Behavior Score Care Coordination Need Score**

Behavior Score Range*	Point Score
0	0
Above 0, under 1.24 SD	0.5
1.25 – 1.74 SD	1
1.75 SD and Above	2.5

The special group statuses include: self-directing with budget authority; START participants, and special population (i.e., those who have lived or are currently living in a special setting: CIT/LIT/RIT/MDU/Autism Unit). Membership to one (1), or more, of these special groups are also assigned a set point value (see Table 3 below).

**Table 3: Special Group Status Care Coordination Need Score**

Special Status	Point Score
Self-Directing with Budget Authority	1.0
Special Population (e.g., CIT)	2.5
START Services	2.5

Next, the corresponding special group status, health, and behavior point scores\* are summed and individuals are assigned to either the Standard, Enhanced, or Enhanced Plus Care Coordination Need level (see Table 4 below).

\* The Health and Behavior Score ranges are based on a set amount of variation (i.e., Standard Deviation (SD)) from the average health or behavior score.

**Table 4: Total Score and Care Coordination Need Level**

Level	Total Score
Standard	0 to .99
Enhanced	1.0 to 2.4
Enhanced Plus	2.5 and above

Individuals are then grouped into one of two residential settings: community living or certified residential setting. Certified residential settings include: Individualized Residential Alternative (IRAs), Community Residences (CRs), Family Care, and Developmental Centers.

Community living includes all other settings (including Individualized Supports and Services (ISS)). Once the care coordination need level and living setting are determined, a care coordination tier is assigned (Table 5 below).

**Table 5: Care Coordination Tiers**

Care Coordination Tier	Living Setting	Care Coordination Need Level
Tier 1	Certified Residential	Standard
		Enhanced
Tier 2	Certified Residential	Enhanced Plus
	Community Setting	Standard
Tier 3	Community Setting	Enhanced
Tier 4	Community Setting	Enhanced Plus

Tier 1 includes those who have lived or are currently living in certified residential setting falling in standard or enhanced care coordination levels. Tier 2 includes those who have lived or are currently living in certified residential settings falling into the Enhanced Plus care coordination level and those who have lived or currently living in the community with standard care coordination level. Tier 3 includes those who have lived or are currently living in the community, falling within the Enhanced care coordination need level. Tier 4 includes those who have lived or are currently living in the community, falling into the Enhanced Plus care coordination need level. Tier 4 also includes

Willowbrook Class Members, who are assigned to Tier 4 solely based on Class Membership.

3. Region: PMPMs will vary based upon the region in which the individual receives services. There are two regions – Upstate and Downstate. The total spread between the fees for each region is approximately 7%. Included in this differential is a “rurality” adjustment that is applied to Upstate fee levels, reflecting the productivity loss that care coordinators in this region will experience, given the greater dispersal of CCO/HH enrollees.

### 3.2 Comprehensive Assessment Policy

NYSDOH and OPWDD are responsible for the oversight of the CCO/HH care management service model which ensures all professionals involved in an individual’s care communicate with one another so that the individual’s developmental disability, medical, behavioral health (mental health and substance use), rehabilitative, long term care and social service needs are addressed in a comprehensive manner.

CCO/HHs provide the strong person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD. CCO/HHs are responsible for providing Care Management to all individuals enrolled in CCO/HHs. Care Management includes the education and engagement of an individual in making decisions that help promote independent living skills, lifestyle choices that achieve the goals of good health, supports and services for their needs, early identification of risk factors, and appropriate screening for emerging health problems. CCO/HHs must ensure that materials and conversations are adapted to the individual’s comprehension level and provide the supports necessary for the individual to understand and implement care coordination and health promotion practices.

CCO/HHs are required to complete a comprehensive assessment process, informed by the State approved functional needs assessment, to create, document, execute, and update individualized Life Plans. The individual’s Life Plan integrates the continuum of supports related to the individual’s developmental disability needs, medical, behavioral health services, rehabilitative, long term care, social service needs, and clearly identifies providers directly involved in their care.

The individual and/or their family/representative must play an active role in the comprehensive assessment process and the development and execution of the Life Plan. Family and other supports should be clearly identified in the Life Plan, along with their role in its execution. The Life Plan must be responsive to the individual’s service needs, and their life goals and aspirations.

During the first year of implementation, CCO/HHs may provide Care Management directly or contract with a CMA. After 7/1/19, CCO/HHs will solely be responsible for

care coordination for individuals with I/DD and contracting with a CMA will not be allowed.

## Policy

As specified in the CCO/HH SPA, CCO/HHs are required to provide the six (6) core services: Comprehensive Care Management, Care Coordination and Health Promotion, Comprehensive Transitional Care, Individual and Family Support, Referral to Community and Social Support Services and Use HIT to link services. Within comprehensive Care Management, a comprehensive assessment process that identifies developmental disability, medical, behavioral health (mental health and substance use), and social service needs is required.

This comprehensive assessment process is a care planning mechanism to develop the individual's person-centered plan of care, known as the Life Plan, which meets the other core services. The State approved functional needs assessment must inform the comprehensive assessment process that CCO/HHs use in the development of the Life Plan.

NYSDOH and OPWDD will ensure that CCO/HHs establish and maintain policies and procedures that define how and when the comprehensive assessment process is completed for all CCO/HH enrollees; the frequency at which the comprehensive assessment process will be completed; clear and focused training on how the comprehensive assessment process is completed; how various elements will be obtained; and a Quality Assurance program to ensure compliance with specified requirements.

Unless specifically stated, this policy applies to adults and children enrolled in CCO/HHs.

### The CCO/HH Comprehensive Assessment Process for all CCO/HH Enrollees

A comprehensive assessment process is both a mandatory functional approach for data collection, as well as an ongoing, dynamic process of information gathering, and an evaluation of the individual's health care and related needs. The information collected must result in a fully integrated Life Plan. The comprehensive assessment process will:

- be informed by the State approved functional needs assessment;
- include a detailed description of the individual's developmental disability support needs, medical and behavioral health (mental health and substance use), as well as psychosocial conditions and needs;
- include an assessment of social determinants of health including the individual's lifestyle, behaviors, social environment, health literacy, and Care Management needs such as entitlement and benefit eligibility and recertification;



- include independent living skills (i.e. activities of daily living (ADLs), instrumental activities of daily living (IADLs)) and self-management skills (from eating to meal planning, dressing, bathing, toileting, communication, mobility, transportation, thinking and planning, sociability/coping skills, activities/interests);
- include a portion that evaluates necessary safeguards to support the individual's overall health and wellbeing;
- include the individual's strengths, support system, and resources;
- include information on transition to adult services for adolescents and transition age youth; and
- include child development milestones and information regarding educational skills and needs for children.

The State approved functional needs assessment does not provide detailed and specific information to fully complete the comprehensive assessment process used to populate the Life Plan and to provide comprehensive Care Management services. However, the State approved functional needs assessment can inform areas of specific need where attention should be paid within the comprehensive assessment process.

The CCO/HH comprehensive assessment process will identify service needs currently being addressed; service and resource needs requiring referral; gaps in care and barriers to service access; and the individual's strengths, goals, and resources available to enhance Care Management efforts and empower personal choice and decision making. The Care Manager will assess for the individual's safeguard needs that will include, but not be limited to; harm to self or others; choking, risk of falls, bowel obstruction, fire safety, food and/or housing instabilities, and safety in the community. CCO/HHs must provide training, guidance, and resource support for all staff (including CMAs when applicable) to support early identification of risk factors.

With the individual's consent, information should be gathered from a variety of sources, for example, current service providers; family and natural supports; community based resources; faith-based organizations identified by the person; and self-report. Where information can be obtained, and transferred from the State approved functional needs assessment and/or other assessments or evaluations, this information can be used in the comprehensive assessment process. For example, the required elements of the comprehensive assessment process may be collected within different documentation gathered and stored in the electronic health record. The CCO/HH will provide direction to support staff in understanding the link of each document and how it fulfills the comprehensive assessment process requirements.

CCO/HHs support continuity of care and health promotion through the development of a supportive relationship with the individual and their care planning team. The care planning team can assist the Care Manager in providing historical information, current service/program care plans, and reviewing outcomes of the comprehensive assessment process information. However, the CCO/HH Care Manager takes full responsibility for the comprehensive assessment process and required documentation as the single point of contact for the coordination of care as outlined in this policy.

## Frequency

For individuals new to the CCO/HH, who have never previously received MSC or PCSS: within sixty (60) days of an individual being enrolled in a CCO/HH, the Care Manager shall conduct a face-to-face meeting with the individual and/or their family/representative, convene the care planning team, review the State approved functional needs assessment, complete the comprehensive assessment process, and develop the individual's Life Plan using a person-centered planning process.

For individuals who have previously received MSC or PCSS and who enrolled on 7/1/18, the timeline will follow, in most cases, the individual's established schedule for care planning meetings (i.e. the twice annual required ISP review). For CCO/HH enrollees in Tier 4, the highest payment Tier (Tier 4 includes all Willowbrook Class Members), the Care Manager shall conduct a face-to-face meeting with the individual and/or their family/representative, convene the care planning team, review the State approved functional needs assessment, complete the comprehensive assessment process, and develop the individual's Life Plan using a person-centered planning process at the next review meeting, but no later than December 30, 2018 (six (6) months following the July 1, 2018 start of CCO/HH services).

For CCO/HH enrollees in Tiers 1, 2 or 3, the Care Manager shall conduct a face-to-face meeting with the individual and/or their family/representative, convene the care planning team, review the State approved functional needs assessment, complete the comprehensive assessment process, and develop the Life Plan using a person-centered planning process at the next "annual" review meeting, but no later than June 30, 2019 (twelve (12) months following the July 1, 2018 start of CCO/HH services).

For all CCO/HH enrollees, the comprehensive assessment process and initial Life Plan development must occur earlier than the above schedule if there is a significant change in the needs of the individual or if requested by the individual and/or their family/representative.

An annual comprehensive reassessment process of each CCO/HH enrollee is required. If the individual experiences a significant change in support needs related to their developmental disability, medical and/or behavioral health or social needs before the annual review, a comprehensive assessment process is not necessary. However, the Care Manager should perform a review of the individual's current status and all elements of the Life Plan particularly needed safeguards, and consult with the individual and/or their family/representative and care planning team to identify necessary changes to the Life Plan and safeguards; it should then be reviewed and signed by a supervisor. Any changes in the individual's goals or service needs should be reflected in the Life Plan and trigger a case review with a supervisor or applicable members of the care planning team. Such significant changes to the individual's condition and/or Life Plan should be reflected later in the annual comprehensive reassessment process.

## Training

CCO/HHs should have clear and focused operationalized policies and procedures that provide well-defined direction to Care Managers regarding training for completing the comprehensive assessment process. Training must also address understanding the function, purpose and use of the State approved functional needs assessment to inform the comprehensive assessment and person-centered planning processes. CCO/HHs must provide access to and information regarding training opportunities that include understanding the person-centered planning process.

## Quality Management Program (QMP)

CCO/HHs must have a Quality Assurance process in place to ensure that Care Managers comply with CCO/HH policies and procedures. Quality indicators must include:

- Completing the comprehensive assessment within required timeframes, and annually thereafter or upon a significant change in condition
- Using the State approved functional needs assessment, including a review with the individual and/or their family/representative, and supports, to inform the comprehensive assessment process
- Gathering information from various sources based on the individual's need (i.e., developmental disability service providers, primary care provider (PCP), Article 16 clinic providers, and behavioral health provider(s) within thirty (30) days
- Addressing all required components of the comprehensive assessment process
- Including members of the CCO/HH enrollee's care planning in the comprehensive assessment process
- Notifying the Care Manager and/or Care Manager supervisor of adverse events and indications of change in the individual's safeguard needs.

## Required Components of the CCO/HH Comprehensive Assessment Process

The following are the required components of the comprehensive assessment process which will inform the Life Plan. The individual has a choice in the sharing of the information gathered during the comprehensive assessment process with their service providers, as not all information may be relevant to the provision of a specific type of support or service.

The components of the comprehensive assessment process must include the following:

### Identification Information

CCO/HH Eligibility and appropriateness criteria (can be completed during intake and verification noted in the assessment process):

- OPWDD eligibility
- ICF Level of Care eligibility determination

- Medicaid eligible
- CCO/HH consent form

#### CCO/HH Enrollee Information

- Contact information
- Parent/guardian/legally authorized representative information, actively involved family member (if applicable)
- Primary language (understood and spoken)
- Is interpreter and/or translation of documents needed?
- Ethnic/cultural background
- Spirituality/faith
- Willowbrook Class Members, representation status

#### Review of the State approved functional needs assessment based upon:

- Identification of areas that require additional review through the comprehensive assessment process
- Use of information from the State approved functional needs assessment to inform the comprehensive assessment process, where applicable.

#### Independent Living Skills

##### Functional assessment, performance & capacity including ADL's and IADL's

- Language skills (receptive and expressive)
- Memory/learning
- Ability to dress, bathe self; personal hygiene; toileting, mobility, positioning, transferring
- Needs assistance eating
- Meal preparation
- Housekeeping/cleanliness
- Managing finances, ability to shop
- Managing medications
- Phone use
- Transportation
- Problematic social behaviors
- Tie back to medical/behavioral health components
- Does the individual have support to help with ADLs and/or IADLs?
- Developmental milestones (children)

##### Skills and resources needed to achieve goals

Strengths of the individual

Is there engagement in the plan?

Identify barriers to service

## Medical Health Care

Current medical diagnoses; for each diagnosis (illness), assess:

- Illness history
- Hospitalizations and other treatments
- For Willowbrook Class Members, hospital staffing needs
- Symptoms and severity
- Adherence to treatment
- Is illness controlled or uncontrolled?
- Dental care

Health promotion (examples)

- Body Mass Index (BMI)
- Diabetes/metabolic disease
- Asthma/respiratory disease
- Cardiovascular disease
- Living with HIV/AIDS
- Physical activity (adequate/inadequate?)

Is there engagement in treatment plan/services?

Advanced directives?

Identify barriers to service

## Behavioral Health Services (if applicable)

Psychiatric History

- Illness history
- Hospitalizations and other treatments

Current problems

- Service use within the last twelve (12) months
- Current functioning
- Symptoms and severity
- Diagnoses
- Dangerous/suicidal behavior
- Trauma/abuse history

Need for behavioral support services

- Challenging behaviors
- Does the individual have a Behavior Support Plan (BSP)
- Use of restrictive physical interventions

Skills and resources needed to achieve goals

Strengths of the individual

Is there engagement in the treatment plan/services?

Identify barriers to service

### Areas for Safeguard Review

- Bowel obstruction
- Choking
- Risk of falls
- Self-harm behaviors
- Fire safety
- Safety in the community
- Housing and/or food instability

### Social Service Needs

#### Financial

- Financial resources/representative payee
- Social Security
- SSI Benefits? Y/N
- Supplemental Nutrition Assistance Program (SNAP)
- Other Financial Resources (i.e. employment)
- Other insurance (y/n) and name
- Other public social service benefits
- Clothing

#### Transportation

- Access to public or private transportation? If so, what is the mode of transportation?
- Medical transportation required or needed (i.e., wheelchair, stretcher)?

#### Legal

- Legal /Needs Status (incarceration, probation, etc.)
- Legal Status Impact on Housing (i.e. Incarceration, probation, etc.)

Any additional social service needs?

Skills and resources needed to achieve goals

Strengths of the individual

Identify barriers to service

### Community/Social Participation and Inclusion

- Interest in self-help, advocacy, and empowerment activities
- Social support network
- Family support systems
- For Willowbrook Class Members, expectations for community inclusion

Skills and resources needed to achieve goals

Strengths of the enrollee

Identify barriers to community/social inclusion

## Educational/Vocational Status

### Education

- Level of education
- If in school:
- Pre-school and/or childcare information
- Current Educational Program/ Individualized Education Plan (IEP), 504 Plan (if applicable)
- Current services and accommodations in educational setting (if applicable)

### Transition Planning (for students ages 14-21)

### Vocational (when applicable)

- Prevocational skills
- History of employment
- ACCES-VR
- Access to vocational rehabilitation and employment programs
- Ticket to work if applicable
- Welfare to work if applicable

Skills and resources needed to achieve goals

Strengths of the enrollee

Identify barriers to service

## Medications

- Pharmacy that individual uses
- Contact information of previous prescribers
- Current medication treatments and doses
- Medical health medications
- Behavioral health medications
- Pain management medications
- Individual/family's understanding of medication and use
- Medication adherence
- Indication as to why individual with chronic condition has no medication

Identify barriers to taking medications

Identify supports that would assist with med management

## Providers

### Treatment Providers Identified

- Developmental Disability provider(s)
- Behavioral Health (Mental Health) provider(s)
- Medical Health provider(s)/specialists
- Other community based providers and/or faith based supports
- Peer support provider

- Educational provider(s)
- Substance use disorder treatment providers
- Deliver the six (6) core services

### 3.3 Performance Management and Quality Metrics

A critical requirement and responsibility of the CCO/HH is performance management and quality oversight. CCO/HHs are responsible for ensuring that high quality Care Management services are delivered to individuals with I/DD. To assist CCO/HHs and Care Managers, in monitoring quality and performance, as well as tracking and reporting key performance measure to CMS and stakeholder(s), the State has developed a comprehensive set of performance measures. The measure set was derived from the measures identified in the NYS Health Home SPA, Health Home Core Set and CMS Health Home Core Quality Measures. The CMS Quality Measures were specifically designed to assess the CCO/HH service delivery model. The majority of measures are National Committee Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures or developed by NYSDOH and OPWDD.

The performance measures monitor overall quality and the degree to which the CCO/HH model, as authorized under the ACA, is meeting its goals, including:

- Reducing utilization associated with avoidable (preventable) inpatient stays;
- Reducing utilization associated with avoidable (preventable) emergency room visits;
- Improving outcomes for individuals with I/DD through care coordination (health as well as personal/social outcomes);
- Improving disease-related care for chronic conditions;
- Improving preventive care;
- Improving transitional care;
- Reducing utilization associated with inpatient stays.

Note that these measures do not require separate data collection efforts on the part of the CCO/HH. Measurement of the process and outcome of the CCO/HH program will be necessary to understand the value of the overall program and the efficacy of any one (1) component. The measurements will also help guide process improvement that may be implemented.

The complete list of performance measures can be found at the following link:  
[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/docs/measures.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/measures.pdf)

For additional information on the proposed outcome metrics, quality measures, and CCO/HH core measures, please refer to Part 1 of the CCO/HH Application at the following link:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hidd_application_part_1.pdf)



In addition, the NYSDOH Health Home Performance Management webpage can be found at the following link:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/performance/index.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/performance/index.htm)

In addition to these measures, other metrics such as a satisfaction survey may be conducted in the future to help guide improvement processes within the program. The State has also added the following performance metrics tailored for individuals with I/DD. These measures will be reviewed as part of the State’s ongoing stakeholder engagement.

**Quality and Process Metrics for the CCO/HH Population**

**Goal: Improve outcomes for individuals with I/DD through care coordination (health/personal/social)**

Measures	Data Source	Measure Description
Implementation of Council on Quality Leadership (CQL) Personal Outcome Measures (POMS)*	CCO/HH reporting	Percentage of Life Plans that have minimum of two (2) POM measures. CCO/HH must record in Life Plan Personal Outcome Measures (POM) drawn from CQL reporting guidelines. Life Plan must reflect at least three (3) personal goals, of which two (2) must be POM directed.
Implementation of personal safeguards	CCO/HH reporting	Percentage of Life Plans that reflect personal safeguards for all individuals. CCO/HH must record personal safeguards in Life Plan.
Transitioning to a more integrated setting	Claims/ TABS	Of the individuals who are in a 24-hour certified setting, the number/percentage who move to a more integrated setting.
Employment	CCO/HH reporting	Of the individuals who indicate in their Life Plan that they choose to pursue employment, the number/percentage of individuals who are employed (compared to the previous reporting period).  CCO/HH will record individual progress and verify support to find and maintain community integrated employment in Life Plan.

Measures	Data Source	Measure Description
Self-direction	Claims	Of the individuals who select self-direction as indicated in the Life Plan, the number/percentage of individuals who enroll in self-direction) compared to the previous reporting period).  CCO/HH will identify those who choose to self-direct their supports and services with either or both employer authority and budget authority in the Life Plan.

**Goal: Improve Preventive Care**

Measures	Data Source	Measure Description
Bladder and Bowel Continence	CCO/HH reporting CAS	Of the individuals with an identified bladder/bowel health risk, the number/percentage that have a Life Plan in place that includes recording of support or device needs bowel/incontinence tracking protocol, bowel/incontinence management protocol. CCO/HH will report risk based on initial screening.
Falls	CCO/HH reporting	Of the individuals with an identified risk of falls, the number/percentage who have a Life Plan that includes supervision, contact guarding, adaptive equipment, environmental modifications or other-directed support. CCO/HH will report risk based on initial screening.
Choking	CCO/HH reporting	Of the individuals with an identified risk of choking, the number/percentage who have a Life Plan with safeguard(s) including modified consistency of foods and/or liquids, avoidance of high risk foods, requires supervision, formal training/dining plan required. CCO/HH will report risk based on initial screening.

**Goal: Improve Transitional Care**

Measures	Data Source	Measure Description
Supporting individuals' transition from institutional settings to community settings	CCO/HH reporting Claims CAS	Of the individuals who move to a setting other than a 24-hour certified setting, the number/percentage of transitions identified in TABS/claims compared to number/percentage of care transition records transmitted to Health Care Professionals by the CCO/HH. CCO/HH must report transitions from 24-hour certified setting to community placement/setting.

## The CQL POMS

POMS focus on the choices individuals have and make in their lives. The twenty-one (21) POMS developed by CQL are organized into five (5) key indicators and experiences that individuals and their families/representatives have said are most important to them as shown below:

### My Human Security:

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected

### My Community:

8. People use their environments
9. People live in integrated environments
10. People interact with other individuals of the community
11. People participate in the life of the community

### My Relationships:

12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles

### My Choices:

17. People choose where and with whom they live
18. People choose where they work
19. People choose services

### My Goals:

20. People choose personal goals
21. People realize personal goals

The CCO/HH will also be expected to collect and report I/DD-specific outcome data demonstrating the degree to which individuals live in the most integrated setting, including the Transformation goals of increasing the number of people employed, self-directing, and living in the community.

Data regarding evaluating this metric will include:

- # people employed;
- # people supported to self-direct their services;
- # people who are supported in independent, integrated living settings; and
- # people who have moved from a certified setting into a less restrictive environment.

CCO/HHs will be designated for an authorized period (e.g., three (3) years) and will be evaluated and monitored by the State. Performance management efforts by the State, including participation from OPWDD's Division of Quality Improvement (DQI), will include site re-designation surveys, evaluation of performance and quality metrics discussed above, and review of policies and procedures and adherence to CCO/HH standards and requirements. The State will be seeking input from CCO/HHs regarding the re-designation process and intends to work collaboratively with CCO/HHs and MMCPs on performance management processes, goals, and objectives. The State expects the quality measures used to monitor and manage CCO/HH performance will evolve over time, particularly as the I/DD population is moved to Managed Care and Value Based Payment (VBP) arrangements emerge.

### 3.4 CCO/HH Monitoring: Reportable Incidents

The State requires that CCO/HHs providing Health Home Care Management develop incident reporting and management policies and procedures that are in accordance with the requirements set forth in this section. These policies must address how CCO/HHs, and any subcontracted CMAs, handle any reportable incidents of abuse/neglect, as well as other incidents, in compliance with the CCO/HH requirements and standards outlined in the CCO/HH SPA. In addition, CCO/HHs must have a Quality Improvement process in place and ensure that CMAs comply with the policies and procedures the CCO/HH has developed.

If a CCO/HH enrollee is receiving services in a program under the jurisdiction of another State agency (e.g., Office of Mental Health (OMH); Office of Alcoholism and Substance Abuse Services (OASAS); or Office of Children and Family Services (OCFS)) which has stated incident, abuse, neglect, or maltreatment reporting requirements, this policy does not relieve the obligation to report in accordance with such regulations. CCO/HHs must cooperate with other providers' incident management activities and also follow the CCO/HH incident management requirements as described in 14 NYCRR Part 624.

It is the intent of this policy of this to require an incident management system, including the reporting, investigation, review, correction, and monitoring of certain events or situations, in order to protect individuals receiving services, (to the extent possible) from harm; ensure that individuals are free from abuse and neglect; and to enhance the quality of their services and care.

The State will work with CCO/HHs to ensure their established policies and procedures:

- Identify, document, report and review individual incidents on a timely basis;
- Evaluate individual incidents against CCO/HHs and CMAs policies and procedures to confirm quality care coordination activities were provided;
- Review a sample of individual incidents to ensure appropriate preventive or corrective action;
- Identify incident patterns and trends through the compilation and analysis of incident data;

- Review incident patterns and trends to identify appropriate preventive or corrective action; and
- Ensure development and implementation of Quality Improvement strategies to address identified incident patterns and trends.

CCO/HHs incident management and reporting policies must also mandate that the CCO/HH notify OPWDD of reportable incidents. If a CCO/HH believes that an incident has occurred at an OPWDD-certified or operated or funded service provider, then the CCO/HH must also notify the affected provider, thereby engaging that provider's incident management procedure.

The CCO/HH will ensure individual safety and well-being as well as program integrity, overall programmatic expectations, and compliance with CCO/HH standards. Care Managers are required to make certain that the individual's health and safety are an integral component of the care planning process.

For additional information and current OPWDD reporting guidance, please see: [https://opwdd.ny.gov/opwdd\\_resources/incident\\_management/the\\_part\\_624\\_handbook](https://opwdd.ny.gov/opwdd_resources/incident_management/the_part_624_handbook)

The Protection of People with Special Needs Act requires persons who are Mandated Reporters under that Act to report abuse, neglect and significant incidents involving vulnerable persons to the Vulnerable Persons' Central Register (VPCR) operated by the NYS Justice Center for the Protection of People with Special Needs. For additional information and requirements, please see: <https://www.nysmandatedreporter.org/NYSJusticeCenter.aspx>

### **CCO/HH Reporting Responsibilities**

The CCO/HH must follow all requirements of the existing 14 NYCRR Part 624 and 625 regulations. At a minimum, CCO/HHs must immediately review the facts and circumstances of a reported incident and must ensure the individual's safety and well-being, as well as program integrity, overall programmatic expectations, and compliance with CCO/HH requirements and standards. The State will review the incident reported by the CCO/HH and make recommendations, if necessary, to ensure that the CCO/HHs reportable incident policy is appropriate and in compliance with established CCO/HH requirements and standards.

CCO/HHs must submit to both NYSDOH and OPWDD, on a quarterly basis, the total number of reports in each of the categories noted below, as well as the status of each incident. The State will provide CCO/HHs with a template for issuing these quarterly reports and they will be due by the 15<sup>th</sup> business day after the end of the quarter:

- January – March, due April;
- April – June, due July;
- July – September, due October; and
- October – December, due January

For incidents involving Willowbrook Class Members, CCO/HHs must comply with the incident reporting requirements of the Willowbrook Permanent Injunction.

For more information please see the link below:

[https://opwdd.ny.gov/opwdd\\_resources/willowbrook\\_class/willowbrook\\_permanent\\_injunction](https://opwdd.ny.gov/opwdd_resources/willowbrook_class/willowbrook_permanent_injunction)

CCO/HH policies and procedures must mandate that all contracted CMAs inform the CCO/HH of all reportable incidents and serious notable occurrences immediately, including all known facts and circumstances of the incident.

1. Allegation of Abuse/Neglect, including
  - Physical abuse
  - Sexual Abuse
  - Psychological Abuse
  - Deliberate inappropriate use of restraint
  - Use of aversive conditioning
  - Obstruction of reports of reportable incidents
  - Unlawful use or administration of a controlled substance
  - Neglect
2. All Significant Incidents
3. All Notable Occurrences

### **Mandated Reporter Requirements**

CCO/HH Care Managers and other applicable CCO/HH employees are mandated to report suspected child abuse or maltreatment. Reports of suspected child abuse or maltreatment are to be made immediately by telephone, to the mandated reporter line at 1-800-635-1522. The mandated reporter line is available 24 hours a day, 7 days a week. This line is dedicated to mandated reporters. Please do not provide this number to the public, who can report child abuse or maltreatment by calling 1-800-342-3720. In addition to the report made by phone, the mandated reporter must complete a written form (form LDSS 2221A) and submit it, within 48 hours, to the child protective services of which the child resides.

The Office of Child and Family Services offers free training online for mandated reporters that can be completed at any time of day, any day of the week. Upon completion of the online training, participants will electronically receive a certificate of attendance. There are no costs associated with this requirement.

### **Definitions**

#### **(1) Reportable Incidents of Abuse/Neglect**

Any of the following acts by a custodian or an individual service provider. A custodian is a director, operator, employee, or volunteer of an agency; or a consultant or an employee or volunteer of a corporation, partnership, organization, or governmental

entity that provides goods or services to an agency pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services; or a family care provider; or a family care respite/substitute provider.

**(2) Physical abuse**

Conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services, or causing the likelihood of such injury or impairment. Such conduct may include, but is not limited to: slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, or the use of corporal punishment. Physical abuse does not include reasonable emergency interventions necessary to protect the safety of any party.

**(3) Sexual Abuse**

Any conduct by a custodian that subjects an individual receiving services to any offense defined in article 130 or section 255.25, 255.26, or 255.27 of the penal law, or any conduct or communication by such custodian that allows, permits, uses, or encourages a person receiving services to engage in any act described in articles 230 or 263 of the penal law. For purposes of this paragraph only, individuals with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency is not considered a custodian if he or she has sexual contact with another individual receiving services who is a consenting adult who has consented to such contact.

**(4) Psychological abuse**

Any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services.

- (i) Examples include, but are not limited to taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury.
- (ii) In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a substantial diminution of the emotional, social, or behavioral development or condition of the individual receiving services. Evidence of such an effect must be supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker, or licensed mental health counselor.

**(5) Deliberate inappropriate use of restraint**

The use of a restraint when the technique that is used, the amount of force that is used,

or the situation in which the restraint is used is deliberately inconsistent with an individual's plan of services (e.g., Life Plan or a habilitation plan), or behavior support plan, generally accepted treatment practices, and/or applicable Federal or State laws, regulations, or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to individuals receiving services or to any other party. For purposes of this paragraph, a restraint includes the use of any manual, pharmacological, or mechanical measure or device to immobilize or limit the ability of an individual receiving services to freely move his or her arms, legs, or body.

**(6) Use of aversive conditioning**

The application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of an individual receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form. The use of aversive conditioning is prohibited by OPWDD.

**(7) Obstruction of reports of reportable incidents**

Conduct by a custodian that impedes the discovery, reporting, or investigation of the treatment of an individual by falsifying records related to the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter (as defined in section 488 of the Social Services Law) from making a report of a reportable incident to the statewide VPCR or OPWDD with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement, or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies, or procedures; or, for a custodian, failing to report a reportable incident upon discovery.

**(8) Unlawful use or administration of a controlled substance**

Any administration by a custodian to an individual of a controlled substance as defined by Article 33 of the Public Health Law, without a prescription, or other medication not approved for any use by the Federal Food and Drug Administration (FDA). It also shall include a custodian unlawfully using or distributing a controlled substance as defined by Article 33 of the Public Health Law, at the workplace or while on duty.

**(9) Neglect**

Any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of an individual. Neglect includes, but is not limited to:

- (i) Failure to provide proper supervision, including a lack of proper supervision that results in conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian;



- (ii) Failure to provide adequate food, clothing, shelter, or medical, dental, optometric, or surgical care, consistent with Parts 633, 635, and 686, of this Title (and 42 CFR Part 483, applicable to ICFs), and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric, or surgical treatment have been sought and obtained from the appropriate parties; or
- (iii) Failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of Article 65 of the Education Law and/or the individual's IEP.

For definitions of Significant Incidents and Notable Occurrences, refer to OPWDD's 14 NYCRR Part 624 Handbook on the OPWDD Website. Requirements for 14 NYCRR Part 625 Event/Situations are also contained in the Part 624 Handbook.

All contracted CMAs and their employed Care Managers are subject to the requirements of OPWDD's 14 NYCRR Part 624 and 625 until June 30, 2019.

For the purposes of this policy, reference to Medicaid Service Coordinators (MSCs) and Service Coordinators found in NYCRR Part 624 and 625 are applicable to CCO/HH Care Managers.

In addition to requirements of 14 NYCRR Part 624, CCO/HHs must adhere to the requirements of 14 NYCRR Part 625.

### **3.5 CCO/HH Monitoring: Surveys**

#### **Purpose**

The CCO/HH monitoring review process has been designed to review the performance of each CCO/HH in its progress towards meeting the stated triple aim of the ACA: to improve the health of Medicaid members, to improve the delivery of health care service to Medicaid members, lower Medicaid costs, reduce preventable hospitalizations and emergency room visits and avoid unnecessary care. The CCO/HH Monitoring process will ensure all CCO/HHs across the State are in compliance with CCO/HH standards.

#### **Section 1: Scope of Monitoring Surveys**

NYSDOH's Division of Program Development and Management (DPDM) and OPWDD are responsible for overseeing the CCO/HH Program and collaboratively reviewing each CCO/HHs performance. NYSDOH and OPWDD, with input from stakeholders and provider associations, will develop policies and procedures for the performance of surveys to evaluate CCO/HHs in the following areas:

- Outcomes and Quality
- Delivery of CCO/HH Services

- Governance and Operational Integrity

Surveys will generally be performed as an on-site visit; however, desk reviews of process and quality measures against program benchmarks will be used to monitor CCO/HHs and identify opportunities for improvement, as well as determine the scope of the comprehensive survey. The method of monitoring may vary over time and will be determined by the joint, on-going efforts of NYSDOH and OPWDD.

Please note that the guidance provided throughout this document applies to the CCO/HH model and was developed in partnership between NYSDOH and OPWDD. NYSDOH and OPWDD have added performance metrics tailored for individuals with I/DD which includes the twenty-one (21) POMS developed by CQL. The CCO/HH will be expected to collect and report I/DD-specific outcome data. Performance management will be done by NYSDOH and OPWDD and include participation from OPWDD's DQI.

### **Section 1A: Comprehensive Survey**

A comprehensive survey is a full review of CCO/HH operations. Representatives from NYSDOH and OPWDD will be given the option to participate in the survey. The survey checklist will include the following domains:

- Review of CCO/HH Policies, Procedures and Compliance
- Provider Qualifications, Network and Program Capacity
- HIT Standards
- Confidentiality, Data Access and Security
- Qualifications of Staff and Training
- Success of the Delivery of the Six (6) Core services
- Success of OPWDD Valued Outcomes (see Section 6.3)
- Informed Consent, Enrollment and Disenrollment Process and number of individuals passing through each stage of the process
- Quality of Care (including, but not limited to, individual record review)
- CCO/HH Enrollee Referral Process and Outcomes
- Enrollee Eligibility Status
- Medicaid Provider Enrollment
- Billing, Claims and Encounter Data
- Management of Complaints and Incidents
- Quality Improvement

### **A comprehensive survey is performed in the following circumstances:**

#### **Initial Readiness**

During specific designated application periods, and as directed by the State, organizations may apply to participate in the CCO/HH Program. Application periods for additional CCO/HHs will be determined by the State as needed.

Newly designated CCO/HHs will have an initial readiness review. Initially designated CCO/HHs will be granted a three (3) year period prior to the first re-designation review. However, based on the finding of the initial readiness review, the State may opt to grant a period of less than three (3) years prior to a re-designation review. Within one (1) year of designation, CCO/HHs will have a comprehensive survey to determine initial readiness.

### **Significant Change in Operations and/or Governance**

A significant change in operations or governance is defined as a change in ownership, executive control, or composition of the governing body, or the addition or withdrawal of a significant partner such that the original structure of the CCO/HH organization, is considered to be materially changed as presented in the original application reviewed and approved by the State. CCO/HHs **must** submit a Health Home Notification of Change form to the State to report any changes in operations and/or governance. If the change is determined to be significant, a comprehensive survey will be performed within three (3) months of the notification of the event (Note: a change that is not determined to be significant may, at the option of NYSDOH and OPWDD, be evaluated through the performance of a focused survey- see Section 1B)

### **Re-designation**

After the initial three (3) year period of designation and prior to the renewal of a CCO/HHs designation, the State will collaboratively review each CCO/HHs performance to determine if the program's designation status will continue. State re-designation of CCO/HHs will be determined based on the needs of the State and compliance with Federal and State program requirements. Performance on program benchmarks and quality metrics will be reviewed and considered when determining whether a CCO/HH should be re-designated.

CCO/HHs that have met or exceeded process and quality benchmarks and have demonstrated a successful self-evaluation/monitoring program, which includes effective internal policies and processes to identify and address non-compliance and subsequent corrective actions, may be deemed by the State to have met re-designation criteria and the requirement for a comprehensive re-designation survey may be waived once.

If the State determines that a CCO/HH does not meet performance standards, including but not limited to: compliance with State and Federal program requirement, program benchmarks and quality metrics, the CCO/HHs request for re-designation may be declined. In instances where CCO/HHs performance does not prevent re-designation but does require corrective action, progressive sanctions may be placed on the CCO/HH by the State until compliance can be demonstrated by the CCO/HH (i.e., limitations may be placed on future enrollments until appropriate corrective action is taken).

## Section 1B: Focused Survey

A focused survey is an in-depth review which focuses on one or more specific areas of CCO/HH operations. Focused surveys are an essential tool to be used for verifying objective evidence and reviewing objective data to determine the ability of the CCO/HH to meet established benchmarks, to assess how successfully the program has been implemented, and to investigate complaints and incidents. Information gleaned from a focused survey may also be used to identify best practices, allowing other programs to amend their working practices and, contributing to continual improvement of Care Management overall.

The team for the focused survey will be selected based on the issues that are identified. The focused survey checklist will include one (1) or more previously listed domains in **Section 1A** and can be customized as needed to address the areas of concern at the State's discretion.

A focused survey may be authorized by NYSDOH and OPWDD in the following circumstances:

### Evaluation of Process and Quality Metrics:

CCO/HH performance will be monitored regularly through a variety of quality and process metrics. Benchmarks and Annual Improvement Targets (AIT) will be established for key indicators; failure to meet established benchmarks and Annual Improvement Targets may result in a recommendation for a focused survey.

To date, process and quality metrics include:

- Data including but not limited to metrics identified in the CCO/HH measure set, continuous program monitoring and trigger event domains; and
- Annual CCO/HH Quality Metrics

### Trigger Events:

Trigger events are episodes or events that are determined to be serious enough to warrant an on-site investigation.

#### Complaints:

- Complaints about Care Managers, Care Management services, or other services identified in the individual's Life Plan
- Complaints about breach of privacy issues

#### Incidents:

- Allegations of abuse/neglect or mistreatment committed by staff to an individual or between individuals, a suicide attempt; or an unexpected death of an individual

- Reports of theft, fraud, or other crimes that have been reported to the police
- Significant injuries resulting in inpatient hospitalization
- Reportable incidents described in Section 3.4

### Threats to Program Integrity

- Program integrity creates an environment that supports better health outcomes within a context that avoids over or underutilization of services. It also requires effective program management and ongoing program and fiscal monitoring

### Contract Network Partner Issues

- Network adequacy: after a partner of one (1) of the core services leaves CCO/HH Network. Note: this may or may not be a trigger event depending on the scope of the services provided and the role of the provider (e.g., if a partner with a governance role leaves the network) this may trigger a comprehensive survey].

### Other Issues

- Follow up on issues discovered during comprehensive site visit
- Issues identified by NYSDOH and OPWDD
- Evaluate the ability of CCO/HH to identify and successfully deliver the six (6) Core Services.

## Section IV: Billing and Claims Submission for CCO/HH Services

### 4.1 General Requirements for CCO/HH Claim Submission

The CCO/HH bills Medicaid for CCO/HH services as follows:

- CCO/HHs bill eMedNY directly for individuals who are FFS or Managed Care members receiving CCO/HH services from a Care Management provider. CCO/HHs then distribute payments to any CMAs for the first year of operations.
- Until the I/DD population transitions to Managed Care under the 1115 Waiver authorization CCO/HH will bill eMedNY directly for all enrolled individuals beginning on July 1, 2018. During the first year of operations, CCO/HHs may provide Care Management services through a contract with a CCO/HH as a CMA. These CMAs are existing Medicaid Service Coordination entities enrolled in the New York State Medicaid program. CCO/HHs will distribute payments to any downstream CMA partners within fifteen (15) days of receiving payment from the State.

CCO/HHs are billed on a monthly basis. In order to be reimbursed for a billable unit of service, CCO/HH providers must, at a minimum, provide one (1) of the core services in a given month. In addition to the monthly documentation of at least one (1) core service, Care Managers must also adhere to the following face to face meeting requirements:

- For individuals in Tiers 1-3, the CCO/HH Care Manager must have at least one (1) face to face meeting with the individual each quarter (January-March; April-June; July-September; and October-December).
- For individuals in Tier 4, the Care Manager must have a monthly face to face meeting with the individual.

The quality and individual and family satisfaction of the provision of CCO/HH services will be carefully assessed during the initial year of operation. During that time, the State is generally providing the CCO/HH Care Managers the flexibility to manage caseloads according to the individual's needs, and is not mandating caseload requirements for individuals that have acuity in the CCO/HH PMPM rate Tiers 1-3. Due to the higher support needs of individuals in Tier 4, including Willowbrook Class Members, Care Managers will be required to maintain a caseload level of no greater than 20 individuals. For non-Willowbrook Class Members, CCO/HHs will have 90 days from July 1, 2018 to come into compliance with these standards.

Individuals enrolled in a CCO/HH who have never before received care coordination through OPWDD, the CCO/HHs are eligible for an enhanced transition payment for the first month of enrollment in the CCO/HH. This one-time enhanced payment is available to accommodate the additional time required to assist the individual with the initial Medicaid application, gathering of documentation supporting the developmental disability diagnoses, and the ICF Level of Care eligibility determination. Once the CCO/HH bills this initial enhanced billing level, any subsequent billing will be at the assigned tier level provided to the CCO/HH by OPWDD.

For CCO/HHs, the first of the month is used for billing the reimbursement rate, regardless of when the service(s) was provided during the month. The individual must be enrolled in the program on the first of the month in order for services to be reimbursed. Enrollments into the CCO/HH processed during the month will result in the enrollment being processed on the first of the following month. For example, an individual's enrollment is submitted on October 14<sup>th</sup>; the enrollment will be formally processed effective November 1<sup>st</sup> and that will be the first date of service billed for the individual.

Claims are submitted electronically using the 837-I institutional claim type format or paper UB04. The claim submissions must include standard identifiers including the CCO/HH NPI, the primary diagnosis code, revenue code, rate code, and the charge amount of the claim. The rate code on the Medicaid claim will correspond to the approved reimbursement tier/level authorized for the individual by OPWDD. Claims will

be paid directly to the CCO/HH until the time that OPWDD transitions to Managed Care under the 1115 authorization.

Billing and remittance questions should be directed to eMedNY at 1-800-343-9000 or visit: [www.emedny.org](http://www.emedny.org)

For information on electronic remittance advice guidelines refer to: [https://www.emedny.org/providermanuals/allproviders/general\\_remittance\\_guidelines.pdf](https://www.emedny.org/providermanuals/allproviders/general_remittance_guidelines.pdf)

## 4.2 Guidance Regarding CCO/HH Governance Fees and Payment Structures

Please be advised that CCO/HH governance fees, and other payment structures must not violate the fraud and abuse prohibitions that apply to providers that participate in Medicaid programs. The provisions of State and Federal Statutes, New York Code of Rules and Regulations, 18 NYCRR 515.2(5) and the United States Code, 42 U.S.C. 1320a-7b(b), require that Medicaid providers must accept the payment from Medicaid as payment in full and prohibit referral fees, including soliciting referral fees whether in case or in kind, in return for referring an individual to someone for any medical care, services, or supplies for which payment is claimed under the program.

As a reminder, CCO/HHs are responsible for making sure that Care Manager assignments are according to factors that ensure the individual's needs are met, including, but not limited to: the qualifications and ability of the Care Managers to meet specialized needs of the individual; where the individual lives; and alignment between the individual's MMCP and the CCO/HH.

If you have any questions please send an email to the NYSDOH Health Home mailbox at: [hhidd@health.ny.gov](mailto:hhidd@health.ny.gov)

## 4.3 CCO/HH Locator Code

Upon designation, the CCO/HH will be asked to complete information to assist the State in ensuring accurate payment for CCO/HH services, such as their NPI number and MMIS provider identification number. MMIS is a computerized system for claims processing. In New York State, the MMIS is commonly referred to as eMedNY.

Each CCO/HH must submit the NPI and a corresponding address on the claim submission to Medicaid. This is done via inclusion of the Zip +4 when submitting the claim. The Zip +4 will link to the service address, or location code on file that is registered as part of the provider enrollment process. Providers serving both upstate and downstate regions will have a Zip+4 and location code specific to each region.

The upstate/downstate configurations for CCO/HHs are based on defined OPWDD regions. CCO/HH reimbursement will be determined on the TABS program code enrollment of the individual. Downstate is NYC, Long Island, Westchester, Rockland, Orange and Sullivan, OPWDD Regions 4, 5 and part of Region 3 respectively. Upstate is considered all other counties, except for Westchester, Rockland, Orange, and Sullivan, OPWDD Regions 1,2 and the rest of Region 3.

#### 4.4 Guide to Coverage Codes and CCO/HH Services

Below please see the table of included/excluded Medicaid coverage codes that are allowed to co-exist with CCO/HH enrollment.

CODE	WMS MNEMONIC	COVERAGE CODE NAME	COMPATIBLE WITH CCO/HH SERVICES?
01	FUL-COVR	FULL COVERAGE	Yes
02	OPAT-COV	OUTPATIENT COVERAGE	Yes
04	N-COV	NO COVERAGE-INELIGIBLE	No
05	SANCT	SANCTIONED	No
06	PROVSNL	PROVISIONAL-EXCESS INCOME	Yes
07	EMER-SER	EMERGENCY SERVICES ONLY	No
08	PR-EL-HC	PRESUMPTIVE ELIGIBILITY HOME CARE	No
09	MED-CDO	MEDICARE CO-INSURANCE & DEDUCTIBLE ONLY	No
10	AS-NOLTC	ALL SERVICES EXCEPT NURSING FACILITY SERVICES	Yes
11	FUL-COVR	ALIESSA ALIENS	Yes
13	PE-PC-A	PRESUMPTIVE ELIGIBILITY PRE-NATAL CARE A	No
14	PE-PC-B	PRESUMPTIVE ELIGIBILITY PRE-NATAL CARE B	No
15	PRNTLCAR	PERINATAL COVERAGE	No
16	HR-COV	SAFETY NET (HISTORIC ONLY) NYC CODE	No
17	HIP-ONLY	HEALTH INSURANCE PREMIUM	No
18	FAM-PL	FAMILY PLANNING SERVICES ONLY	No
19	CC-LTC	COMMUNITY COVERAGE WITH COMMUNITY- BASED LONG-TERM CARE	Yes
20	CC-NOLTC	COMMUNITY COVERAGE WITHOUT LONG TERM CARE	Yes
21	OP-LTC	OUTPATIENT COVERAGE WITH COMMUNITY-BASED LONG-TERM CARE	Yes
22	OP-NOLTC	OUTPATIENT COVERAGE WITHOUT LONG-TERM CARE	Yes
23	OP-NONUR	OUTPATIENT COVERAGE WITH NO NURSING FACILITY SERVICES	Yes
24		COMMUNITY COVERAGE WIHTOUT LONG-TERM CARE (LEGAL ALIEN DURING 5 YR. BAN)	Yes
25	INPT-OMH	INPATIENT OMH	No
26	INPTPSNR	INPATIENT PRISONER	No
27	FMPL-FP	FAMILY PLANNING EXTENSION PROGRAM	No
30	PCP-F-CV	PCP FULL COVERAGE (MANAGED CARE)	Yes
31	PCP-CV-O	PCP COVERAGE ONLY	No



CODE	WMS MNEMONIC	COVERAGE CODE NAME	COMPATIBLE WITH CCO/HH SERVICES?
32	PCP-HR	PCP/SAFETY NET (HISTORIC ONLY)	No
33	PCP-G-HR	PCP GUARANTEE/SAFETY NET (HISTORIC ONLY)	No
34	FHP-P	FAMILY HEALTH PLUS	No
36	FHPGT	FAMILY HEALTH PLUS	No

#### 4.5 Guide to Recipient Restriction Exception (RRE) Codes for CCO/HH Services

Below please find the table of included/excluded RRE codes allowable to co-exist with CCO/HH enrollment.

RE CODE	RE CODE DESCRIPTION	COMPATIBLE WITH CCO/HH SERVICES?
02	RRP Podiatry	Yes
03	RRP Dental	Yes
04	RRP Durable Medical Equipment	Yes
05	RRP Pharmacy	Yes
06	RRP Physician	Yes
08	RRP Clinic	Yes
09	RRP In-patient Hospital	Yes
10	RRP Dental Clinic	Yes
11	RRP Physician Group	Yes
12	RRP Physician Assistant/Nurse Practitioner	Yes
13	RRP Alternative Pharmacy	Yes
20	Enrollee in Special Needs MC Plan (HIV SNP)	Yes
21	Enrollee in Special Needs MC Plan (HIV SNP)	Yes
23	OMH Children's Waiver	No
25	OPWDD – Sub-Chapter A Exception	Yes
30	LTHHCP – Long Term Home Health Care Program (Lombardi Waiver)	No
35	Case Management Program; Medicaid Service Coordination/Case Management Program (Medicaid OMH, COBRA, AI TCM, OPWDD)	No
38	ICF/DD Res	No
39	Aid Continuing	Yes
44	HCBS at Home Non-Intensive Residential Habilitation	Yes
45	HCBS at Home Intensive Residential Habilitation	Yes
46	OPWDD Home & Community Based Services Waiver – HCB (Pure Waiver)	Yes
47	OPWDD HCBS Community Habilitation Phase 2	Yes
48	OPWDD HCBS Supportive IRAs and CRs	Yes
49	OPWDD HCBS Supervised IRA	Yes
55	MCC Pharmacy	Yes

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RE CODE	RE CODE DESCRIPTION	COMPATIBLE WITH CCO/HH SERVICES?
56	MCC Physician	Yes
58	MCC Clinic	Yes
59	MCC Hospital	Yes
60	Nursing Home Transition and Diversion Waiver	No
62	Care at Home (CAH) I (Administered by DOH)	No
63	Care at Home (CAH) II (Administered by DOH)	No
64	Care at Home (CAH) III (OPWDD)	No
65	Care at Home (CAH) IV (OPWDD)	No
67	Care at Home (CAH) VI (OPWDD)	No
72	Bridges to Health (B2H) Seriously Emotionally Disturbed (SED)	No
73	Bridges to Health (B2H) Developmentally Disabled	No
74	Bridges to Health (B2H) Medically Fragile (MedF)	No
75	LTC D/D Asset Protection	Yes
76	LTC Total Asset Protection	Yes
77	LTC Insurance-Non-Partnership	Yes
81	Traumatic Brain Injury (TBI)	No
82	Non-MMIS ID RRP Provider	Yes
83	Alcohol & Substance Abuse (ASA)	Yes
84	OMH Base/Community Rehab & Support (CRS) with Clinical Treatment	Yes
85	OMH Base/Community Rehab & Support (CRS) without Clinical Treatment	Yes
86	OMH Intensive Rehab & Ongoing Rehab Services (IR/OR)	Yes
89	Money Follows the Person	Yes
90	Managed Care Excluded	Yes
91	Managed Care Exempt	Yes
92	DOH/Managed Care Exempt	Yes
93	Managed LTC	Yes
94	OMH Exempt	Yes
95	OPWDD Waivered Services Look-Alikes	Yes
96	Seriously & Persistently Mentally Ill Adults (SPMI) & Seriously Emotionally Disturbed Children (SED)	Yes
A1	Health Home Program – Care Management Agency	No
A2	Health Home Program – Health Home	No
AL	Assisted Living	No
B7	Non EP BHP Aliessa	Yes
C1	Copay Exempt (Hospice)	Yes
CF	Community First Choice Option	Yes
CH	Home and Community Based Services – CREPS	Yes
CM	Managed Long-Term Care - CREPS	Yes
CO	Community First Choice Option OPWDD	Yes
D0	DSRIP Opt out Undeliverable Mail	Yes
D1	DSRIP Opt out of Data Sharing	Yes
D2	DSRIP Opt in to Data Sharing	Yes

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RE CODE	RE CODE DESCRIPTION	COMPATIBLE WITH CCO/HH SERVICES?
G1	Transgender Male to Female	Yes
G2	Transgender Female to Male	Yes
H1	HARP Enrolled without HCBS Eligibility	No
H2	HARP Enrolled with Tier 1 HCBS Eligibility	No
H3	HARP Enrolled with Tier 2 HCBS Eligibility	No
H4	HIV SNP HARP Eligible without HCBS Eligibility	No
H5	HIV SNP HARP Eligible with Tier 1 HCBS Eligibility	No
H6	HIV SNP HARP Eligible with Tier 2 HCBS Eligibility	Yes
H7	Opted out of HARP	Yes
H8	State-identified for HARP Assessment	Yes
H9	HARP Eligible-Pending Enrollment	Yes
I1	OPWDD MC Class 1	Yes
I2	OPWDD MC Class 2	Yes
I3	OPWDD MC Class 3	Yes
I4	OPWDD MC Willowbrook	Yes
I5	CCO/HH Enrollment Level 1	No
I6	CCO/HH Enrollment Level 2	No
I7	CCO/HH Enrollment Level 3	No
I8	CCO/HH Enrollment Level 4	No
I9	CCO/Basic HCBS Plan Support	No
KK	Family of One Budgeting for Medicaid	Yes
M1	MAGI Remains in WMS	Yes
N1	Regular SNF Rate – MC Enrollee	No
N2	SNF AIDS – MC Enrollee	No
N3	SNF Neuro-Behavioral – MC Enrollee	No
N4	SNF Traumatic Brain Injury – MC Enrollee	No
N5	SNF Ventilator Dependent – MC Enrollee	No
N6	Partial Cap 21+ Nursing Home Certifiable	No
N7	NH Budgeting Approved	No
N8	Transfer Penalty Period DHPKO	No
N9	NH Resident Pending NH Eligibility Determination	No
NH	Nursing Home	No
PL	Pre-Release Upstate MC Ineligible	Yes
PR	Pre-Release Downstate MC Ineligible	Yes
S1	Surplus Client Not Eligible for Medicaid MC or Medicaid Advantage (NYC Only)	Yes
T1	Upstate Temporary Assistance Non-MAGI	Yes
T2	NYC Tax Claim	Yes
T3	NYC Enhanced Shelter Allowance	Yes

## CCO/HH Rate Codes and corresponding RRE Codes

Below are the identifiers for CCO/HH enrollment status by Tier, RRE code and Medicaid Rate Codes.

Tier	Description	RRE Code	Rate Code	Transitional Rate Code
1	CCO/HH Enrollment Level 1	15	1900	1905
2	CCO/HH Enrollment Level 2	16	1901	1905
3	CCO/HH Enrollment Level 3	17	1902	1905
4	CCO/HH Enrollment Level 4	18	1903	1905
0	CCO/HH Opt-Out	19	1906	

### 4.6 Claim Submission

If a problem arises with a claim submission, the CCO/HH biller should first contact eMedNY to assist in understanding the denial reason; as the denial explanation will help determine the next course of action. For instance, in some cases a claim may have been denied because action is required by the individual's LDSS. For NYC Human Resources Administration (HRA) (eligibility issues) or in cases where OPWDD is the Medicaid (District code 98) local Revenue Support Field Operations (RSFO) unit, the provider should contact the LDSS, NYC HRA, or RSFO for resolution.

For additional information concerning how to contact eMedNY, refer to Section 2.4 CCO/HH Provider Eligibility and Enrollment of the NYS Medicaid Program and Section 6.1 CCO/HH Medicaid Eligibility Determination.

### 4.7 The Use of PMPM Payments for Incentives, Gifts or Inducements

Gifts and incentives to CCO/HH enrollees are allowable but subject to the requirements outlined in a Special Advisory Bulletin issued by the NYS OIG, Federal Register, Vol. 67, No. 169, Friday, August 30, 2002. The bulletin provides a "bright line" on gift giving. Any provider that wants to offer gifts should consult their own legal counsel for a complete analysis of the facts and circumstances.

The bulletin can be found on page 55855 at the following link:

<https://www.gpo.gov/fdsys/pkg/FR-2002-08-30/pdf/FR-2002-08-30.pdf>

#### **18 NYCRR 515.2(5) "Bribes and Kickbacks" 515.2**

Unacceptable practices under the medical assistance program.

(a) General. An unacceptable practice is conduct by a person which is contrary to:

(5) Bribes and kickbacks: Unless the discount or reduction in price is disclosed to the client and the department and reflected in a claim, or a payment is made

pursuant to a valid employer-employee relationship, the following activities are unacceptable practices:

- (i) Soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program;
- (ii) Soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program;
- (iii) Offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program; or
- (iv) Paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.

**42 U.S.C. 1320a-7b(b)**

**(b) *Illegal remunerations***

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

- (A) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
- (B) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five (5) years, or both.

## **Section V: Managed Care ASAs with CCO/HHs**

CCO/HHs will provide services to eligible MMCP members through an ASA between the Plan and the CCO/HH. CCO/HHs should utilize the MMCP's contracted network of providers for direct care services that are included in the benefit package when arranging care for individuals. MMCP's may opt to expand their provider networks based on the needs of individuals.

Refer to the links below for additional information on the following topics:

- Managed Care Information
- Managed Care Roles and Responsibilities
- CCO/HH and Managed Care Agreements
- Managed Care and Health Home Questions and Answers

Managed Care Organizations:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/managed\\_care.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/managed_care.htm)

## Section VI: Enrollment and Disenrollment

### 6.1 CCO/HH Medicaid Eligibility Determination

It is important to determine Medicaid eligibility prior to providing CCO/HH services. This is because individuals entering CCO/HHs are required to be enrolled in Medicaid, and their Medicaid eligibility is date specific. An individual's Medicaid eligibility may change frequently and it is incumbent on the provider to ensure that the individual is actively enrolled in the NYS Medicaid program prior to rendering such services. If the provider does not verify eligibility and the extent of coverage for each enrollee, each time services are requested, the provider may be at risk for non-reimbursement for those services provided. The State cannot compensate a provider for a service rendered to an individual who is not an eligible Medicaid member and actively enrolled in the NYS Medicaid program. In determining Medicaid eligibility, the provider is responsible for reviewing the type of Medicaid coverage authorized, as well as any restrictions that may exist.

If the individual is not eligible for Medicaid or their Medicaid coverage has lapsed, the referring entity should work with the LDSS, New York City HRA, or the RSFO as appropriate to apply for or reactivate Medicaid coverage. In addition, an individual who is not eligible for Medicaid should be provided with assistance in finding appropriate health care options.

Medicaid eligibility information, including covered services, is identified in the Medicaid eligibility verification process. For more information, consult the Medicaid Eligibility Verification System (MEVS) Manual, online at:

<http://www.emedny.org/ProviderManuals/AllProviders/index.aspx>

Questions concerning Medicaid eligibility verification may be addressed to eMedNY at (800) 343-9000.

## 6.2 CCO/HH: Eligibility, Enrollment, Core Services, and OPWDD Valued Outcomes

### CCO/HH Chronic Condition Eligibility Criteria:

- The individual (adults and children) **must** be enrolled in Medicaid; **AND**
- Have an ICF Level of Care eligibility determination; **AND**
- Have received a determination made by OPWDD; **AND**
  - ✓ Have received a determination made by OPWDD that the individual's Developmental Disability chronic condition originated prior to age 22 and results in functional limitations that constitute a substantial handicap as defined by NYS Mental Hygiene Law Section 1.03(22).
- Have one (1) chronic condition in the Developmental Disability category
  - ✓ Developmental Disability Chronic Condition Categories:
    - Intellectual Disability
    - Cerebral Palsy
    - Epilepsy
    - Neurological Impairment
    - Familial Dysautonomia
    - Prader-Willi Syndrome
    - Autism

### Developmental Disability Definition:

Developmental disability means the disability of an individual which:

- (b) (1) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi Syndrome or autism;
- (2) is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person; or
- (3) is attributable to dyslexia resulting from a disability described in subparagraph one (1) or two (2) of this paragraph;
- (b) originated before such person attains age twenty-two (22);
- (c) has continued or can be expected to continue indefinitely; and
- (d) constitutes a substantial handicap to such person's ability to function normally in society."

In cooperation with DDROs, CCO/HH Care Managers will be responsible for assisting individuals and families with gathering the required documentation, evaluations, and assessments needed for both OPWDD and ICF Level of Care eligibility determinations.

Please refer to the CCO/HH SPA for a list of single qualifying Developmental Disability eligibility conditions.

For additional information on Health Home eligibility criteria please visit:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/hh\\_children/guidance/health\\_home\\_chronic\\_conditions.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children/guidance/health_home_chronic_conditions.htm)

## **CCO/HH Enrollment**

The primary mechanism for referral to CCO/HHs for individuals with I/DD will be OPWDD, through its DDROs or designee. OPWDD's DDROs are well connected to area schools, health care providers, and other governmental and non-governmental social service providers and will make referrals to CCO/HHs to meet an individual's needs. DDRO referrals will consider the region the individual lives and the connectivity of providers, including the current MSC Service Coordinators and PCSS providers who are transitioning to CCO/HHs and who are serving individuals who are also transitioning to CCO/HHs. CCO/HHs may also directly receive referrals from the community, including providers and MMCPs. Individuals determined eligible by OPWDD will be given the option of choosing to enroll in CCO/HH Care Management or Basic HCBS Plan Support, or another CCO/HH. Information on Basic HCBS Plan Support can be found in Section X of this Manual.

### **Core Services:**

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Individual and Family Supports
5. Referral to Community Supports
6. Use of HIT to Link Services

CCO/HHs must develop policies and procedures that deliver the six (6) core services, in addition to the following OPWDD Valued Outcomes.

- ✓ Individuals live and receive services in the most integrated settings
- ✓ Have meaningful and productive community participation, including paid employment, and accommodating individual's needs as they change
- ✓ Develop meaningful relationships with friends, family, and others in their lives, including the option of participating in the self-advocacy association, peer support and mentoring program; and
- ✓ Experience personal health, safety, and growth.

Further information outlining the six (6) core services can be found at:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/docs/hidd\\_application\\_part\\_1.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hidd_application_part_1.pdf)

In addition, when a Willowbrook Class Member enrolls or disenrolls, CCO/HHs must establish communications, as necessary, to comply with the requirements of the Willowbrook Permanent Injunction.



### 6.3 CCO/HH Enrollment into OPWDD CHOICES

CCO/HHs will not use the MAPP Health Home Tracking System. The individual's status will be reported by State rosters. An individual or program enrollment inquiry can be conducted via CHOICES, OPWDD's internal electronic repository containing program information for individuals receiving services from OPWDD service providers.

#### Tracking Requirements for CCO/HH

CCO/HH enrollment will be tracked in OPWDD's CHOICES system and the CCO/HH may access current enrollments via CHOICES anytime. The CCO/HH is also required to use the CHOICES system to submit enrollments and disenrollments of its enrollees.

### 6.4 CCO/HH Patient Information Sharing Consent Form (Consent FAQ, DOH-5055, DOH-5200, and DOH-5201)

Prior to enrollment into a CCO/HH, individuals and/or their family/representatives are required to review and sign consent forms developed by NYSDOH. The purpose of the consent forms is to improve the coordination of supports and services by allowing information sharing among service providers identified by the individual and/or their parent, guardian, or legally authorized representative. At a minimum, the individual's CMA (when applicable), MMCP (when applicable), as well as the primary care physician and/or health care provider the individual utilizes the most (i.e., mental health provider) must be listed on the consents. Additional information can be added over time as appropriate. The CCO/HHs are responsible for securing completed consent forms for all CCO/HH enrollees. Care Managers are expected to assist individuals, parents, guardians, and legally authorized representatives with completing all consent forms. The State expects Care Managers to ensure their understanding of each form and read forms to them, if appropriate. The Care Manager should answer any questions they may have.

There are three (3) consent forms that Care Managers must review with individuals under 18 years of age:

- Frequently Asked Questions (FAQ) For Use with Children Under 18 Years of Age
- DOH 5200 - Enrollment for Use with Children under 18 Years of Age
- DOH 5201- Information Sharing for Use with Children Under 18 Years of Age

The FAQ For Use with Children Under 18 Years of Age must be reviewed with individuals under 18 years of age and/or their parent, guardian, or legally authorized representative prior to completion of the DOH-5200 and DOH-5201 consent forms. The FAQ explains the CCO/HH program, eligibility, consents and sharing of the individual's information.

The DOH-5200 is the consent required to enroll the individual into the CCO/HH and should be reviewed with and signed by a parent, guardian or legally authorized

representative. The DOH-5201 is completed following the DOH-5200 and identifies what, and with whom, health information can be shared. The DOH-5201 consent form has two (2) sections. Section one (1) is to be completed by the parent, guardian or legally authorized representative and identifies the health care providers who can share the child's information. Section two (2) is for the child to complete with the Care Manager separate from the parent, guardian or legally authorized representative. Section two (2) should be left blank if the child is unable to complete or is otherwise not capable of understanding the information presented in this section and the Care Manager must document this.

Once consents for enrollment are in place, the Care Manager should obtain consent for release of educational records, as applicable using the DOH-5203 Health Home Consent Information Sharing Release of Educational Records. For children/adolescents under age 18 this form is completed by the parent as defined in the DOH-5203. Consent for release of educational records for those aged 18 and over must be provided by the individual. If consent for release of educational records is withdrawn during enrollment or at the time of disenrollment from the CCO/HH, the Health Home Consent Withdrawal of Release of Educational Records (DOH-5204) must be used.

There is one (1) form that Care Managers must review with adults:

- DOH 5055 – Patient Information Sharing Consent

The DOH-5055 is a combined consent form, used for enrollment and information sharing purposes. This form should also be completed by children/adolescents who are parents, pregnant, and/or married and who are otherwise capable of consenting. By completing the consent form, the individual is agreeing to allow their health information to be shared among the consented CCO/HH partners. Adults signing the DOH-5055, are providing consent for the CCO/HH to access the RHIO/QE for information available within the community.

In order to allow data sharing, converting MSC programs are responsible for obtaining signatures for the individuals they currently serve on the appropriate consent forms. These programs may continue to work with individuals while they obtain the consents, but are required to inform the individual that they must choose to enroll in a CCO/HH or Basic HCBS Plan Support in order to continue receiving OPWDD Waiver services. CCO/HHs that will be sharing data with their network partners (MSC provider agencies) prior to obtaining an individual's consent must first have an approved BAA on file for these network partners.

In keeping with State requirements, consent forms are available in English and seven (7) additional languages including: Chinese, French, Haitian Creole, Italian, Korean, Russian and Spanish. Forms used for children and adults are available at the following link:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/lead\\_hhc.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm)

## 6.5 Sharing of Protected Health Information (PHI)

Protecting the privacy of individuals with I/DD is a critical part of the CCO/HH function. Privacy measures, when put into practice, contribute to a high standard of care and service delivery. The sharing of PHI in all cases must be restricted to the minimum amount of information necessary to accomplish the purpose. Additionally, the parties sharing PHI must obtain legal assurance to ensure confidentiality of the information and prevention of unauthorized re-disclosure to other parties. This may come in the form of a DUA, BAA, Confidentiality and Non-Disclosure Agreements (C&NDA) or Qualified Service Organization Agreements whereby the recipient agrees to abide by these confidentiality provisions, and, in the event it does re-disclose any such information, that it will enter into a similar agreement with the sub-recipient of the information.

## 6.6 Guidance to CCO/HHs, Care Management Agencies, Providers, and Mental Hygiene Law (MHL) Privacy

### Introduction

New York State is implementing a number of transformational Medicaid reform initiatives that emphasize person-centered services and comprehensive Care Management. The exchange of information is critical to the ability of the CCO/HHs, and the various service providers to integrate and coordinate services, and to treat the individual in a person-centered, effective and efficient manner.

Individuals' PHI, however, is extremely sensitive. For that reason, there is a large body of law at both the State and Federal level protecting the confidentiality of health information. These laws establish the fundamental principle that PHI is confidential, and may not be shared absent an individual's consent, unless certain limited exceptions apply. In such circumstances, disclosure may be permitted, but to the minimum extent necessary to accomplish the purpose for the exception. These laws were written with the intent of balancing the interests of confidentiality with the need to communicate information necessary to provide health and behavioral health services to those individuals. Generally stated, it is almost always best, and almost always the least complicated legally, to share information with the consent of the individual.

In some situations, however, obtaining such consent is not possible or practical. In extremely limited circumstances, the various legal authorities protecting the confidentiality of PHI do allow for the exchange of clinical information, but only for specific purposes, and only to the minimum extent necessary to accomplish those purposes. They also include requirements for protections to prevent the recipient of such information from re-disclosing information unless it is for a similarly legitimate purpose, and includes similar protections governing the recipient of the re-disclosed information. These procedures and protections represent an attempt to provide the individual with the ability to decide what information, and to whom, their sensitive PHI will be disclosed.

## Relevant Federal and State Authorities

The relevant laws that come into play in the relationship between the State, CCO/HHs, CMAs, service providers, and the recipients are as follows:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (PL 104–191). This law was primarily intended to protect health insurance coverage for individuals who lost their jobs by making such insurance more portable. In recognition of the administrative burden the portability requirements would place on health care providers, the law also included provisions to facilitate the electronic exchange of health information. But in so providing, Congress also recognized that by facilitating the exchange of information, the law could also result in a loss of confidentiality of this information. Accordingly, Congress directed the Federal Department of Health and Human Services (HHS) to promulgate regulations protecting the confidentiality of such information. These regulations generally prohibit a covered entity from disclosing PHI except as otherwise required or permitted by the regulations.
- Federal Medicaid Law and Regulations (42 USC §1396a (a)(7); 42 CFR §§431.300–431.307). These authorities restrict the use or disclosure of information concerning individuals to purposes directly related to the administration of the Medicaid program.
- Federal Medicaid Alcohol and Substance Use Confidentiality Restrictions (42 CFR Part 2). This law restricts the disclosure of any information which would identify an individual, either directly or indirectly, as receiving, having received, or having been referred for substance abuse or alcoholism treatment without the individual's explicit consent (42 CFR §2.13(c)(1)).
- State Mental Health Confidentiality Law (MHL §33.13). Under the Mental Hygiene Law clinical information maintained by a provider of mental health services may only be disclosed without the individual's consent pursuant to the provisions of §33.13.
- State Public Health Confidentiality Law (PHL §18 (6)) and Article 27F. This law requires written authorization from the individual before a health care provider may disclose information to a third party, unless it is pursuant to a court order, for law enforcement purposes, fraud and abuse investigations, or otherwise authorized by law.

## Sharing Protected Health Information (PHI): General Guidance

In determining whether sharing of PHI is permissible, it is therefore necessary to:

- Describe the purpose for which information is proposed to be shared. If the information is being shared by a "covered entity" under HIPAA, the purpose for the sharing of the information must be permissible under HIPAA. If the information is Medicaid data furnished by NYSDOH, then the purpose must relate to the administration of the Medicaid program. If the information is being shared by an entity covered by the Mental Hygiene Law, then it must be for a purpose permitted under §33.13. If the information relates to the prevention or

treatment of an alcohol or substance use disorder, then the disclosure must be consistent with 42 CFR Part 2. If the information is being shared by an entity licensed by NYSDOH, then it must be permissible under PHL §18 (6) and Article 27F.

- Determine the minimum amount of information necessary to accomplish the legitimate purpose for which it is being shared. The "minimum necessary" standard is common to all of the above authorities.

When PHI is shared consistent with the above legal authorities, it does not lose its confidential status. The recipient of the information is bound by these same requirements, and may only re-disclose the information consistent with the same legal authorities.

## 6.7 Health Commerce System (HCS)

The Health Commerce System (HCS) is an electronic information exchange tool used by NYSDOH to communicate with New York State healthcare providers, employees, and partner agencies. The HCS also collects provider information to help conduct business involving public health. It is a comprehensive web-based technology that supports, integrates, and secures the electronic exchange of health data and information among partners.

### Health Commerce System - Access

If an organization does not have a HCS account or if information is needed regarding the name of the HCS Director or Coordinators for the organization, contact the NYSDOH Health Home program either electronically by visiting the NYSDOH Health Home Website and clicking on the tab "Email Health Homes" or by going directly to: [https://apps.health.ny.gov/pubdoh/health\\_care/medicaid/program/medicaid\\_health\\_homes/emailHealthHome.action](https://apps.health.ny.gov/pubdoh/health_care/medicaid/program/medicaid_health_homes/emailHealthHome.action)

Selecting "Health Commerce Accounts for Health Homes" as the subject. You can also call the NYSDOH Health Home Provider Line at (518) 473-5569.

Note: Organizational changes including changes in CCO/HH name or NPI number affect the HCS account status for the staff person submitting data to the NYSDOH Health Home portal.

Once an active HCS account is identified or obtained, the following offices/units may be contacted for relevant questions:

Informatics Unit may be contacted at 518-473-1809 or electronically at: [hcsoutreach@health.ny.gov](mailto:hcsoutreach@health.ny.gov) with questions regarding:

- Communications Directory
- Coordinator Training
- Roles

Commerce Accounts Management Unit (CAMU) may be reached at 1-866-529-1890 or electronically at: [hinhpn@health.ny.gov](mailto:hinhpn@health.ny.gov) with questions regarding:

- Account Status
- Passwords

## 6.8 CCO/HH Enrollee Disenrollment/Opt-out

Adults and Children under 18 who want to disenroll from the CCO/HH program and who have a signed consent on file, need to sign the Withdrawal of Consent Form (DOH-5058) for Adults (adults and children/adolescents under 18 who are a parent, pregnant, and/or married and able to self-consent) or the Withdrawal of Health Home Enrollment and Information Sharing for Use with Children under 18 years of Age (DOH-5202). It is important that the individual be fully informed of the consent process. It is the CCO/HH Care Manager's responsibility to ensure that the individual and/or their family/representative understand the information, have the opportunity to ask questions and are provided DOH-5058 or DOH-5202 in their primary language and in a manner in which they understand. In addition, DOH-5058 and DOH-5202 consent forms must be provided to all relevant parties and maintained in the individual's Care Management record. CCO/HH Care Managers are also responsible for reporting enrollee disenrollments to the CCO/HH. The CCO/HH is responsible for notifying the State of an individual's choice.

The Opt-out Form (DOH- 5059) is used when an individual declines enrollment into the CCO/HH program. It is a CCO/HH standard that when an individual wants to receive HCBS services and declines CCO/HH enrollment, the CCO/HH must educate them on Basic HCBS Plan Support services. Individuals must be enrolled in a Care Management service in order to receive OPWDD HCBS services.

All consent forms relating to CCO/HHs are in English and translated into seven additional languages including: Chinese, French, Haitian Creole, Italian, Korean, Russian and Spanish.

These forms and additional information can be found at the following link: [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/forms/](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/forms/)

In addition, CCO's are required to adhere to the Willowbrook Permanent Injunction requirements., including that all Willowbrook representatives will receive copies of all notices or other communications.

## 6.9 Individuals Changing CCO/HHs

If an individual chooses to be in a different CCO/HH, the individual and/or Care Manager should notify their MMCP or their assigned CCO/HH Care Manager immediately. There should be a discussion with the individual regarding their request to

change CCO/HH and a plan of transfer made to the new CCO/HH. Whenever possible, a transition meeting should be held with the individual and/or their family/representative and involved professionals, for a warm hand off to the newly assigned Care Manager and to ensure continuity of care. The current CCO/HH must upload the individual's Life Plan and any other supporting documentation to CHOICES in order for the new CCO/HH to begin Care Management at the time of enrollment.

The transfer would be effective on the first day of the next month. The CCO/HH involved needs to discuss the timing of the transfer. Only one (1) CCO/HH may bill for an individual in a given month. The current CCO/HH along with the individual and/or their family/representative must sign a Withdrawal of Consent Form (DOH-5058). The new CCO/HH must obtain a Consent to Enroll Form (DOH-5055 or DOH-5200 & DOH-5201).

In addition, CCO's are required to adhere to the Willowbrook Permanent Injunction requirements, including that all notices and communications regarding Willowbrook Class Members will be shared with CAB.

## **6.10 CCO/HH Notices of Determination (NOD) and Fair Hearing Process**

### **Policy**

The State and CCO/HHs have roles in the CCO/HH Notice of Determination (NOD) process. The State requires that CCO/HHs maintain policies and procedures to notify individuals of their Fair Hearing rights, and assist DDROs with preparing the evidence packet if a CCO/HH enrollee requests a Fair Hearing challenging enrollment or disenrollment from the CCO/HH. A Notice of Determination is sent when an individual is enrolled in or disenrolled from a CCO/HH.

CCO/HHs are responsible for assisting individuals and their families with gathering the required documentation, evaluations, and assessments needed for both OPWDD and ICF LCEDs.

The six (6) reasons an individual must be disenrolled from Health Home Care Management or Basic HCBS Plan Support are:

1. No longer enrolled in Medicaid;
2. No longer residing in an appropriate setting;
3. Enrolled in another comprehensive Care Management program;
4. No longer residing in New York State;
5. No longer DD eligible or no longer meets the ICF LCED criteria; and/or
6. Confirmed deceased.

As discussed in Section 6.2, the DDRO will determine an individual's ICF Level of Care eligibility. Individuals are eligible for CCO/HH services when they meet the ICF LCED

and Developmental Disability eligibility determination criteria, are Medicaid enrolled, and live in a residential setting as described in 14 NYCRR Subpart 635-10.

CCO/HHs are also responsible for coordinating with the DDRO, as needed, regarding an individual's enrollment into or disenrollment from a CCO/HH.

### Relevant Statutes and Standards

- 18 NYCRR Part 358
- §2703 of the Patient Protection and Affordable Care Act (Pub. L. 111-148)
- §1945(h)(4) of the Social Security Act
- NYS SPA #11-56, 12-10, 12-11 (Health Homes for Individuals with Chronic Conditions)
- NYS SPA #15-0020 (Health Home Eligibility Criteria for Children)
- Office of Temporary and Disability Assistance's (OTDA) Office of Administrative Hearings (OAH) Procedures Transmittal #13-02, *Waiver of Personal Appearance Instructions for Agencies*
- NYS SPA #17-0025 (Health Homes for Individuals with Developmental Disability chronic conditions)
- New York State Mental Hygiene Law Section 1.03(22)

### Glossary of Terminology

**Adequate Notice** – Notice issued that meets the specifications of 18 NYCRR § 358-2.22; adequate notice is given when an application for CCO/HH enrollment is accepted or denied.

**Aid Continuing** – The right of a CCO/HH enrollee to have services continue unchanged until a Decision After Fair Hearing is issued. Aid Continuing directives are issued by the Office of Temporary Disability and Assistance (OTDA).

**Agency Conference** – An informal meeting that may be requested by the individual/family and/or representative, in addition to requesting a Fair Hearing, where the individual may submit additional information in support of their disagreement with the determination on enrollment or disenrollment in the CCO/HH Program.

**Evidence Packet** – Documentation supporting enrollment/disenrollment determinations including, but not limited to, the signed DOH-5055, DOH-5200, and DOH-5201 (if needed) consent forms; the updated Life Plan; care record notes; medical documentation; a written summary of the case; the applicable program policy upon which the decision is based; a copy of the notice sent to the individual.

**Fair Hearing** – A proceeding before an Administrative Law Judge (ALJ) that provides the opportunity for an individual and the agency to present evidence in support of a determination that the individual does not agree with.



**Notice Date** – The date the CCO/HH Notice of Determination is issued.

**CCO/HH Notice of Determination** – A written notice to a CCO/HH enrollee or potential enrollee of the CCO/HH’s determination of eligibility for CCO/HH enrollment or disenrollment.

**Timely Notice** – Per 18 NYCRR § 358-2.23, a timely notice is one that is mailed at least ten (10) days before the date upon which the proposed action is to become effective.

**Waiver of Appearance** – Per 18 NYCRR § 358-4.3 (c) (1), no later than 5 (five) calendar days before the hearing date, the agency may request a waiver from appearing and appear on papers only

### **CCO/HH Notice of Determination**

The State has developed two (2) notices for CCO/HHs to use to advise CCO/HH enrollees and/or their family/representative, of the CCO/HH’s notice of enrollment into or disenrollment from the CCO/HH program. These notices inform the individual of the decision being made, the reason for the decision, the individual’s right to a Fair Hearing, the ways by which to request a Fair Hearing, notice of the individual’s right to access his/her CCO/HH file and copies of documents in the case record, the individual’s right to Aid Continuing in certain circumstances, and the individual’s right to have an Informal Agency Conference with the DDRO.

These notices can be found at the following link:

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/lead\\_hhc.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/lead_hhc.htm)

### **CCO/HH and DDRO Responsibilities**

DDROs and CCO/HHs must communicate with and assist each other when issuing a CCO/HH Notice of Determination.

Additionally, the CCO/HHs must:

- Monitor eligibility via the CCO/HH roster provided by the State;
- Comply with the Decision after Fair Hearing as to enrollment or disenrollment from the CCO/HH program;
- Send a copy of the CCO/HH Notice of Determination to the individual and/or their family/representatives (see section titled “CCO/HH Notice of Determination” above) with a copy to the DDRO;
- Assist the DDRO when a Fair Hearing has been requested; and
- Have clear and focused training on Medicaid notice requirements, and are required to maintain a Quality Assurance program to ensure compliance with specified requirements.

The DDRO must:

- Authorize an individual's eligibility and its continuation;
- Record an individual's eligibility in the State's system;
- Hold an informal Agency Conference with the individual and/or his/her family/representative, and a representative of the CCO/HH, upon request of the individual;
- Have well-documented evidence to support enrollment/disenrollment determinations when a Fair Hearing is scheduled including, but not limited to: the signed DOH-5055, DOH-5200, and DOH-5201 (if needed) consent forms; the Life Plan (if available); care record notes; medical documentation, as well as a written summary of the case; the applicable program policy upon which the decision is based; and a copy of the notice sent to the individual;
- Create and provide a copy of the evidence packet/waiver of appearance to the individual and/or his/her family/representative and provide copies of other documents from the individual's case file upon request from the individual or his/her family/representative prior to the hearing;
- As requested, attend the Fair Hearing (unless a waiver of appearance has been granted by OTDA), be familiar with the case, and have the authority to make binding decisions at the hearing including the authority to withdraw the decision; and
- Comply with the Decision after Fair Hearing as to enrollment or disenrollment from the CCO/HH program.

### The Fair Hearing Process

The individual has **sixty (60) days from the date of the notice to request a Fair Hearing** from OTDA. When a Fair Hearing is requested, OTDA's OAH will issue form OAH-4420 (Acknowledgement of Fair Hearing Request), the Fair Hearing number assigned, and Confirmation of Aid Status. OTDA's OAH will then issue form OAH-457 (Notice of Fair Hearing) to the DDRO and the individual. Form OAH-457 will provide the Fair Hearing number assigned by OTDA, as well as the date, time, and location of the hearing. Form OAH-457 will indicate the aid status and whether the CCO/HH is being directed to provide Aid Continuing (i.e., to continue providing services unchanged until the Decision After Fair Hearing Notice is issued).

The individual has the right to be represented by legal counsel, relative, friend or another person, or to represent him/herself. At the hearing, the individual, his/her attorney, or other family/representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any person(s) who appear at the hearing. The individual has the right to bring witnesses to speak in his/her favor.

The DDRO must work with OPWDD Counsel's Office to prepare for and attend the Fair Hearing on the scheduled date, time, and location directed on form OAH-457.

## **CCO/HH Notice of Determination for Enrollment into the CCO/HH Program (DOH-5234)**

Form DOH-5234 notifies the individual and/or their family/representative of the individual's CCO/HH enrollment and the commencement of Care Management services. The notice should be mailed to the individual along with the CCO/HH welcome letter.

## **Notice of Determination for Disenrollment from the CCO/HH Program (DOH-5235)**

If a determination is made to disenroll a CCO/HH enrollee, timely notice by means of Form DOH-5235 is required before the CCO/HH can take any action. As defined in 18 NYCRR § 358-2.23, timely notice is one that is mailed at least ten (10) days before the date upon which the proposed action is to become effective.

## **Maintaining CCO/HH Enrollee Status in the Tracking System**

If Aid Continuing is not granted by OTDA, the CCO/HH should end the enrollment in the OPWDD system at the end of the month of disenrollment. If the Fair Hearing is in favor of the individual, enrollment will be adjusted accordingly.

## **Aid Continuing**

If the individual requests a Fair Hearing before the effective date stated in the notice, they may continue to receive benefits unchanged until the Fair Hearing decision is issued if granted Aid Continuing by OTDA. However, if the individual checks the box "I agree to have the action taken on my medical assistance benefits, as described in this notice, prior to the issuance of the Fair Hearing Decision" under Continuing Your Benefits on the back of the notice, the enrollment will remain unchanged in the OPWDD system until the Decision After Fair Hearing is issued.

## **Agency Conference**

Pursuant to 18 NYCRR § 358-3.8, at any reasonable time prior to the Fair Hearing, the individual can request an informal Agency Conference with the DDRO. If the individual requests an Agency Conference, the DDRO must arrange for a meeting with the individual and/or their family/representative or any person they choose (friend, family, attorney, neighbor, etc.), and a representative from the CCO/HH. The DDRO must allow the individual to submit additional information related to the Fair Hearing issue. The DDRO must review its determination on enrollment or disenrollment considering the additional information provided by the individual at the Agency Conference. The DDRO can withdraw its determination and enroll or re-enroll the individual. If the DDRO decides to uphold its initial determination, the individual will still be entitled to have the initial determination reviewed through the Fair Hearing process.

## Waiver of Appearance

Under certain circumstances and no later than five (5) calendar days before the hearing date, the DDRO may request a waiver of appearance from OTDA. If OTDA grants this request, the DDRO can submit a written evidentiary packet instead of appearing at the hearing location. Waiver requests will be reviewed and granted by OTDA on a case-by-case basis. Blanket waivers of appearance are not granted; however, if the agency contact does not receive a telephone call from OAH prior to the hearing date indicating otherwise, it will be presumed that the waiver of appearance has been granted. The waiver request should contain the primary and back-up contact person's names and telephone numbers. The waiver request must also contain the Fair Hearing number, date of hearing, and a summary of the specific facts relevant to the issue under review at the hearing.

## Examination of Case Record and Providing Documentation Prior to Fair Hearing

At any reasonable time prior to the Fair Hearing, the individual and/or their family/representative has the right to examine the contents of the individual's case record.

Additionally, the DDRO must provide complete copies of its documentary evidence and hearing summary to the ALJ at the time of the hearing. The DDRO must provide copies of this evidentiary packet to the individual and/or their family/representative at the hearing, or, if requested, within ten (10) business days of the scheduled date of the hearing. The evidentiary packet must include substantiation to support enrollment/disenrollment determinations including, but not limited to, a copy of the notice being challenged; the signed DOH-5055, DOH-5200, and DOH-5201 (if needed) consent forms; the updated Life Plan; care record notes; and medical documentation, as well as a written summary of the case; the applicable policy governing the program; an explanation of the action taken and why it was appropriate and in compliance with that policy; and any additional relevant information.

If the individual and/or their family/representative needs additional documentation to prepare for the Fair Hearing, the DDRO must provide the requested documentation within a reasonable time prior to the Fair Hearing date. If the individual's request is made less than five (5) business days before the hearing, the DDRO must provide such copies no later than at the time of the hearing. Case file documents should be mailed only if the individual specifically asks that they be mailed. If there is insufficient time for the documents to be mailed and received before the scheduled date of the Fair Hearing, the documents may be presented at the hearing instead of being mailed. Documents must be provided without charge to the individual or their family/representative.

## Decision After Fair Hearing

When the Decision After Fair Hearing is issued, it is binding upon the CCO/HH and DDRO and must be complied with in accordance with 18 NYCRR § 358-6.4.

If the Decision After Fair Hearing is in favor of the disenrolled individual, OPWDD will adjust the enrollment accordingly to ensure no lapse in the segments.

If the individual does not feel the DDRO has complied with the Fair Hearing decision within a reasonable time after receiving the decision, the individual may submit a Compliance Complaint to OTDA for investigation. Either party may request that OTDA reconsider the Decision After Fair Hearing if the party feels there has been an error in law or fact.

A request for reconsideration must be sent to the OTDA Litigation Mailbox at [litigationmail.hearings@OTDA.NY.GOV](mailto:litigationmail.hearings@OTDA.NY.GOV) or faxed to (518) 473-6735. While the reconsideration is under review, the Decision After Fair Hearing remains in effect. OTDA will notify the party of the result of its review. OTDA will note, if applicable, that it is correcting an error of law or fact in the decision, and/or reopen the hearing.

### **Training**

CCO/HHs must provide training to CMAs on notice procedures and management of the Fair Hearing process. CCO/HHs must provide access to and information regarding training opportunities that include the Fair Hearing Process described in this policy.

### **Quality Management Program**

CCO/HHs must have a Quality Assurance process to ensure that Care Managers and CMAs comply with CCO/HHs policies and procedures (see Section 3.3 Performance Measurements and Quality Metrics).

Quality indicators must include, but are not limited to, whether:

- The CCO/HH forwarded a correct and complete, timely and adequate notice to the individual/family/representative
- The CCO/HH provided notification of a Notice of Determination to the DDRO
- The DDRO provided the evidence packet to the individual and their family/representative; and
- The DDRO provided additional information requested by the individual and/or their family/representative within the required timeframes.

## **Section VII: CCO/HH Referrals**

### **7.1 DDRO Referrals**

The primary mechanism for referral to CCO/HHs for individuals with I/DD will be OPWDD, through its DDROs or designee. Individuals who present themselves at the DDRO's for OPWDD eligibility may be referred by provider offices, schools, etc. The DDRO's will determine if an individual meets the OPWDD eligibility criteria. Individuals

identified by the DDRO and by the nature of their diagnosis will, in most cases, meet the CCO/HH criteria. Referrals from DDRO's will be accepted by CCO/HH's to provide CCO/HH Care Management. If the DDRO determines that the individual does not meet CCO/HH criteria they may refer the individual to Health Home's serving adults or children.

There are at least two (2) CCO/HHs serving each of the five (5) regions of New York State. For a comprehensive list of CCO/HHs, their service area, and contacts for making referrals, please see:

[https://opwdd.ny.gov/news\\_and\\_publications/press-release/new-york-provides-people-developmental-disabilities-improved-way](https://opwdd.ny.gov/news_and_publications/press-release/new-york-provides-people-developmental-disabilities-improved-way)

## 7.2 Hospital Referrals

As required by Section 1945(3)(d) of the Social Security Act, all hospitals must have procedures in place for referring any eligible individual with chronic conditions seeking or needing treatment in a hospital ER/ED to a NYSDOH Designated Health Home.

# Section VIII: Health Information Technology (HIT)

## 8.1 Statewide Health Information Network of New York (SHIN-NY)

The SHIN-NY is comprised of eight (8) RHIO/QE's which support HIPAA-compliant clinical data exchange and use between their participating data providers and consumers. The RHIO/QEs are supported by shared technology, governance, and policy standards led by NYSDOH and facilitated by the New York eHealth Collaborative (NYeC) that oversees the SHIN-NY. Over the past decade, New York State has made major investments in the SHIN-NY and RHIO/QEs to facilitate data exchange between clinicians and Care Managers to support the delivery of high-quality coordinated, preventive, and patient-centered care, resulting in improved patient outcomes, reduction of avoidable tests and procedures, lowered costs, and support of new models of care delivery.

For more information on the SHIN-NY, the eight (8) regional RHIO/QEs, and NYeC, visit the NYeC website at the link: <https://www.nyehealth.org>

## 8.2 Health Information Exchange via NYS RHIO/QE

Health information in New York State is exchanged between providers, hospitals, payers and other authorized stakeholders, via the SHIN-NY, and its component RHIO/QE networks (described in more detail in Section 8.1). Providers, hospitals, CCO/HHs and other stakeholders sign a data sharing agreement to become a participant with a RHIO/QE so they can access and exchange electronic health information with participants in their region, and throughout New York State. With limited exceptions, a CCO/HH participating with a RHIO/QE can access individual's information

via the RHIO/QE's interface only if the individual signs a written consent form authorizing such access.

Individuals can provide this written consent in a variety of ways. The current DOH-5055 consent form is a single entity RHIO/QE consent, in that it allows the CCO/HH to access the individual's health information through the RHIO/QE named on the consent form (provided the CCO/HH is a participant with that RHIO/QE). If the RHIO/QE can support the use of a multi-entity consent form, such form is permitted. The individual must give the CCO/HH permission to directly access their health information at each RHIO/QE. In other words, a CCO/HH can access the individual's information via more than one RHIO/QE interface, provided each RHIO/QE is named on the signed CCO/HH consent form (and the CCO/HH has a data sharing agreement to participate with each RHIO/QE).

The CCO/HH is required to participate with at least one (1) RHIO/QE to meet the final HIT requirements. There may be financial considerations to joining a RHIO/QE or using their interface for data exchange. Ultimately, the CCO/HH must be able to transmit and receive data electronically with its associated organizations and providers.

If a CCO/HH Withdrawal of Consent Form (DOH-5058) is signed, permission to share new data among CCO/HH partners is negated and the CCO/HH cannot access the individual's health information via the RHIO/QE(s) named on that form.

## Section IX: CCO/HH Record Keeping Requirements

### 9.1 CCO/HH Services and Minimum Billing Standards

CCO/HHs must provide at least one (1) of five (5) core services (exclusive of HIT) per month to meet minimum billing requirements. CCO/HH Care Managers must adhere to the following face-to-face meeting requirements:

- For individuals in Tiers 1-3, the Care Manager must have at least one (1) face-to-face meeting with the individual on a quarterly basis (January – March; April – June; July – September; and October – December).
- For individuals in Tier 4, the Care Manager must have a monthly face-to-face meeting with the individual.

Active, ongoing, and progressive engagement with the individual must be documented in the Care Management record to demonstrate active progress towards care planning, and/or the individual achieving their personal goals. Except for interviews to make assessments and plans, case contacts do not need to be all face-to-face encounters. They may include contacts with collaterals or service providers in fulfillment of the individual's plan.

The State retains the right to review CCO/HH Care Management records as required to assure that services were provided in each month for which a Medicaid payment was

made for CCO/HH services. It is the State's expectation that the written documentation in the Care Management record will clearly demonstrate how the core services, with the exception of the use of HIT, are being met. It is the CCO/HH's fiduciary responsibility to ensure compliance with minimum billing standards and develop an ongoing quality monitoring process of valid billable services. The CCO/HH Payments and Minimum Billing Standards are provided in Part 1 of the CCO/HH Application.

## 9.2 CCO/HH Record Keeping Requirements

A separate Care Management record must be maintained for each individual served and for whom reimbursement is claimed. In addition to the record keeping requirements, the record must contain:

- A copy of the individual's signed consent form (FAQ, DOH-5055, DOH-5200, DOH-5201);
- An initial comprehensive assessment will be required. Reassessment will be required annually and/or if there is a significant change in the individual's health, behavioral health, or social needs status;
- The Life Plan and subsequent updates, containing goals, objectives, timeframes, etc. as agreed to by the individual and the Care Manager;
- Copies of any releases of information signed by the individual; and
- Medical/behavioral health and social service referrals made.
- For CCO/HHs, to initiate and bill for CCO/HH services, Care Managers will be required to complete a CCO/HH Service Checklist designed to initiate a smooth transition into CCO/HH services for the individuals they serve.
- CCO's are also required to adhere to all Willowbrook Permanent Injunction requirements.

## Section X: Basic HCBS Plan Support

### Overview

Basic Home and Community Based Service Plan Support (Basic HCBS Plan Support) is a separate and distinct HCBS Waiver service. This service is for individuals who choose not to enroll in CCO/HH Care Management services. This service provides the necessary assistance to conduct timely reviews and updates of an individual's Life Plan, and to maintain documentation supporting the individual's HCBS Waiver ICF Level of Care eligibility determination. The service is designed to meet the needs of the individual as described in their Life Plan. Individuals receiving a Waiver service must have a Life Plan and this requirement can be met through Basic HCBS Plan Support Care Management for individuals who do not need or want ongoing comprehensive Care Management. Basic HCBS Plan Support services support individual's enrolled in the HCBS Waiver and this service coordinates and arranges for the provision of Waiver services only.



## **Consent to Enroll in HCBS Basic Support Service**

Individuals must consent to enroll in the Basic HCBS Plan Support service program. The Care Manager must obtain a signed Basic HCBS Plan Support consent form. The Care Manager must review the consent form annually with the individual and/or their family/representative and note the review in the individual's record.

## **Basic HCBS Plan Support Care Manager Role & Responsibilities**

The Care Manager responsibilities require that individuals enrolled in this service, have a Life Plan. The Care Manager must follow the requirements as outlined in OPWDD's person-centered planning regulation, found at 14 NYCRR § 636, subpart 636-1 person-centered planning for the development and implementation of the Life Plan. The Care Manager must develop and monitor the individual's Life Plan and provide education to individuals about their freedom of choice of available CCO/HH options in their region.

The Care Manager ensures that individuals who choose to enroll in Basic HCBS Plan Support Care Management have:

- a current Life Plan;
- a current ICF Level of Care eligibility determination;
- a completed annual re-determination of ICF Level of Care eligibility determination on file;
- notified the Regional Office of an individual's eligibility for HCBS Waiver services changes;
- at a minimum, met two (2) times per year or at the request of the individual and/or family representative or advocate to maintain, monitor, review and revise the individual's Life Plan;
- identified the necessary safeguards in the Life Plan to protect the health and welfare of the individual; and
- maintained a complete and comprehensive Basic HCBS Plan Support record.

The Care Manager will use a person-centered approach to develop the Life Plan by identifying the desired goals and Valued Outcomes of the individual and the supports and services the individual wants or needs to achieve those outcomes. The Care Manager helps the individual by promoting and supporting informed choice and developing a personal network of activities, supports, services, and community resources based on the individual's needs. The Care Manager helps the individual identify the Care Management activities and interventions needed to meet their goals and Valued Outcomes as described in the individual's Life Plan. The Care Manager documents in the Life Plan the supports, services, community resources needed and chosen by the individual, the entities that will provide the services and the duration of the service (effective start and end date).

To implement the Life Plan, the Care Manager is responsible for coordinating access to the delivery of supports and services identified in the Life Plan by:

- helping to locate and/or create natural supports and community resources
- locating funded services
- helping to determine eligibility
- making referrals
- facilitating visits and interviews with family members, service providers, housing options etc.; and
- ensuring essential information is available to the individual, providers and others with the consent of the individual

The Life Plan must be reviewed at least twice in a twelve (12) month period by the Care Manager, the individual and/or family/representative. Both reviews must be face-to-face at the individual's residence or at an alternate site mutually agreed upon by the individual and/or their family/representative and the Care Manager. At least one (1) of the Life Plan meetings must include all Developmental Disability service providers and others as necessary and agreed upon.

### **Life Plan**

The Life Plan only requires the integration of HCBS services. The Life Plan is an understandable and personal plan with required attachments for implementing decisions made through the person-centered planning process. The Life Plan identifies the services and supports that the individual receives, identifies the providers of services, the frequency services and includes any required habilitation plans, either integrated or as attachments. For individuals who live in an IRA, an IPOP is required to be incorporated into or attached to the Life Plan. The Basic HCBS Plan Support Life Plan is not required to include POMS and/or a special consideration section. The Life Plan is required to be accessible to the individual and/or their family/representative with appropriate consideration for language and literacy, via mail.

### **Basic HCBS Plan Support Service Record**

The provider delivering Basic HCBS Plan Support must maintain a Basic HCBS Plan Support record for all individuals receiving this service. The Basic HCBS Plan Support record must contain:

#### **Waiver Enrollment**

- Consent for participation in Basic HCBS Plan Support
- Preliminary Life Plan
- Documentation of Choices;
- Notice of Decision;
- Initial, current, and each annual (re-determination) of ICF Level of Care eligibility determination eligibility;
- Name of the individual's advocate (or a statement that the individual is self-advocating).
- Any clinical assessments that support the individual's ICF Level of Care eligibility determination;

- ICF Level of Care eligibility determination final summary and post discharge plan for individuals enrolled in the HCBS Waiver who moved directly from an ICF to Waiver enrollment, if applicable;

#### **Life Plan with attachments**

- HCBS Waiver habilitation plans (or integrated into the Life Plan);
- IPOP if the individual lives in an IRA

#### **Written Evaluation/Clinical Assessments**

- Any clinical assessments that support the individual's ICF Level of Care eligibility determination;
- ICF/MR final summary if applicable;
- Post discharge plan for an individual who moves directly from an ICF to HCBS Waiver enrollment
- Notes to substantiate claims for Basic HCBS Plan Support service

#### **Basic HCBS Plan Support – Service, Billing, and Frequency**

This service is billable up to four (4) service months per a twelve (12) month period. If service coordination activities are needed more than four (4) months per a twelve (12) month period, the individual should be advised of the CCO/HH service option and the benefits of the program.

No less than two (2) service months within a twelve (12) month period, Basic HCBS Plan Support meetings will be conducted to review and update the individual's Life Plan, related records and to ensure the HCBS Waiver ICF Level of Care eligibility determination is completed annually. During these two (2) service months, the Care Manager must document and conduct a face to face meeting and review (may include the creation of the initial Life Plan) and/or update the Life Plan, or complete a Life Plan addendum. At least one (1) Life Plan meeting must include all Developmental Disability service providers and others as necessary or agreed upon.

For the two (2) additional months within the twelve (12) month period, the Basic HCBS Plan Support Care Management service can be provided for those months when there is an "unexpected need". Unexpected need must include one of the following:

- Addressing a health or safety issue
- Obtaining a needed service
- Negotiating and resolving conflict, or
- Accessing entitlements and benefits for the individual

For the CCO/HH to qualify the additional service months, the Care Manager must complete at least one (1) face to face contact or two (2) of the following contacts within a month: non-face to face contact with the individual, a direct contact with a qualified contact, or a direct contact with other agencies. The Care Manager must document the

purpose of the contact as related to a least one (1) of the four (4) “unexpected needs” identified above.

Non-face to face and direct contacts include; phone call or personal contact exchange, email, or letter/correspondence exchange. A qualified contact is someone directly related to assisting or resolving the unexpected need of the individual (family member, service providers, educators).

When hospital admissions are expected to last thirty (30) days or less, the relationship with the Care Manager may be continued and if requirements are met, may be counted towards billing requirements. However, after the 30<sup>th</sup> day, Care Management activity does not qualify for reimbursement. The Care Manager should work with the individual’s team to assess and identify the needs of the individual and to provide support through the discharge planning process.

### **Service Documentation for Billing**

Documentation for Basic HCBS Plan Support service is required for monthly billing. The documentation must include the following in the monthly service note:

- 1) The individual’s name
- 2) Identification of the service provided and the CCO/HH providing Basic HCBS Plan Support
- 3) Month and year the service is provided
- 4) The location of the service meeting for Life Plan review only
- 5) A description of the activities that justifies meeting the minimum billing requirement that is described above. If the activity involves contact with a qualified contact, the identity of the qualified contact and the relationship to the individual must be documented
- 6) The name, title, and signature of the Care Manager delivering the service and the day, month and year the note was written. The note should be written at the time of service delivery or shortly after the time the service was provided. A monthly service note includes documentation of the service coordination activity and a monthly summary completed and signed by the 15<sup>th</sup> day of the month following the service month.

In addition to the service note supporting Basic HCBS Plan Support service delivery, the CCO/HH must maintain the following documentation to support claims for payment:

- Evidence that the Care Manager attended basic training or received instructions using an OPWDD approved curriculum
- For individuals enrolled in the HCBS Waiver, a copy of the ICF Level of Care eligibility determination and the annual redetermination completed and signed

within 365 days from the effective date of the initial ICF Level of Care eligibility determination or from the signature date of the previous year's review date.

- A copy of the Life Plan that includes:
  - 1) Identification of the service provided
  - 2) Identification of the CCO/HH
  - 3) Frequency of service
  - 4) Identification of the effective date of Basic HCBS Plan Support. The effective date must be on or before the first date of service that the CCO/HH bills for Basic HCBS Plan Support.
- Evidence that the individual's Life Plan has been reviewed twice annually. Evidence of a review may include, but is not limited to, a review sign-in sheet, a monthly service note indicating that the Life Plan was updated or revised, a Life Plan addendum, a revised Life Plan, or a review section on the Life Plan. All evidence of Life Plan reviews must include the following elements:
  - 1) The individual's name
  - 2) Name of the CCO/HH providing Basic HCBS Plan Support
  - 3) The name, signature and title of the Care Manager and/or supervisor who conducted the review
  - 4) The date of the review
  - 5) Description of any changes made to the Life Plan. If no changes were made, then this should be noted.

An individual's first Life Plan must be written and signed, at minimum, by the Care Manager and the individual and/or their family/representative within sixty (60) days of enrollment in the HCBS Waiver or Basic HCBS Plan Support enrollment which ever date comes first.

### **Documentation Retention**

All documentation specified above, including the Life Plan and service documentation, must be retained for a period of at least six (6) years from the date the service was delivered or when the service was billed, whichever is later. Diagnostic information and other clinical records are generally maintained for a longer period of time and are not the subject of this policy.

### **Initial Basic HCBS Plan Support Payment**

The CCO/HH may bill for a one (1) time initial payment for one (1) month when an individual has never been enrolled in the Waiver, never received Health Home or Medicaid Service Coordination services and the Care Manager is developing and implementing the Life Plan. The Care Manager must document in the individuals record

that substantiates the eligibility for the one (1) time initial payment. The amount of the payment is three (3) times the regular rate for Basic HCBS Plan Support services.

### **Basic HCBS Plan Support Care Manager Qualifications & Requirements**

CCO/HH Basic HCBS Plan Support Care Managers serving individuals with I/DD must meet the following qualifications:

- 1) A Bachelor's degree with two (2) years of relevant experience, OR
- 2) A License as a Registered Nurse with two (2) years or relevant experience, which can include any employment experience and is not limited to case management/service coordination duties OR
- 3) A Master's degree with one (1) year of relevant experience.
- 4) Current MSC Service Coordinators are "grandfathered" to facilitate continuity for the individual receiving coordination. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC Agency or the CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.

CCO/HH Care Manager qualifications will be waived for existing MSC Service Coordinators who apply to serve as Care Managers in CCO/HHs. CCO/HHs will be required to provide the CCO/HH core services training for current MSC Service Coordinators transitioning to CCO/HH Care Management and who do not meet the minimum education and experience requirements. Such training shall be provided by the CCO/HH within one (1) year of contracting with an MSC Service Coordinator. The CCO/HH will adjust training activities for Care Managers serving individuals enrolled in Basic HCBS Plan Support.

### **Notice of Decision and Notice of Termination Processes**

When an individual enrolls in Basic HCBS Plan Support the CCO/HH will be responsible for sending a written notice of the determination (also called a Notice of Decision) to the individual and/or their family/representative. The CCO/HH should maintain a copy of this Notice of Decision in the individual's record.

If at any point while enrolled in Basic HCBS Plan Support, the individual is no longer eligible to receive the service, the DDRO will be responsible for sending a written notice of the termination (also called a Notice of Termination). The CCO/HH will communicate the change in eligibility status to the DDRO so that the Notice of Termination can be issued.

This service is a Medicaid-funded service and a Medicaid Fair Hearing will be required to be offered on the transmittal for determination terminating enrollment in the Basic HCBS Plan Support service.

The allowable basis on a determination for termination are:

- The individual is deceased
- The individual is not Medicaid enrolled
- The individual is not residing in appropriate setting
- The individual is enrolled in another comprehensive Care Management program
- The individual has chosen to voluntarily withdraw from the program
- The individual no longer meets ICF Level of Care eligibility criteria
- The individual has moved out of state

## Section XI: State Paid Care Management

### Overview

State Paid Care Management services may be authorized for individuals in need of Care Management services but do not qualify for Health Home Care Management or Basic HCBS Plan Support. These individuals include:

- Willowbrook Class Members who reside in residential settings that preclude enrollment into Health Home Care Management or Basic HCBS Plan Support
- individuals who are not able to obtain Medicaid but require Care Management services
- children enrolled in Early Intervention (EI) services who are also enrolled in the HCBS Waiver

Type of State Paid Care Management	Billing Frequency	Description
Willowbrook Case Services	Monthly	Willowbrook Class Members residing in an ICF/IID
Willowbrook Service Coordination	Monthly	Willowbrook Class Members residing in a Nursing Home or other non-qualifying setting
State Paid Care Management	Monthly	Individuals who qualify under the Liability for Services Regulations for State Paid Care Management
Early Intervention (EI)	Twice annually	EI children enrolled in the HCBS/1115 Waiver

## **Enrollment**

Individuals who are authorized for State Paid Care Management must be enrolled into the appropriate TABS program code. CCOs will be able to obtain a roster of enrolled individuals via the Enrollment Inquiry in CHOICES.

## **Billing and Payment Forms**

To bill for State Paid Care Management, the CCO must submit the billing form that accommodates the various types of State Paid Care Management. Price IDs, which OPWDD utilizes to authorize these services are assigned to each CCO and must be included on the billing form. In addition to the billing form, CCOs must submit a standard voucher or claim for payment form to authorize the payment. In lieu of completing the information on the designed billing form, CCOs can choose to submit the information in a spreadsheet of their own design as long as all the required elements are captured. Should CCOs establish an alternate form based on their particular needs, an original signature would still need to be submitted to authorize payment. CCOs can complete the identifying information on a single cover sheet and submit along with the format they have chosen.

## **Payment Standards**

Payment for State Paid Care Management requires the following for each individual served:

- prior authorization from the OPWDD Regional Office where the individual resides
- enrollment into the appropriate TABS program code

Individuals enrolled in State Paid Care Management do not qualify for initial payments. This is consistent with OPWDD's State paid payment processes prior to the July 1, 2018 transition to Care Coordination Organizations Health Home and Basic HCBS Plan Support.

The unit of service for State Paid Care Management is a month. To bill for a month of State Paid Care Management, providers must meet and document one (1) of the following activities:

1. Face-to-face service meeting with the individual. (Note: to bill for a month of service for Willowbrook Class Members, Care Managers must continue to deliver and document a minimum of one (1) face-to-face service meeting per month)
2. Life Plan reviews (which may include the creation of the initial Life Plan, a face-to-face Life Plan review, and any non-face-to-face Life Plan review)
3. Updates to the Life Plan (this does not have to be a face-to-face service meeting)
4. Completion of the ICF LCED or redetermination (this does not have to be a face-to-face service meeting)
5. Or document at least two (2) activities from the following list:



- a. Non-face-to-face contacts with the individual
- b. Direct contact with someone who the Care Manager gathers information from (i.e., qualified contact or direct contact with other agencies)

Non-face-to-face and direct contact includes:

- Phone call or personal contact;
- Email exchange;
- Letter/correspondence exchange

### **Service Documentation for Billing**

All services submitted for State payment will be required to have supporting documentation on file to substantiate claims paid. Monthly service note documentation for each service required must include the following:

- the individual's name
- identification of the service provided and the CCO providing State Paid Care Management
- the month and year that the service was provided
- the location of the service meeting for the Life Plan review only
- a description of the activities that justifies meeting the minimum billing requirement described in the Payment Standards above. If the activity involves communication with a qualified contact, documentation must include the identity of the qualified contact and their relationship to the individual
- the name, title and signature of the Care Manager delivering the service and the day, month and year the note was written. The note should be written at the time of service delivery or shortly after the time the service was provided. A monthly service note includes documentation of the Care Management activity and a monthly summary completed and signed by the 15<sup>th</sup> day of the month following the service month.

In addition to the service note supporting each monthly State Paid Care Management claim, the CCO must maintain the following documentation to support claims for payment:

- evidence that the Care Manager attended basic (i.e., The Fundamentals of OPWDD) training or received instruction using an approved OPWDD curriculum.
- for individuals enrolled in the HCBS Waiver, a copy of the if the ICF LCED and the annual redetermination completed and signed within 365 days from the effective date of the initial ICF LCED or from the signature date of the previous year's review date

- A copy of the individual's Life Plan (except for Willowbrook individuals permanently residing in an ICF or nursing home) that includes:
  - identification of the service provided
  - identification of the CCO providing State Paid Care Management
  - frequency of the service
  - the effective date of State Paid Care Management. The effective date must be on or before the first date of service that the CCO bills for State Paid Care Management.
- evidence that the individual's Life Plan has been reviewed twice within a twelve (12) month period. Evidence of a review may include, but is not limited to the following:
  - review sign-in sheet
  - monthly service note indicating that the Life Plan was updated or revised
  - a revised Life Plan or a review section on the Life Plan

All evidence of Life Plan reviews must include the following elements:

- the individual's name
- name of the CCO providing State Paid Care Management
- the name, signature, and title of the Care Manager and/or supervisor who conducted the review.
- the date of the review which must include the day, month, and year
- a description of any changes made to the Life Plan. If no changes were made, then this should be noted

An individual's initial Life Plan must be written and signed, at minimum, by the Care Manager and the individual and/or their family/representative within sixty (60) days of the State Paid Care Management enrollment date.

### **Early Intervention (EI)**

Children participating in the EI Program receive an Individual Family Service Plan (IFSP) for their EI services, but they must also have a Life Plan if they are receiving an HCBS Waiver Service at the same time. For these children, the CCO may only bill a maximum of twice within a twelve (12) month period. The Care Manager must document and conduct a face to face meeting and review (may include the creation of the initial Life Plan) and/or update the Life Plan. At least one (1) Life Plan meeting must include all Developmental Disability service providers and others as necessary or agreed upon.

The initial transition payment is not available for children enrolled in the EI program.

### **Documentation Retention**

All documentation specified above, including the Life Plan and service documentation, must be retained for a period of at least six (6) years from the date the service was delivered or when the service was billed, whichever is later. Diagnostic information and other clinical records are generally maintained for a longer period of time and are not the subject of this policy.

For Willowbrook Class Members, all documents, including those specified above, must be retained indefinitely.

## Section XII: CCO/HH Training Guidelines

To support the successful transition of MSC Service Coordinators into CCO/HH Care Managers, a guide was designed and developed to outline the training and professional development requirements for Care Managers.

The interactive “Guide for Training Care Managers,” was developed by the New York Association of Emerging and Multicultural Providers (NYAEMP) in collaboration with the OPWDD, NYSDOH, and the New York State Technology Enterprise Corporation (NYSTEC). The guide provides learning objectives and comprehensive resources for development of curricula that is based upon the required six (6) core services and OPWDD’s ten (10) Skill Building areas for Care Managers.

CCO/HHs should use this guide to develop trainings that would accomplish the learning objectives for Care Managers. The extensive resources listed in the guide are considered the most appropriate at the current time to equip CCO/HHs with the tools needed to ensure a highly skilled and ethical workforce. Also within the draft guide is Appendix A, which integrates the required OPWDD trainings that support the skill areas. It also clarifies expected timeframes for training the transitioning MSC Service Coordinators and newly hired Care Managers. Any additional Care Manager trainings from OPWDD related to policy or the operations of the CCO/HH will be developed as needed and shared with the CCO/HHs.

## Section XIII: Glossary of Terms

For the purposes of the CCO/HH program and as used in this Manual, the following terms are defined.

**Adverse (Significant) Event:** An event involving an individual, which has, or may have, an adverse effect on the life, health, or welfare of the individual and/or another person. This can include:

- a change in functioning (including an increase or decrease of symptoms or a new diagnosis);
- in-patient or outpatient hospital admittance and/or discharge;
- a serious injury; or
- admittance, discharge or transfer from a residential placement; or

- a significant change in housing or support resources.

**Business Associate Agreement (BAA):** an agreement not to use or further disclose PHI, other than what is permitted or required by the agreement or as required by law. This includes using the appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by the agreement. The agreement includes implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that it creates receives, maintains, or transmits on behalf of the covered entity.

**Care Management:** a process of coordinating and arranging for the provision of needed services in accordance with goals contained in an individual's written Life Plan.

**Client Identification Number (CIN):** Medicaid Client Identification Number that is unique to each Medicaid beneficiary.

**Claims Payment:** a process within eMedNY that generates a payment of all approved claims and prepares a Remittance Statement with each payment cycle which lists the status of all paid, denied, and pended claims.

**Conflict-Free Care Management (CFCM):** Federal Home and Community-Based Settings rule, 42 CFR 441.301(c)(1)(vi), effective March 2014 requires that "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan (Life Plan)." The intention of this Federal rule is to ensure that Case Management services are person-centered and promote the individual's interests, not those of the provider agencies.

**Coordinated Assessment System (CAS):** An assessment tool specifically tailored to capture the unique health and support needs of individuals with I/DD in New York State. The CAS is used to help develop the Life Plan for individuals in a CCO/HH. The CAS is being implemented in phases and until it is implemented Statewide, the DDP2 will be the assessment tool used to determine CCO/HH PMPM rates and for the development of the Life Plan where applicable.

**Data Use Agreement (DUA):** a legally binding agreement between the Requestor and NYSDOH by defining the terms and conditions of the MCD release, should DOH accept the Requestor's Agreement. An additional purpose of the DUA is to assure DOH that a Requestor will maintain the security of MCD that DOH releases to the Requestor.

**Designated CCO/HH Provider:** a provider approved and designated by NYSDOH and OPWDD as a provider of CCO/HH services.

**Developmental Disability** – A severe, chronic disability which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual's functioning in several major life activities.

**Dually Eligible Individual:** an individual that qualifies and receives both Medicare and Medicaid.

**eMedNY:** Electronic Medicaid System of NY. Allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible individuals.

**Fee-for-Service (FFS) Member:** members that do not belong to a MMCP and receive services from providers who are contracted with the State based on an agreed upon rate for services.

**Front Door:** The Front Door refers to the process by which OPWDD connects individuals to the services they need and want by providing assistance in navigating the steps involved in determining OPWDD eligibility, identifying needs, goals and preferences and developing a plan for obtaining those services.

**Health Commerce System (HCS):** an electronic resource designed to protect the confidentiality of data by requiring that organizations adhere to NYSDOH health data security standards. This secure website can be used to send/request data and reports. The HCS is maintained by the NYSDOH Bureau of HEALTHCOM Network Systems Management.

**Health Home Service Provider:** a provider of CCO/HH Services that has a contractual relationship with a CCO/HH.

**Health Home Services:** services as defined in Section 1945(h)(4) of the Social Security Act including: comprehensive Care Management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and the use of health information technology to link services as feasible.

**CCO/HH Service Organizations:** the collective list of CCO/HH Service Providers.

**CCO/HH Participant:** a Medicaid eligible candidate who agrees to receive CCO/HH services.

**Health Information Exchange (HIE):** the process of reliable and interoperable electronic health information sharing managed such that confidentiality, privacy and security of the information is maintained. A health information exchange is the platform that is used to manage this process and that has a number of functionalities to allow this secure management and exchange of data.

**Home and Community-Based Services (HCBS):** HCBS services provide opportunities for individuals to receive services in their own home or community rather than institutions or other isolated settings.

**Interdisciplinary Team (IDT):** also known as the care planning team. The team of individuals who participate in the person-centered planning process and the development of an individual's Life Plan. The team must be comprised of the individual and/or their family/representative, Care Manager, primary providers of developmental disability services and other providers either as requested by the individual and their family member/representative.

**Intellectual Disability:** A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers a range of everyday social and practical skills.

**LGU:** Means a County, except a County within the City of New York. The unit of local government is given authority by the government to provide local services.  
[http://law.onecle.com/new-york/mental-hygiene/MHY041.03\\_41.03.html](http://law.onecle.com/new-york/mental-hygiene/MHY041.03_41.03.html)

**Long Term Supports and Services (LTSS):** Services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals and administering medications.

**Managed Care Organization/Plan (MCO or MCP):** A health maintenance organization/plan or prepaid health service plan, certified under the Public Health Law, that contracts with health care providers and medical facilities to provide care for individuals at reduced cost(s).

**Medicaid:** A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources and/or high cost medical conditions.

**Medicaid Managed Care (MMC):** A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and often additional services through contracted arrangements between State Medicaid agencies and MCOs that accept a set PMPM capitated payment for these services.

**Medicare:** The Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD).

**National Provider Identifier (NPI):** An identification number assigned by the National Plan and Provider Enumeration System (NPPES).

**Office for People With Developmental Disabilities (OPWDD):** New York State agency responsible for coordinating services for more than 128,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down Syndrome, autism spectrum disorders, and other neurological impairments. It provides services directly and through a network of approximately 750 nonprofit service agencies. Supports and services, including Medicaid funded long-term care services, such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the State. In addition to these Medicaid services, OPWDD also provides New York State-funded family support services.

**Personal Outcome Measures (POMS):** Developed by the CQL, POMS is a list of twenty-one (21) personal outcomes designed to measure if the individual is supported in a way that achieves the outcomes that are most important to them.

**Regional Health Information Organization (RHIO):** organizations of regional partners that may include hospitals, physicians, and MCOs and others that oversee the infrastructure for the secure electronic exchange of clinical information.

**State Approved Functional Needs Assessment:** OPWDD requires that individuals determined eligible for OPWDD services have a completed state approved functional needs assessment that is used to inform the comprehensive assessment process. When the CAS has been completed for an individual, that CAS functions as OPWDD's State approved functional needs assessment to inform the comprehensive assessment process. If a CAS has not yet been completed for the individual, then the DDP2 is the State approved functional needs assessment to be used to inform the comprehensive assessment process.

## Section XIV: CCO/HH Contact Information

Billing, Remittance, And Training	<p><b>eMedNY Call Center</b> (800) 343-9000                  E-mail: <a href="mailto:emednyproviderrelations@csra.com">emednyproviderrelations@csra.com</a></p>
CCO/HH Policy NYSDOH	<p><b>NYS Department of Health (NYSDOH)                  Office of Health Insurance Programs (OHIP)</b>                  One Commerce Plaza                  99 Washington Ave.                  Albany, NY 12210                  Phone: 518-473-5569                  Email: <a href="mailto:hhidd@health.ny.gov">hhidd@health.ny.gov</a>                  Website:  <a href="https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm">https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/index.htm</a></p>
CCO/HH Policy – OPWDD	<p><b>NYS Office for People With Developmental Disabilities (OPWDD)</b>                  44 Holland Ave.                  Albany, NY 12229                  Phone: (518) 486-6466                  Email: <a href="mailto:care.coordination@opwdd.ny.gov">care.coordination@opwdd.ny.gov</a>                  Website:  <a href="https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations">https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations</a></p>
Office of Quality and Patient Safety (OQPS-NYSDOH)	<p><b>New York State Department of Health</b>                  Empire State Plaza                  Corning Tower                  Albany, NY 12237                  Office: (518) 474-5423                  Email: <a href="mailto:SHINY-NY@health.ny.gov">SHINY-NY@health.ny.gov</a>                  Website: <a href="http://www.health.ny.gov/technology/regulations/shin-ny">http://www.health.ny.gov/technology/regulations/shin-ny</a></p>
Health Commerce System (HCS)	<p><b>Informatics Unit, BHNSM, NYSDOH</b>                  800 North Pearl Street, Room 236                  Albany NY 12204                  General Inquiries: (518) 473-1809                  Commerce Accounts Management Unit (CAMU): (866) 529-1890                  Website: <a href="https://commerce.health.state.ny.us/hcsportal/hcs_home.portal">https://commerce.health.state.ny.us/hcsportal/hcs_home.portal</a></p>