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

Memorandum

TO: Care Coordination Organization (CCO) Chief Executive Officers
Developmental Disabilities Regional Offices (DDRO) Directors
Provider Associations

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

DATE: August 19, 2019

SUBJECT: CCO Referrals and Transitional Services for Individuals in Excluded Settings

This memo is immediately effective and content will be incorporated into the next revision of the CCO/Health Home Provider Policy Guidance and Manual available at this link: https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx

The purpose of this policy memorandum is to clarify the roles and responsibilities of the Care Coordination Organization (CCO) when facilitating referrals and transitional services for individuals in "excluded settings".

"Excluded settings" are institutional settings that include but are not limited to: inpatient hospital settings, Intermediate Care Facilities (ICF), Developmental Centers, residential schools, correctional settings (i.e., jail and/or prison), and nursing homes. This also includes State-operated psychiatric centers in relation to individuals who are between 21 and 64 years of age and residing in the center.

Each OPWDD Regional Office will have mechanisms in place to ensure that individuals are educated on the available CCOs in their area so they can make an informed decision on which CCO they would like to be referred to.

Each CCO, as indicated in the CCO Health Home Policy and Guidance Manual, must accept all referrals of individuals with intellectual/developmental disabilities who are eligible for OPWDD services made by an OPWDD Regional Office or other referring entities. These referral entities may include but are not limited to: the criminal justice system, the Department of Corrections and Community Services, county and city jails, hospital inpatient settings, State-operated psychiatric centers, and social service providers. CCOs must have an identified point of contact and clear processes in place for accepting referrals from these sources and

providing necessary supports and services including comprehensive transitional care and comprehensive care management services.

To ensure individuals experience a smooth transition and to allow adequate time for service planning, referrals to CCOs will typically occur prior to the individual's discharge from the institutional setting. It is the expectation that CCOs will begin assisting these individuals at the time of referral to the CCO, even though enrollment into the CCO cannot occur until post-discharge from the institutional setting. CCOs should establish a process that enables them to respond quickly to individuals referred who are discharged unexpectedly or with short notice (e.g., an individual who signs themselves out of a hospital setting against medical advice) or who are in crisis situations.

In recognition of the additional workload associated with assisting individuals with the transition from institutional settings to more independent settings, the CCO is eligible to receive a one-time enhanced transition payment for the provision of Care Management to individuals in transition who have never before received care coordination services through OPWDD. This enhanced payment is available the first month of enrollment in the CCO and is to accommodate the additional time required to assist the individual.