Office for People With Developmental Disabilities

Memorandum

TO: Care Coordination Organizations
CEOs of Voluntary Provider Agencies
Developmental Disabilities State Operations Offices (DDSOO) Directors
Developmental Disabilities Regional Offices (DDRO) Directors
Provider Associations
Willowbrook Consumer Advisory Board

FROM: Allison McCarthy, Director of Managed Care Implementation

DATE: January 1, 2021

SUBJECT: Care Coordination Organization/Health Home (CCO/HH) Provider Policy Guidance and Manual Updates

The purpose of this Memorandum is to implement policy revisions, effective January 1, 2021, to promote service delivery requirement efficiencies and to provide more flexibility to CCOs to deliver person-centered care management services. The CCO/HH Provider Policy Guidance and Manual (Version 2018-1) will be revised to reflect these revisions in the coming months.

<u>Individual and Family Communication Portal</u>

The requirement that CCO/HHs must provide the capability for individuals and/or their family/representative to access, via a secure web-based portal, the Life Plan and to view or upload documents and input information to the Life Plan is hereby deferred. The requirement will be revisited for discussion and a potential implementation timeline prior to CCO/HH Re-Designation in 2024. CCOs must have an electronic means (e.g., secure email) for sharing care planning documents with enrolled individuals and the care team to ensure timely communication. Please note that CCO/HHs must also still provide individuals with access to their records in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable state law.

<u>Developmental Disabilities Profile 2 (DDP2)</u>

The comprehensive assessment process is integral to the provision of comprehensive care management. The CCO/HH must complete a comprehensive assessment process annually for every CCO/HH enrollee to ensure that Health Home services can be delivered comprehensively in accordance with the CCO/HH care management model that requires holistic fully integrated care that addresses the individual's full range of needs across all domains. As part of the CCO/HH's

comprehensive assessment process, Care Managers must assess every individual using the Developmental Disabilities Profile 2 (DDP2), which is currently a state approved functional needs assessment. Effective January 1, 2021, the DDP2 must be completed by the CCO/HH Care Manager at least once every two years (instead of annually), or more frequently if the individual experiences a significant change in functioning.

Additionally, the DDP2 completed by the CCO/HH is a state approved functional needs assessment used in the tier level calculation, effective January 1, 2021. Upon full transition to use of the CAS, it will be used to calculate and determine the individual's rate tier instead of the DDP2. CCO/HHs will be formally notified when the full transition to the CAS, either for an individual or group, is complete. In the interim, a DDP2 must still be completed once every two years by the CCO/HH even if a CAS has been completed for the individual.

Requirements for In-Person and Face-to-Face (FTF) Care Planning Meetings

In-person FTF requirements are considered the minimum number of contacts/visits to support billing for CCO/HH services. It is expected that Care Managers will provide care management services and supports based on the specific needs and method(s) of interaction needed for each individual's unique circumstances taking into account relevant factors such as the person's preferred communication style; use of verbal/non-verbal communication methods; availability of technology to communicate; living situation; need for health and safety checks; major life changes that happen in a person's life; and other relevant factors.

The Care Manager is expected to establish and maintain a trusting and supportive relationship with everyone that maximizes the benefits and goals of the care management service and to address the person's needs and desired outcomes. More frequent in-person contact is especially important when a person is new to the care management service or has a new Care Manager to establish a trusting and supportive relationship. It is not acceptable to assume that the minimum number of in-person FTF and/or telehealth contacts equates to provision of quality care management services. The expectation is that the Care Manager will evaluate, monitor, and adjust as needed on an ongoing basis the number and type of meetings that will best meet the individual's needs and goals and the supports that the Care Manager will provide during the interaction.

In addition, Care Managers are expected to see a person FTF/in-person if there is any potential health or safety risk or concerns relayed to the Care Manager by the person, family members, advocates, providers or another party to the person that need to be mitigated or if the person's needs warrant in-person health and safety checks. Examples include: the home environment

poses a risk to the person; the person is not keeping his/her home clean and sanitary; the person has no weather appropriate clothing or food; there is no natural supports or paid service providers that interact with the person on a regular basis, etc.).

The following is the revised minimum requirements for in-person face-to-face contact and face-to-face contact that can occur through use of telehealth in accordance with applicable OPWDD and DOH telehealth guidance, effective January 1, 2021.

Individual's Tier Level	**January 1, 2021 Revised Minimum Requirements***
Tier 1-3	**Minimum of Quarterly Face-to-Face Contact** (January-March; April-June; July-September; and October-December) **as follows:** **Minimum Requirement of twice annual in-person FTF visits as follows**: • at least one must be in-person FTF at the annual LP meeting; • the other in-person FTF can occur at the semi-annual Life Plan review meeting OR a meeting for another purpose, and should take place at a location of the member/ representative's choosing. All other required visits could occur through telehealth modalities. In-person FTF and telehealth FTF should alternate so that there is at least 1 in-person/FTF visit in each half of the year (i.e., 6-month period).
Tier 4 Non-Willowbrook	**Minimum Requirement is a Monthly FTF as follows:** • At least **one in-person FTF per quarter during the calendar year.** • 1 in-person FTF must be for the annual LP meeting and the other in-person FTF meetings can occur at the semi-annual Life Plan review meeting OR meetings for another purpose, and should take place at locations of the member/ representative's choosing. All other required FTF visits could occur through telehealth modalities. The person or their representative (if the person is unable to provide informed consent) may choose fewer telehealth or in-person FTF contacts, however, this informed choice must be clearly documented in the Life Plan and the care management record.

Individual's Tier Level	January 1, 2021 Revised Minimum Requirements*
	If fewer contacts are chosen and documented through the informed choice process, there still must be **a minimum of two in-person FTF visits per calendar year and two telehealth contacts.**
Tier 4 Willowbrook Class individuals	**Monthly In-Person Face-to-Face Meeting**

***** The year is a calendar year and contacts necessary are prorated due to enrollment or disenrollment or if the person moves between tiers within the calendar year.