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

Frequently Asked Questions

Care Manager Information Session: Care Management Public Health (PHE) End Date and Policies-May 4, 2023

The following FAQ provides responses to questions that were asked at the CCO Information Session titled: Care Management Public health (PHE) End Date and Policies held on May 4, 2023. The session agenda covered post PHE Requirements including an overview on remote technology, and upcoming education and outreach opportunities

Care mangers play a vital role in assisting people to access desired services post pandemic and to support the return to all pre-pandemic polices as applicable. Therefore, we strongly encourage CCO staff to review the trainings to understand their role as outlined in the policies.

For additional Information on COVID-19 Public Health Emergency Unwinding please see guidance located: COVID-19 Public Health Emergency Unwinding Guidance | Office for People With Developmental Disabilities (ny.gov).

Other useful resources are: ADM #2018-06R2 Transition to People First Care Coordination | Office for People With Developmental Disabilities (ny.gov), CCO Policy Manual | Office for People With Developmental Disabilities (ny.gov)

Public Health Emergency (PHE) End Dates and Policies

1. Someone on my caseload has opted for Basic HCBS Plan Support Care Management versus Health Home. Can they choose to have one of the two required face-to-face contacts in a year be remote versus in-person?

   Someone enrolled in Basic HCBS may benefit from the use of remote technology to connect with their Care Manager if necessary but, the required twice annual face-to-face contact must be in-person after May 11, 2023.

2. The PHE is ending mid quarter, will in-person face-to-face (F2F) expectations be in effect immediately after May 11, 2023?

   The end of PHE is considered a triggering event in determining the minimum required contacts associated with a person's tier. Required contacts should be prorated beginning with the first full quarter of the year (which in this case is July - September of 2023). The requirement that the annual Life Plan meeting occur in-person however is effective at the end of the PHE. Any annual Life Plan meetings held on or after May 12, 2023, must occur in-person.

3. If someone participated in their annual Life Plan meeting through telehealth modalities prior to the end of the PHE, will there be a compliance issue after May 11, 2023?

   If you have already completed a person's annual Life Plan meeting via telehealth using the PHE flexibilities that were in place prior to May 11, 2023, that is acceptable. Any annual Life Plan meetings held on or after May 12, 2023, must occur in-person.

4. Is email approval of the Life Plan from person/family/representative acceptable?

   Email approval of the Life Plan should only be used as a last resort when all other options have been exhausted as outlined in ADM #2018-06R2 Transition to People First Care Coordination. It should be clearly documented in the case record what attempts have been made and why they were not successful. The email approval must directly connect the applicable Life Plan with the informed consent.

5. If a waiver provider is refusing to provide written consent to acknowledge the Life Plan, can we still use the SAP?

   Best practice should be that applicable providers are signing the Life Plan. The standard practice should not be accepting the SAP as the Life Plan signature. The Staff Action Plan is acceptable as a form of signature on the Life Plan if the signature on the Life Plan cannot be obtained. The SAP needs to align with the Life Plan, be signed by the provider and be present in the record to suffice as the acknowledgement and agreement to provide the goals, supports and safeguards associated with it.

6. Is the Waiver Termination Request Form required when we are submitting CCO termination for loss of contact? If a person is receiving waiver services but refuse to engage with the Care Manager, will we be able to continue to move forward with disenrollment from the CCO without terminating the waiver?

   Care Management is required for waiver enrollment. If you have lost contact with a person, and documented efforts to locate or reconnect with the person are not successful and the person will be disenrolled from CCO, you must submit the HCBS Waiver Termination Request Form for review for anyone enrolled in the waiver. Loss of contact is a reason on the waiver termination request form. The Care Manager should be in communication with the Care Planning team, including any waiver providers, prior to CCO disenrollment and requesting to have the person's Waiver enrollment termination.

7. Will the Documentation of Choices (DOC) still need to be signed for waiver disenrollments when there is loss of contact?

   No, the requirement to sign the DOC for waiver disenrollment only applied during the PHE.

8. If a person resides in an ICF and there is a change in Day Services delivered at a Day Habilitation site, do we need to complete a Service Amendment Request Form (SARF)?

   No, the SARF is used for waiver enrollees only. To request a change to a person's ICF Day Services, the ICF provider must send an email request or other request in writing to the Regional Field Office (RFO). The RFO will review the request and respond with their decision by email or written letter. Once the ICF Day Services change has been approved by the RFO, the ICF provider will still need to submit a DDP-1 to reflect the change in service.

9. Do we need to submit a new SARF by September 1, 2023, for any waiver services authorized during the PHE?

   If a SARF was already approved, a new SARF is not necessary. If there was no SARF approved (because we were using the flexibility of the retainer program) then a SARF would need to be submitted to formally authorize the service.

10. Is the Evaluation tool required to be submitted with the SARF for In-Residence CH-R?

    It is not required to submit the Evaluation to Receive Community Habilitation-Residential (CH-R) in a Certified Residence with the SARF. Please see the SARF for further information regarding what is required for submission. The Care Manager must evaluate the appropriateness for in-residence CH-R

services and collaborate with the provider. The evaluation tool is an optional tool for Care Managers to use in collaboration with the person and their care planning team to determine the appropriateness of in-residence CH-R services as defined in 21-ADM-02.

11. Is there a way to look up someone's Medicaid expiration date?

    Consult with your CCO's benefits and entitlements staff. They can see this information in ePACES and CHOICES.

12. Can we get people/provider approval signatures at the end of the Life Plan meetings?

    If the Life Plan is reviewed and any necessary changes or updates can be made and agreed to during the meeting, the person receiving services and/or their representative and applicable providers may sign the completed plan. This signature must be different than signing an attendance sheet indicating they were present for the Life Plan meeting. The Life Plan review should be thorough and include any updates needed or requested by the person, providers, or other member of the Care Planning team.

13. Are two Care Manager Observation Reports (CMORs) required by the end of the year or only one due to PHE ending May 2023? Also, must CAB be present if only 1 is required this year?

    The Care Manager Observation Report (CMORs) for Willowbrook Class Members are required to be completed if during the face-to-face visits something of concern is noted. If no concern(s) are noted then the flexibility that was allowed during the PHE, which ends on May 11, requires that CMORs must be completed on or before November 11, 2023. Per the instructions on the second page of the CMOR form, if the individual has Consumer Advisory Board (CAB) representation, then the Care Manager should discuss with the CAB representative if he/she would like to participate in the CMOR and schedule the visit accordingly.

14. Are there any changes to the billing requirements for members that choose remote visits?

    No, there are not. We would encourage that this is tracked to align with future updates to reporting requirements.

15. The PHE Unwinding chart mentions: Post PHE Guidance: Annual in-person meeting and assessments must begin taking place at the end of the PHE. Are assessments required in person?

    In-person meetings and assessments are separate requirements. The assessment requirements have not changed and should be followed according to your agency's policy and must be done on time. The annual face-to-face Life Plan meeting must be done on time, and after May 11th completed in person.

16. Is it required to distribute the LCED with the annual Life Plan?

    The LCEDS must now be completed within 365 days, as of May 11, 2023, and the expectation remains that the LCED is distributed with the Life Plan. LCED redeterminations are required to be completed in CHOICES. Providers are not able to access the LCED form that the CCO completes in CHOICES. The preferred method to share the LCED with providers is to upload the LCED to CHOCIES Supporting Documents, however, if discussions with the provider reveals they are not able to access the LCED in CHOICES, a copy should be included when the Life Plan is distributed until access to CHOICES is resolved. Although it is an expectation that providers are accessing information through CHOICES there continues to be providers that are not able to do this broadly across their staff.

17. Is there flexibility for a later effective date rather than May 11, 2023 that lands in the middle of the month?

    OPWDD does not have flexibility on this, per federal guidance the flexibilities expire on May 11, 2023 or on November 11, 2023 depending on the authority.

Remote Technology

18. How do we best document informed consent provided for remote Care Management delivery?
The Care Manager documents in the person's Life Plan that the person and/or the family/representative have expressed a desire and have consented to engage in Remote care management contacts and the agreed upon schedule in the Narrative in Section I or in the Meeting Summary.

19. What would be the next step if a Care Manager educated the person/family/representative on the in-person requirements for an annual Life Plan meeting but, they are adamant they do not want this?

The care manager should continue to educate the person regarding the requirements of being enrolled in CCO Care Management. Some level of in-person interaction is a required part of Care Management services. Care Managers must work with people receiving services in a person-centered way to address barriers or concerns with meeting in-person. These conversations and concerns should be well documented.

20. Can the semi-annual Life Plan meeting be held using remote technology if the person and representatives choose?

Yes. It must be the person/family/representative's choice, and this choice must be clearly documented in the Life Plan. All requirements outlined in the OPWDD Care Management Remote Technology (Telehealth) Service Delivery must also be met.

21. How many face-to-face visits are required per calendar year?

This will depend on the person's tier. Tiers 1-3 must have quarterly face-to-face contacts and tier 4 Willowbrook and non-Willowbrook must have monthly face-to-face contacts. Please see the OPWDD Care Management Remote Technology (Telehealth) Service Delivery memorandum for the required face-to-face contacts and allowance for remote face-to-face contacts in lieu of in-person contacts if initiated by the person and appropriate.

22. Is there specific verbiage that needs to be in the Life Plan if the person prefers remote service delivery over in person?

No, this is a person-centered decision. Each person has a different life with different situations in place that will determine their preferences. Their individual reasons for wanting remote service delivery should be listed in their Life Plan.

23. What do we do if providers do **not** want to meet in person for the Life Plan meetings?

The Provider is not, and has not been, required to attend Life Plan meetings in person. However, in-person contact is the best practice and remote contact is an option where beneficial to and preferred by the person receiving services. There should not be blanket policies that providers are not attending meetings in-person. The in-person for the Life Plan meeting requirements apply to the person receiving services and the care manager.

24. How is it documented when a person chooses to receive an applicable HCBS service using remote technology?

The use of remote technology must be initiated by the individual or family/representative and should be reflected in the Life Plan in the narrative in Section I, in the special considerations in section II or III, or in the meeting summary in Section VI. Ongoing, the care manager must document that the person has affirmed their preference and have provided their consent to continue receiving remote service delivery

using technology with each semiannual Life Plan review. Remote Technology should be appropriate and effective for the individual and cannot be an exclusive, long term service delivery option. Individuals or family/representatives may choose to end the use of remote technology at any time. Additional information on the use of Remote Technologies to deliver HCBS services is available in 21-ADM-03.

25. Does the Life Plan documentation for remote care management need to be done before remote service delivery can take place? Can this happen at the next Life Plan meeting or does an addendum need to be done?

    Yes, an addendum can be done to document the persons choice for remote service delivery. Documentation needs to be present in the Life plan prior to the delivery of remote face-to-face contact in lieu of required in person face-to-face contact. Other Care Management service delivery that typically occurs through the use of various forms of technology (Teams, email, phone, etc.) can continue as outlined in your agency policy as always.

26. If Telehealth is requested and added to the Life Plan, then they change their mind, would we need to then do another addendum?

    Yes. The Care Manager will take immediate action to amend the Life Plan if the person and/or the family/representative chooses to withdraw consent for the Remote care management contacts.

27. Some people and families receiving Care Management services have grown accustomed to remote contact, and do not have the technology to support video connection. How should this be addressed?

    If the request to continue to receive Care Management via remote technology is made by the person and/or their representative and is documented according to the OPWDD Care Management Remote Technology (Telehealth) Service Delivery memorandum it may continue. If the person does not have technology to support a video/audio connection, the Care Manager should assist them with trying to obtain the needed technology. If video/audio connection cannot be established in-person visits must resume and should be done in a person-centered way that supports any concerns or barriers the person/family may have with meeting in-person more frequently. Care Managers may want to consult with Technology-Related Assistance for Individuals with Disabilities (TRAID) PROGRAM at https://www.justicecenter.ny.gov/traid-program.

28. What about the small group of members/families who continue to advocate that they not receive any services (including the annual Life Plan) In Person due to health concerns?

    As stated, some level of in-person interaction is a required part of the Health Home service. OPWDD encourages Care Manager's to support families to explore available resources to access the necessary technology. If a video/audio connection cannot be established in-person visits should resume in a planful way that supports any safety concerns or barriers the person/family may have with meeting in-person more frequently.

29. Does the HCBS evaluation for remote technology need to be completed for care management services being provided remotely or is this only for waiver providers (as outlined in the ADM for HCBS via remote technology)?

    This evaluation is an optional tool for evaluating the use of HCBS service delivery remotely. However, the evaluation could be a great tool for CCO HH services as well if the CCOs would like to adapt it for this purpose.

30. The ADM states that the members must be able to see the team and the team to see them when using remote technology. If a provider cannot participate via visual, only via audio, but the CM and member and all other IDT members are able to use audio and visual, is the meeting invalid? The guidance is not clear here.

The guidance is specific to the in-person or remote contact that occurs between the Care Manager and the person. All member of the Care Planning team must participate in the annual Life Plan meeting, and it is best practice that a provider is in-person, however providers have the option of utilizing technology conferencing tools for the annual, if necessary, this is inclusive of an audio only connection.

31. CCOs are looking for clarification in reference to the “New Enrollees” section of the remote technology memo, specifically the first bullet stating meetings must be held in-person with the person and their family. Why is family included as required if the person is a self-advocate or does not have family involvement?

    The document is being updated to remove both references to the section only being applicable to new enrollees and removing that the family is required.

32. For the section specific to “New Enrollees”, CCOs are looking for OPWDD to clarify the second bullet regarding prorating required contacts? Does this apply to all individuals served?

    The chart has been updated to remove “New Enrollees” as this section is applicable to all enrollees.