Frequently Asked Questions (FAQ)
Care Coordination Organizations / Health Homes (CCO/HH)
7/28/17

General:

1. **What is a Care Coordination Organization / Health Home (CCO/HH)?**

   A Care Coordination Organization / Health Home (CCO/HH) is a Health Home that is tailored to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD). CCO/HHs will be designated by the NYS Department of Health (DOH) in collaboration with the NYS Office for People With Developmental Disabilities (OPWDD) under an Application process. Health Homes and Health Home care managers provide person-centered care management, planning and coordination.

   The CCO/HH will provide care management and coordination services that are tailored specifically to help people with I/DD and their families coordinate all services.

   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, comprehensive care plan (known as a "Life Plan") that includes health and behavioral health services, community and social supports, and other services. CCO/HHs will assist individuals and families with accessing services that support well-rounded and fulfilling lives.

2. **What are the qualifications of an approved CCO/HH?**

   CCO/HH Applicants must demonstrate they are controlled (at least 51 percent) by one or more non-profit organizations with a history of providing or coordinating developmental disability, health, and long term care services to persons with I/DD, including MSC and/or I/DD long term supports and services (LTSS). New York State's expectation is that the governance structure and leadership of the CCO/HH (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State, prior experience in overseeing and operating entities that have delivered Medicaid Service Coordination (MSC) or I/DD Home and Community Based Services (HCBS) waiver services to individuals with I/DD, and are in good standing with the State.

3. **When will CCOs/HHs begin operating?**

   It is anticipated that successful Applicants will be designated CCO/HHs and will begin readiness activities in early 2018. CCO/HHs will begin coordinating care for individuals with I/DD in July of 2018.

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Individuals and Families:

4. Why are we transitioning to CCOs/HHs?

CCO/HH care coordination will provide a more robust, integrated system of care management that not only includes the existing OPWDD services, but brings together medical, behavioral health services and other LTSS in a single coordinated care plan. In addition, the change in care management is the first step in preparing the I/DD system for working in a managed care environment. This does not mean that I/DD services (i.e., OPWDD HCBS services) will be part of managed care now but, in the future, services will be delivered in managed care. When the I/DD system transitions to managed care, the same CCO/HHs that will deliver Health Home services beginning in 2018 may also coordinate care for individuals with I/DD within managed care.

5. What services will be coordinated by a CCO/HH?

CCO/HHs will coordinate all of your I/DD HCBS services andwill coordinate other health-related supports and services with community providers such as personal care, mental health, home health aides or medical services. It also allows people receiving supports and services better continuity of care between all providers, whether they are providers of I/DD services or community providers of other health-related services.

6. Is joining a CCO/HH mandatory? How does individual choice play a role?

Enrollment in a Health Home is optional, but CCO/HHs will be the primary means by which people with I/DD will receive access to:

- Comprehensive Care Management
- Care Coordination and Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support
- Referral to Community and Social Support Services
- Use of Health Information Technology to Link Services

Once the CCO/HH is designated, Care Managers will begin to work with each individual and their family members, caregivers and advocates to help them understand the importance of the Health Home Program in accessing the supports and services they need.

For individuals who opt not to receive CCO/HH services but chose to receive HCBS, needed case management services will be available from a CCO. The CCO will be responsible for arranging and providing care management with respect to only the HCBS services and not Health Home care management services. The State will develop a separate fee schedule for providing care management to individuals who opt out of Health Home.

7. Will I be able to choose my own services and providers?

Yes, you will continue to choose your services and providers. Within the CCO/HH, an interdisciplinary team of professionals, including a Care Manager (formally referred to as an MSC) will work together with you to coordinate your developmental disability and/or long-term care services, as well as other types of services, based on your person-centered goals and needs. You will be able to choose a CCO/HH designated in your region.

8. Will I lose my Medicaid Service Coordinator (MSC)?

The person coordinating your services and supports will now be called a CCO/HH Care Manager. The CCO/HH model is intended to allow for enhanced care coordination to you. The CCO/HH is required to work with your MSC provider to offer the opportunity to transition former MSCs directly or through a subcontract for a period of time to allow for continuity of care.

Within the CCO/HH you will not lose any of the benefits of MSC but will experience enhanced service coordination. Although every effort will be made to ensure continuity of relationships, you may or may not have your current MSC as your Care Manager in the CCO/HH, just as today, people's MSCs may change.

9. Who will have access to my plan and how will my personal information be protected?

CCO/HHs will be required to have an electronic health record system that links the various service providers involved in your care together and allows your health information and Life Plan to be accessible to you and your interdisciplinary care team. All CCOs/HHs must ensure security protocols and precautions are in place to protect your Personal Health Information (PHI). CCO/HHs will work with you and your family/caregiver to ensure you agree to share your information with the care team.

10. What happens if I want to leave the CCO/HH?

The State's goal is to provide CCO/HH services statewide, including your choice of CCO/HH in the region where you live. If you are dissatisfied with the CCO/HH in which you are currently receiving services, you may opt to join a different CCO/HH within your region. If you opt out of receiving enhanced Health Home care coordination, you can receive coordination of just your OPWDD services from the CCO.

11. Will I be able to get a choice of more doctors or dentists in my area?

To provide comprehensive, timely and high quality Health Home services, CCO/HH providers are expected to develop and maintain a network of partnerships with cross-system service providers to meet the requirements of the Health Home care coordination model and support effective Health Home care coordination for all enrollees. These partnerships between the CCO/HH and other providers are not for payment purposes, and the CCO/HH enrollee is not limited to receiving services only from network providers. Instead, the CCO/HH and its network providers agree to participate in care planning and information sharing to better meet the cross-system needs of the member. CCO/HHs must partner with medical care providers, I/DD service providers, long- term supports and service providers, dentists, behavioral health care providers, regional START teams, community-based organizations, social services providers, and others.

12. What will happen if the CCO/HH decides to change my services or give me fewer services?

The CCO/HH will not authorize services and therefore will not change or take away your services. You, in partnership with your inter-disciplinary team, will identify the supports and services you receive based on your wants and needs. The Front Door will continue to be the means by which OPWDD connects people to the OPWDD HCBS services they need and want by providing assistance in navigating the steps involved in determining OPWDD eligibility and referring eligible individuals to a CCO/HH to provide care management services. Just like it happens today, CCO/HHs will work with individuals and their advocates and request OPWDD HCBS service authorization through the OPWDD regional offices.

13. How will I know which CCO is better for me?

CCO/HHs will be formed by agencies that currently provide OPWDD services and will deliver care management. In most cases, an individual will likely opt to maintain the

relationship with his or her current MSC provider once the transition to CCO/HH care coordination takes place and start in the CCO/HH that his or her MSC provider joined. However, an individual is free to choose any CCO/HH in his or her region. CCO/HHs will work to explain the benefits of their programs to you.

Medicaid Service Coordination Providers:

14. How does the CCO/HH affect my agency?

OPWDD encourages provider agencies to come together to form partnerships as CCO/HHs or to make contact with a CCO/HH to arrange for the provision of care management services. All MSC agencies will join CCO/HHs, and current MSCs will be offered the opportunity to apply to work in CCO/HHs as Care Managers.

In addition, to ensure a smooth transition of staff, during the first year of operations, with appropriate firewalls and supervisory structures in place, former MSC agencies may provide CCO/HH care management services through a contract with a CCO/HH if the CCO/HH chooses.

15. What if a provider does not to join a CCO/HH? What will happen to smaller agencies or agencies that only provide MSC?

OPWDD encourages organizations to join together in CCO/HH conversations and explore the various opportunities to partner and align with these emerging entities. The CCO/HH is expected to develop and maintain a network of partnerships with cross-system services providers, including I/DD service providers, to meet the requirements of the Health Home care coordination model and support effective Health Home care coordination for all enrollees. The CCO/HH is required to work with prior MSC providers to employ the MSCs directly or through subcontract for a one-year period to allow for continuity of care for the individuals served.

OPWDD will begin working through its Regional Offices with small agencies and those that only provide MSC to discuss how best to work together and navigate the transition to CCO/HHs.

16. What will happen if Applicants are not successful in being designated as a CCO/HH?

Given the regional scope of CCO/HH operations, it will not be possible for a single OPWDD provider agency to independently operate as a CCO/HH. Successful applicants will be formed by regional cooperatives that represent many current OPWDD providers. We encourage providers to build on existing relationships and partner with community-based resources when developing an application to be a CCO/HH. OPWDD's Regional Offices are available to assist in connecting with CCO/HHs with emerging CCO/HHs and addressing issues with the transition as they arise.

MSC Service Coordinators:

17. What happens to MSCs? Who will they work for?

MSCs currently working for provider agencies will have the opportunity to apply to become care managers and work for one of the CCO/HHs. To ensure a smooth transition, during the first year of operation, CCO/HH care managers can continue to work for their MSC provider agency under contract with the CCO/HH for the delivery of HH Care Management services if the CCO/HH chooses this arrangement. During this period, appropriate firewalls and supervisory structures must be in place to ensure that services meet the federal conflict of interest standards for HH Care Management. After one year of operation, all care managers (including former MSCs) providing care management under a designated CCO/HH must be directly employed by the CCO/HH. The only organization that may continue to provide HCBS and Care Coordination services after July 1, 2018 are federally recognized Tribes that operate an OPWDD certified agency.

18. What are the qualifications to become a Care Manager?

CCO/HH Care Managers who serve adults and children with I/DD must meet the following qualifications:

a) A Bachelor of Arts or Science degree with two years of relevant experience, OR
b) A License as a Registered Nurse with two years or relevant experience, OR
c) A Master's degree with one year of relevant experience.

CCO/HH Care Manager education and experience requirements will be waived for existing MSCs who apply to serve as Care Managers in CCO/HHs. CCO/HH will be

required to provide Health Home core services training for current MSCs who transition to the Health Home program and do not meet the minimum education and experience requirements. This training will be provided by the Health Home within six months of employing or contracting for the former MSC's services. Based on existing MSCs' experience and this training, it is anticipated that most MSCs will transition to Care Manager roles.

19. Will current MSCs be grandfathered in to the Care Manager role? Under what terms?

Care Manager education and experience requirements will be waived for existing MSCs who apply and are determined by the CCO/HH to have the special skills and abilities necessary to provide Care Management. Core training will be required within the first six months of being hired by the CCO/HH to equip those coordinators to develop skills in broader care coordination competency areas. MSCs who have the skills and abilities necessary to transition to Care Manager roles will be employed by the CCO/HH.

Willowbrook Class Members:

20. Are Willowbrook Class Members required to join a CCO/HH? How will the Willowbrook protections be assured?

All individuals, including Willowbrook Class Members, will have the option to opt out of CCO/HH services. CCO/HH services provided to Willowbrook class members will comport with all entitlements of the Permanent Injunction.

CCO/HH Provider Contracting and OPWDD Program Coordination:

21. What contracting agreements will be allowed under CCO/HHs for MSCs?

CCO/HH applicants will be responsible for describing in their applications how they will transition the current MSC's new CCO/HH Care Manager roles as employees of a CCO. CCO/HHs may subcontract with existing I/DD MSC provider agencies for a one-year period, and then those subcontracted Care Manager positions must transition to direct employment with the CCO/HH.

22. Will there be exceptions made when there are a limited number of providers in a region?

After one year of operation, all care managers (including former MSCs) 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. A CCO/HH may transition Care Managers to become direct employees of the CCO/HH at any time during that first year.

23. How will CCO/HH responsibilities interface with the Front Door? How will enrollment and authorization for services occur?

The Front Door will continue to be the means by which OPWDD connects people to the OPWDD HCBS services they need by providing assistance in navigating the steps involved in determining OPWDD eligibility and referring eligible individuals to a CCO/HH to provide care management services. Just like it happens today, CCO/HHs will work with individuals and their advocates and request OPWDD HCBS service authorization through the OPWDD Regional Offices.

CCO/HH Funding and Payments:

24. What funds will be available for start-up expenses?

The State anticipates providing start-up funds for entities that are successful in being designated as CCO/HHs. An announcement is expected to be made in late 2017 with more details.

25. What will be the level of monthly payment to CCO/HH for care coordination services?

The preliminary care management per member per month (PMPM) rates for CCO/HHs and the proposed methodology for a tiered PMPM rate structure are draft and subject to review and approval by CMS and the State. The draft rates, published in the draft Application, will include rates for the first month of enrollment and rates applicable to each month of enrollment thereafter.

The tiered rate structure for CCO/HH service is based upon the acuity/functional capability status of the individual, whether the individual lives in a certified residential setting or in their own or family home, or is a member of a "special group status" that includes the individual's status as a Willowbrook class member.

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CCO/HH Care Management:

26. How often will a CCO/HH enrollee be seen face- to-face? Are there specific timeframes that must be adhered to?

The draft Application states that within ten business days of a member being enrolled in a CCO/HH (i.e., the member has signed the appropriate Health Home consent forms), the care manager shall conduct a face-to-face-meeting with the member. Within 90 business days of enrollment into a CCO/HH, the member's Life Plan must be completed using a person-centered planning process. The Developmental Disabilities Profile (DDP)/Coordinated Assessment System (CAS) must be conducted at least annually, or more frequently if the person experiences a significant change. No less than annually, a person-centered planning review meeting must occur face-to-face, and all members of the interdisciplinary team must participate.

In addition to the monthly documentation of at least one Health Home core service, care managers must also adhere to the following face-to-face meeting requirements:

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