Memorandum

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

FROM: Katherine Marlay, Deputy Commissioner, Division of Policy and Program Development
Abiba Kindo, Deputy Commissioner, Regional Offices
Maryellen Moeser, Interim Director, Office of Strategic Initiatives

DATE: August 2, 2021

SUBJECT: Care Planning and Service Options Post Pandemic

PURPOSE:

This Memorandum outlines the person-centered care planning discussions and activities that will be required for individuals who have had Life Plan service and support changes resulting from the COVID-19 public health emergency (PHE), and the responsibilities of OPWDD-certified providers and CCOs in that process. These discussions and related activities must take place between July 1, 2021 and six months after the end of the PHE and have the following goals:

- Assist the individual to make an informed choice of post-pandemic service and support options, in conjunction with the care planning team, and update the Life Plan accordingly;
- Coordinate required service access processes for the individual with providers and the DDRO to facilitate the desired post-pandemic service and support options; and,
- Follow-up and monitor service delivery to ensure implementation of the Life Plan in accordance with the person's needs and goals and that the person is satisfied with service delivery and progress towards desired outcomes.

BACKGROUND:

After a Public Health Emergency (PHE) was declared by the Secretary of the United States Department of Health and Human Services due to the Coronavirus Disease 2019 (COVID-19) pandemic, the Centers for Medicare & Medicaid Services' (CMS) authorized an Appendix K to the Office for People With Developmental Disabilities (OPWDD) 1915(c) Comprehensive Home and Community Based Services (HCBS) Waiver and granted waivers of certain federal regulations pursuant to Section 1135 of the Social Security Act. These actions permitted regulatory flexibilities for the delivery of OPWDD-certified HCBS in order to protect the health and safety of individuals receiving services and to allow providers to continue to deliver needed supports and services during the COVID-19 PHE. Examples of the flexibilities provided

for care planning included:

- Alternatives to the requirement to obtain beneficiary and provider signatures of Life Plans;
- Allowance for services in alternative sites to be authorized prior to updating the participant's Life Plan; and
- Temporarily extend the timeframes for completion of Level of Care (LOC) assessments and Plan of Care review.

(Full information about COVID-19 PHE flexibilities for providers, including guidance documents and presentation materials can be found at https://opwdd.ny.gov/providers/home-and-community-based-services-waiver, and https://opwdd.ny.gov/coronavirus-guidance/covid-19-guidance-documents). When the COVID-19 PHE comes to an end, the flexibilities authorized by CMS will also begin a schedule to sunset. Providers must prepare for this transition and ensure that planning discussions take place with individuals and families that have been impacted so that they may make an informed decision regarding their post-PHE services.

PERSON-CENTERED CARE PLANNING DISCUSSIONS FOR POST-COVID SERVICE AND SUPPORT OPTIONS

Care Managers will play a critical role in the planning process to prepare for the return to in-person service delivery. Care Managers are essential to ensure:

- Conflict free person-centered discussions occur;
- Individuals are making informed choices; and,
- Due process is provided as applicable.

Care Managers are expected to convene the care planning team of individuals whose services and supports were impacted by the COVID-19 public health emergency. This may occur at the individual's next annual or semi-annual review or sooner if needed. The purpose of this meeting is to discuss service delivery options and determine the individual's preferred service delivery modalities when in-person operations resume.

In accordance with OPWDD Person-Centered Planning Regulations Part 636, these discussions should be led by the individual and their family/representative (to the extent possible and desired), with the support and facilitation of the individual's Care Manager and entire care planning team. The discussion must be tailored to help the individual and their family/representative understand all service delivery options and the advantages and disadvantages of each option in accordance with the individual's unique needs, goals and desire for community inclusion, etc. The discussion should include a review of all services and modalities that the individual was receiving prior to the COVID-19 PHE and their desired preferences and goals, as in-person service delivery resumes. When appropriate, life planning discussions should include consideration of Remote Technology and In-Residence Community Habilitation which are new services available to help individuals achieve their goals. These services should be used in accordance with the newly released guidance in Administrative Memorandums #2021-02 and #2021-03 found at https://opwdd.ny.gov/regulations-guidance. The goal is to ensure the individual and those supporting them have all the necessary information to make an informed choice. Supported

decision making must be based on informed choice and in the best interest of the individual.

The Care Manager must document the discussion and the individual's service delivery preferences in the Care Management Record. The discussion should appraise what the individual liked and disliked about the changes and their current preferences going forward taking into consideration the new service options and modalities as appropriate to the needs and interests of the individual (i.e. in-home Community Habilitation and Telehealth modalities).

OPWDD authorized HCBS Waiver or State Plan services that the individual chooses to receive when in-person service delivery resumes must be reflected in Section IV of a revised Life Plan if that service is not already reflected in the Life Plan. All other services and supports, whether paid or unpaid, should be documented in Section V.

The person and/or his or her family/representative, the provider, and the Care Manager each have role in these person-centered care planning discussions for post-COVID service and support options as described below.

Role and Responsibility of the Individual and their Actively Involved Family Member/Advocate:

- Prepare for the care planning meeting.
- Tell the Care Manager who they want at the meetings.
- Lead and participate in the care planning meetings as able and desired.
- Think about how the changes in service delivery during COVID have affected their life and what the current service needs are.
- Listen and help outline benefits, wants and concerns related to returning to their choice of day services or exploring other service and support options.
- Make wishes known, ask questions and make an informed decision.
- The person and/or family/representative will contact the Care Manager, at any time, if the use of the new service modalities (remote technology or in-residence service) or other services are no longer desired or effective.
- If a person cannot express or convey their desire the family member or representative makes the final decision based on this process.

Role and Responsibility of the Care Manager:

The Care Manager's role is to help the individual and their family member/representative consider the available service options and coordinate the process to discuss and identify individual and family interests.

The Care Managers will:
- Coordinate these care planning discussion(s).
- Coordinate for maximum participation of all members of the Care Planning Team.
- Help and support the person to lead their care planning discussion.

During this discussion the CM will support the person to:
- Identify what they liked and did not like about their services during COVID and how that

compared to services they had prior to COVID;
- Talk about community inclusion experiences they want to have in the future and what they would like their day to look like post PHE as Day Services and activities re-open and capacity increases;
- Help identify and coordinate access to the services and supports that might help the person to best achieve their goals.
- Identify if other service options should be considered for those who are interested or as appropriate.
    - Evaluate the use of remote technology or in-residence services, if initiated by the individual, to assure that the requirements of the Care Manager described in the ADMs are met, the appropriateness for remote delivery of services or in-residence services for the person, and the collaboration with the provider has occurred.
    - If a program is no longer available a decision has to be made about other appropriate and available options.
    - Services are not based on what is in the best interest or convenience of a particular program or provider agency.
- Document all discussions in the Care Management Record and update the Life Plan accordingly;
- Submit the necessary Service Amendment Request Form (SARF) with supporting documentation to the Regional Office for added services or service changes;
- Ensure that the person's decision and any needed safeguards are executed; and,
- Monitor and follow-up with the person and service providers.

Role and Responsibility of Provider:

- Participate in the care planning discussions and execute decisions made.
- Provide all needed information to support informed choice and decision-making.
- Develop or update associated service delivery plans and implement needed individualized safeguards for return to day services in person or through other modalities.
- Execute decisions of the individual.
- Follow the "Interim Guidelines for Reopening Day Services" and any updated guidance as applicable.
- Communicate and follow-up with the Care Manager and care team on how the person is doing and any challenges or concerns.

LIFE PLAN UPDATES AND SERVICE AUTHORIZATION PROCESSES

No action is needed to rescind the Addendum to the Life Plan/Staff Action Plans that was executed for participation in the Day Service Retainer Program or for in-residence Community Habilitation during the pandemic. Information on the Day Services Retainer Program can be found at: https://opwdd.ny.gov/providers/home-and-community-based-services-waiver.

The Life Plan must be updated to include the desired services and supports that the individual wants to engage in post-pandemic as in-person service delivery resumes. OPWDD is currently engaging in conversations with providers to ensure that, to the extent possible, sufficient service capacity exists to allow each individual to engage in the services they choose. OPWDD will work in collaboration with providers to address any capacity challenges so that over time the maximal level of service opportunities will be available. As this important work continues, we ask that Care

Managers meet with each individual and their care planning team to identify the best available options to meet each person's needs.

Any changes in the type or amount of services from what was in place prior to the PHE, should go through the normal Regional Office (RO) Authorization process. The Care Manager will submit a Service Amendment Request Form (SARF) to the RO for changes in service or provider. Please see the following for a link to the form and process: service_amendment_request_form.pdf (ny.gov). If, through the person-centered planning process, it is determined the person would prefer to return to their services as they were identified in the Life Plan prior to the PHE and Day Services Retainer Program, it is not necessary to submit a SARF or an update to the Life Plan.

If it is determined that the person would like a permanent change to their services as they were reflected in the Life Plan prior to the PHE and Day Services Retainer Program, an updated Life Plan, including a SARF for the change in services, must be submitted to the Regional Office.

For any new service or change in service provider that will be different from what was in effect prior to the public health emergency) the provider agencies must submit a Developmental Disabilities Profile (DDP-1) and DDP-1 Supplement (when required) to
enroll the person in the correct program

TRAINING

For more information on care planning and service options as in-person service delivery resumes, see the Quarterly Care Manager's Conference presentation, held on June 30th, 2021, recorded and made available in the Statewide Learning Management System (SLMS) here or under class code: **WebEx-QCMC-20210630-930A.**