June 2017

**Overview of the CCC Plus Care Coordinator Responsibilities**

The Contractor's responsibility for ensuring care coordination starts with the role of Care Coordinator. The responsibilities of the Care Coordinator include, but are not limited to:

- Assessing and planning of services;
- Linking the Member to services and supports identified in the individualized care plan (ICP);
- Assisting the Member directly for the purpose of locating, developing, or obtaining needed services and resources;
- Coordinating services and service planning with other agencies, providers and family individuals involved with the Member;
- Making collateral contacts to promote the implementation of the ICP and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and
- Training, education, and counseling that guides the Member and develops a supportive relationship that promotes the ICP.

The basis of all care coordination starts with a comprehensive Health Risk Assessment (HRA). It is this assessment that introduces the Member to the Care Coordinator who will identify the needs of the individual and begin to plan for comprehensive services to meet those needs. The comprehensive, person-centered, Individualized Care Plan (ICP), subsequent reassessments, and ongoing monitoring of progress toward goals identified in the ICP, with revisions as necessary, helps the Care Coordinator to determine the urgency and intensity of services needed and to keep current on the Member's needs, including as their needs change. This comprehensive process is accomplished by working with an engaged Interdisciplinary Care Team (ICT), which includes medical, behavioral, long term services and supports (LTSS), early intervention, and other providers as well as other formal and informal supports identified by the member and documented in the ICP.

Risk stratification, using data received from DMAS as well as data maintained in the Contractor's clinical, claims, and service authorization files, is critical to prioritizing outreach and necessary Care Coordinator services to Members. It is expected that the data gathered through the stratification process will be verified during the comprehensive HRA. Additionally, a variety of other factors not identified in the transition files may impact the Member's risk stratification, including social determinants, etc. A thorough and accurate HRA will provide a solid foundation for a full spectrum of integrated services to occur.

**Health Risk Assessment (HRA)**

The goal of the HRA is to assess and address all needs of a Member from a whole person approach. It is important to consider all needs of an individual including psychosocial factors, functional, medical, behavioral health (BH), cognitive, LTSS, wellness and preventive needs, as well as the Member's strengths. In order to develop an effective ICP, the Member's strengths and goals must be identified, as well as any challenges or barriers to meeting the identified goals within a projected timeframe and goal date. Access to specialty care, community resources or unique services must be referenced. The HRA must be developed based on the Member's preferences

related to their health care needs and as deemed necessary to improve the health and well-being of the Member.

Reassessments are essential and provide the opportunity to update the Member's status and modify the care plan to account for any accomplishments or setbacks that may have occurred. It is paramount that the clinical presentation of a Member is kept current for meaningful care planning and effective and efficient communications between the Care Coordinator, treating providers and the Member.

**Individualized Care Plan (ICP)**

The Care Coordinator must develop an initial ICP at the time of the HRA, which is agreed upon and signed by the Member.

The ICP must address all issues identified during the HRA. This includes identifying all psychosocial as well as medical and behavioral health needs. Typical standardized care plans do not include all of the elements as required under the CCC Plus Program. The ICP must be person-centered and highlight the priorities identified by the Member. The Care Coordinator must ensure that each element of the HRA is reflected in the ICP, including the identified goals, a description of the CCC Plus Waiver services, and other planned/expected services and resources to be provided until the next person-centered ICP review occurs. In addition, the Care Coordinator will facilitate ICT meetings and communications in a manner that ensures that all relevant aspects of the Member's care are addressed in a fully integrated manner on an ongoing basis.

The ICP must be reviewed and updated as needs or circumstances change (including as impacted by triggering events), when milestones are anticipated, at regular intervals and at the request of the member as required in the CCC Plus Contract.

**Interdisciplinary Care Team (ICT)**

The Care Coordinator will arrange for each Member, in a manner that respects the needs and preferences of the Member, the formation and operation of an interdisciplinary care team (ICT). The Care Coordinator will also ensure that each Member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention and social needs) is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to his/her licensure and relationship with the Member. The Member will be encouraged to identify individuals that he/she would like to participate on the ICT. The ICT will be person-centered, built on the Member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity. The care coordinator will lead the ICT. The ICT is intended to be a centralized and productive means of communicating the comprehensive and often complex needs of a Member among the informal and formal supports providing care and services to the Member. When managed effectively, the ICT facilitates efficient communications between providers and improves the quality of care for the Member.

If the Member is receiving targeted case management (TCM) services, the Care Coordinator will work collaboratively with, and not duplicate the services provided by, the TCM. TCM includes

early intervention, addiction and recovery treatment services (ARTS), mental health, developmental disabilities, treatment foster care, and high risk prenatal and infant case management services.

**Transitions/Discharge Planning**

CCC health plans will have at least one dedicated Transition Care Coordinator without a caseload to assist individuals with care transitions. Care transitions include transitioning individuals from nursing facilities (NFs), hospitals, inpatient rehabilitation, or other institutional settings into the community, and assisting individuals who prefer to remain in or move to a community setting.

The Transition Care Coordinator works with the Care Coordinator to ensure a seamless transition between levels of care. The roles of the Regional Transition Care Coordinator and the Care Coordinator are detailed in the CCC Plus Contract. Additional discharge planning interventions are also outlined in the Contract.

The Care Coordinator and Transition Care Coordinator will work with early intervention providers to transition care for children who "age-out" of the early intervention program and need to continue receiving therapy services. The Care Coordinator will ensure that services are transitioned to non- early intervention providers (PT, OT, speech, etc.). The Care Coordinator will ensure the ICP is updated to incorporate all changes in services and providers. The members of the ICT will need to be modified to include changes in the member's list of treating providers, including the EI service team. The Contractor is responsible for ensuring that all EI network providers are certified by the Department of Behavioral Health and Developmental Services (DBHDS) and that Care Coordinators have access to this specialized network to help meet the needs of EI members.

## CCC Plus Contract Sections Related to Early Intervention

### *SECTION 4.5 - EARLY INTERVENTION (EI)*

Early Intervention (EI) services, authorized through Part C of the Individuals with Disabilities Education Act (20 USC § 1431 et seq.), as amended, and in accordance with 42 CFR § 440.130(d), are covered under this Contract. Children from birth to age three who have (i) a 25% developmental delay in one or more areas of development; (ii) atypical development; or, (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are eligible for EI services. EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social or emotional, or adaptive).

Children are first evaluated by the local lead agency to determine if they meet Part C requirements. If determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, the Department of Behavioral Health and Developmental Services (DBHDS) staff enters the early intervention (EI) level of care in the DMAS system. Once the LOC is entered, the EI services are billable based upon the physician's order on the IFSP. All EI service providers must be enrolled with the child's health plan prior to billing.

EI services are provided in accordance with the child's Individualized Family Service Plan (IFSP), developed by the multidisciplinary team, including the MCO care coordinator and EI service team. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. EI services are performed by EI certified providers in the child's natural environment, to the maximum extent appropriate. Natural environments can include the child's home or a community based setting in which children without disabilities also participate.

In accordance with Chapter 53 of Title 2.2 of the *Code of Virginia*, the Contractor shall provide coverage for EI services as described in the Member's IFSP developed by the local lead agency. The Contractor shall work collaboratively as part of the Member's multidisciplinary team to: (1) ensure the member receives the necessary EI services timely and in accordance with Federal and State regulations and guidelines, (2) to coordinate other services needed by the member, and (3) to transition the member to appropriate services. Medical necessity for Early Intervention services shall be defined by the Member's IFSP, including in terms of amount, duration, and scope. Service authorization shall not be required.

The IFSP shall be approved by the child's primary care provider. The Member's physician signature on the IFSP or a letter accompanying the IFSP or an IFSP Summary letter within 30 days of the first visit for the IFSP service is required for reimbursement of those IFSP services. If physician certification is delayed, services are reimbursed beginning the date of the physician signature. The Contractor shall ensure that its EI policies and procedures, including credentialing, follow Federal and State EI regulations and coverage and reimbursement rules in the DMAS Early Intervention Services Manual and the DBHDS Manual.

The Contractor shall ensure that Members have access to EI providers who are certified by the Department of Behavioral Health and Developmental Services (DBHDS). The Contractor's EI network shall be sufficient in all disciplines to provide assessments and ongoing services in accordance with Federal timelines and DMAS program requirements. EI providers shall be contracted with or have a memorandum of agreement (MOA) in place with the local lead agency for the catchment area in which the Member resides.
Refer to *Comprehensive Health Coverage* section of this Contract for information on the handling of TPL for EI services, the Attached *CCC Plus Coverage Chart* (Section 3B) for covered services and billing codes, and *Provider Payment* for special EI claim processing requirements.

**Per Section 5.9.2,** the Care Coordinator will also work with early intervention providers to transition children who "age-out" of the early intervention program and need services to continue. The care coordinator shall ensure that services are transitioned to non- early intervention providers (PT, OT, speech, etc.).

### 6.2.8 Early Intervention Services

Service authorizations shall not be required for Early Intervention Services. Reference Section 4.5 *Early Intervention (EI) for additional information.*

### 8.2.10 Early Intervention Providers

The Contractor shall develop and maintain a network of early intervention providers, certified by DBHDS, with sufficient capacity to serve its CCC Plus members in need of early intervention services. Early intervention providers shall be reflected in the Contractor's networks. Provider qualification requirements for early intervention are described at 12VAC30-50-131 and 12VAC35-225 et seq, in Appendix G of the DMAS *Early Intervention Services Manual*, and the DBHDS Practice Manual. Early intervention providers must be contracted with or have memorandum of agreement with the local lead agency for the catchment area in which the Member resides. In order to ensure adequate early intervention provider participation, the Contractor shall adhere to the Department's early intervention coverage rules and shall comply with special payment provisions described in Section 12.4.2.

### 12.4.2 Exceptional Processing and Payment Rules for Nursing Facility, LTSS, ARTS, and Early Intervention

1. The Contractor shall ensure clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), ARTS and Early Intervention providers are processed within fourteen (14) calendar days of receipt of the clean claim, as clean claim is defined in this contract, for covered services rendered to covered Members who are enrolled with the Contractor at the time the service was delivered.

### 12.4.7 Uniform Billing Practices

DMAS requires the Contractor to implement uniform billing practices and claims submissions processes for NFs, LTSS, early intervention, and community behavioral health providers. The Contractor shall participate in working sessions with the Department and other CCC Plus program Contractors to develop and implement such uniform billing practices. Consideration will be made towards the development of uniform billing procedures especially for small providers who are not familiar with electronic billing through managed care organizations. The Contractor shall develop, train providers on, and implement uniform practices in conjunction with DMAS and the other selected CCC Plus program Contractors.

## *INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS CHECKLIST (PER CMS HOME AND COMMUNITY BASED SETTINGS FINAL RULE)*

The **Individualized Care Plan (ICP)** must reflect the services and supports that are important for the individual's identified needs and preferences for delivery of such supports and services. According to Section **441.301 (2) (i)** through **(xiii)** of the Final Rule (**CMS 2249-F/2296-F)**, a **written ICP** must:

- Reflect that the current residential setting was the individual's choice and is integrated in, and supportive of full access of the individual to the greater community.
- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs that have been identified through a functional needs assessment.
- Includes individually identified goals and outcomes.
- Reflect the (paid/unpaid) services/supports, and providers of such services/supports that will assist the individual to achieve identified goals.
- Reflect risk assessment, mitigation, and backup planning.
- Be understandable (e.g. linguistically, culturally, and disability considerate) to both the individual receiving HCBS/the individual's support system.
- Identify the individual and/or entity responsible for monitoring the ICP.
- With the written, informed consent of the individual, be finalized, agreed to, and signed by all individuals/providers responsible for implementation of the ICP.
- Be distributed to the individual and others involved in the ICP.
- Include services that afford the individual the option to self-direct.
- Prevent service duplication and/or the provision of unnecessary services/supports.
- Document that any modifications to compliance with the HCB settings requirements for provider owned/operated residential settings are supported by a specific assessed need and justified in the ICP in the following manner:

    1) Identify a specific and individualized assessed need.
    2) Document previous positive interventions and supports utilized prior to any modifications to the ICP.
    3) Document less intrusive methods of meeting the need(s) of the individual that did not work.
    4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
    5) Include a regular collection and review of data to measure the ongoing efficacy of the modification.
    6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    7) Included informed consent of the individual.
    8) Include an assurance that interventions and supports will cause no harm to the individual.

- The ICP must be reviewed and revised upon reassessment of functional need at least once every 12 months, **OR** when the individual's circumstances/needs change, **OR** at the request of the individual.

# *CCC PLUS MODEL OF CARE (MOC) ASSESSMENT AND INDIVIDUALIZED CARE PLAN (ICP) REQUIREMENTS*

| | Initial HRA *New Members at Launch*[1] | Initial ICP *New Members At Launch* | Initial HRA *New Members After Launch* | Initial ICP *New Members after Launch* | Reassessment and ICP Review | As Needed ICP Revised | Annual LOC Review and Nursing Facility Reassessments |
|---|---|---|---|---|---|---|---|
| **CCC Plus Waiver Technology Assisted Subpopulation** | Within 14 days of enrollment with Contractor (must be face-to-face)[2] | Within 30 days of enrollment (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.[3]) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA. | Within 14 days of enrollment (must be face-to-face) | Within 30 days of enrollment | Every 6 months[4] (must be face-to-face) | Upon triggering event such as a hospitalization or significant change in health or functional status | Contractor conducts annual face-to-face LOC review for continued eligibility for the Tech assisted individuals in the CCC Plus Waiver[5] |
| **CCC Plus Waiver Subpopulation other than Tech Assisted** | Within 30 days of enrollment with Contractor (must be face-to-face) | Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA. | Within 30 days of enrollment (must be face-to-face) | Within 30 days of enrollment | Every 6 months[6] (must be face-to-face) | Upon triggering event such as a hospitalization or significant change in health or functional status | Contractor conducts annual face-to-face level of care review for continued eligibility for the CCC Plus Waiver |
| **Nursing Facility Vulnerable Subpopulation** | Within 60 days of enrollment with Contractor (must be face-to-face and incorporate MDS) | Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA | Within 60 days of enrollment (must be face-to-face) | Within 60 days of enrollment | Follow MDS guidelines/time frames for quarterly and annual reassessment and ICP development | Upon triggering event such as a hospitalization or significant change in health or functional status | Contractor works with facility on annual reassessment reviews for continued nursing facility placement |
| **Vulnerable Subpopulation[7] (Excluding CCC Plus and Nursing Facility)** | Within 60 days of enrollment with Contractor | Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA | Within 60 days of enrollment | Within 60 days of enrollment | By ICP anniversary date | Upon triggering event such as a hospitalization or significant change in health or functional status | N/A |
| **Emerging High Risk Subpopulations other than those listed as Vulnerable Subpopulations** | Within 90 days of enrollment with Contractor | Within 90 days of enrollment. (Contractor must honor all existing ICPs and SAs until the authorization ends or 90 days from enrollment, whichever is sooner.) The ICP must be developed and implemented by the Contractor no later than the end date of any existing SA | Within 60 days of enrollment | Within 90 days of enrollment | By ICP anniversary date | Upon triggering event such as a hospitalization or significant change in health or functional status | N/A |

[1] "At Program Launch" means the first month that a CCC Plus region goes live. The "clock" begins on the Contractor effective date. All days are calendar days.
[2] The clock starts at the effective date of enrollment and days are measured in calendar days.
[3] Service authorizations will be provided in the enrollee's transition report.
[4] Contractors shall comply with requirements for the CCC Plus Waiver for the Tech assisted subpopulation as described in 12 VAC 30-120-900 et seq.
[5] Local and Hospital Pre-Admission Screening Teams conduct the initial assessment for eligibility for LTSS (including nursing facility, CCC Plus Waiver).
[6] Contractors must comply with requirements for the CCC Plus Waiver individuals as established in 12 VAC 30-120-900 et seq.
[7] Vulnerable and emerging high risk Subpopulations are defined in Element #1 of the Model of Care in Sections 5.1.1.1 and 5.1.1.2.