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Draft Transition Plan for Home and Community-Based Services (HCBS), Health Home Care Management for Individuals with Intellectual and/or Developmental Disabilities (I/DD), and the Development of Specialized Managed Care

New York State Department of Health

New York State Office for People With Developmental Disabilities

February 21, 2018

Contents

I. Purpose

A. Overview

With Federal and State approval, beginning July 1, 2018, New York State will initiate the transformation of the State's system of services for people with intellectual and/or developmental disabilities (I/DD) to better integrate services, promote the better use of resources to meet growing and changing needs, and become truly person-centered. This transformation will include:

- Providing comprehensive Health Home Care Management for individuals with I/DD provided by entities called Care Coordination Organizations/Health Homes (CCO/HHs) and transition from case management through State Plan Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS);
- Moving the Federal authorization for Home and Community-Based Services (HCBS), now provided under the OPWDD Comprehensive 1915(c) Waiver, to New York State's 1115 Medicaid Redesign Team (MRT) Waiver; and
- Initiating the transition to managed care (MC) for individuals with I/DD.

This document describes the planned activities associated with the I/DD service system transformation that will occur over a five-year period. The Draft Transition Plan was available for a public comment period from December 5, 2017 through January 5, 2018. Based on public comment, this Draft Transition Plan has been amended and submitted to the Federal Centers for Medicare and Medicaid Services (CMS) for its review and approval. The trajectory to full implementation of managed care for the I/DD population will depend on the experiences and the outcomes of the early phases of the transition, and this Plan will be updated and shared as the program further develops. Comments may be submitted to HHIDD@health.ny.gov.

B. Organization of this Transition Plan and the Timeline for 1115 Actions

The Transition Plan is organized into two main sections. The first section describes the actions leading to the July 1, 2018 transition of the HCBS authority to the 1115 and the initiation of Health Home services. The subsequent section describes the implementation of specialized managed care for individuals with I/DD. The Transition Plan reflects a technical change from the submitted 1115 Waiver Application. To facilitate a timely Federal approval, all activities associated with managed care are consolidated within the final two phases of the Application.

The major phases described in this Transition Plan are described below.

Phase	Timing	Description
Phase I	2018	I/DD Targeted HCBS and I/DD populations are moved under the 1115 Demonstration (July) I/DD population transition to Health Homes (July) New I/DD-led Mainstream Managed Care Plans (Early Adopters) begin operation as Mainstream Managed Care Plans (Health care benefit only, no IDD services)[1]
Phase II	2019	Early adopter I/DD Specialized Managed Care Plans may begin voluntary enrollment with I/DD benefit. Other Specialized Plans may be approved. Downstate Voluntary Enrollment into MC Plans
	2020	Rest of State Voluntary Enrollment into MC Plans
Phase III	2021	Downstate Mandatory Enrollment into MC Plans
	2022	Rest of State Mandatory Enrollment into MC Plans

Each section is organized to describe key policy and implementation topics associated with a phase of the Transition Plan. The key policy and implementation topics addressed are:

- Overview
- Purpose
- Service and Program Changes
- Continuity of Care Provisions for Individuals, Families and Providers
- Administrative Processes, Operations and Oversight
- Proposed Timeline associated with actions

[1] Early Adopters are entities that are controlled by not-for- profit entities with experience coordinating care and delivering I/DD services in New York State.

C. Stakeholder Outreach and Engagement

The State is committed to a transparent transition process with extensive opportunities for public engagement on important issues surrounding the People First Care Coordination initiative, also referred to as Care Coordination Organization/Health Homes (CCO/HHs), which will combine services for developmental disabilities with health, wellness, and behavioral health services to create a single, integrated and individualized Life Plan. A Care Coordination Organization/Health Home (CCO/HH) is a Health Home that is tailored to meet the needs of individuals with I/DD. 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 their families with accessing services that support healthy, well–rounded and fulfilling lives.

There are four formal advisory bodies that support State decision-making regarding the transition of the OPWDD service system to the 1115 Waiver.

- Developmental Disability Advisory Council (DDAC) is a standing advisory body, established by New York State law, which has the ongoing responsibility to advise OPWDD in development of its comprehensive state plan and on the ongoing improvement, policies, goals, budgets and operations of the developmental disabilities services system.
- Joint Advisory Council (JAC) is established in Mental Hygiene Law Section 13.40(f) and advises the Commissioners of the OPWDD and the Department of Health (DOH) regarding the design of managed care models that will provide services to individuals with developmental disabilities.
- The Transformation Panel has advised the Commissioner of OPWDD on the Transformation Agenda, offering managed care in our system and ensuring its long-term fiscal sustainability for people currently receiving services and those who will need to access our services in the coming years.
- The Medicaid Managed Care Advisory Review Panel (MMCARP) was created by Chapter 649 of the Laws of 1996 to monitor enrollment of Medicaid recipients in managed care plans and ensure access to care in these health care delivery systems.

The State has developed a transition team that is comprised of staff from both DOH and OPWDD to routinely solicit feedback from external stakeholders. Throughout the transition period, the State will deliver educational materials through a variety of ways including, but not limited to, brochures and other educational materials in print, in-person presentations, and web-based formats to explain what will be changing in relation to the CCO/HH and 1115 Waiver transition and how individuals can access CCO/HH services. Key documents will be translated into commonly used languages.

Where indicated, both timely and adequate notices will be delivered to all affected individuals during each phase of this transition period. All materials will be written in plain language and made available in a manner consistent with State accessibility protocols. Medicaid Service Coordination (MSC) Service Coordinators who will transition to the role of CCO/HH Care Managers will be the primary source of information for families as they have established relationships and routine contact. To facilitate and support this method of education, the State will provide information to OPWDD Regional Offices (DDROs), MSC Service Coordinators and Care Managers. The State will issue separate guidance for providers as needed to ensure a smooth transition.

Through July 2018, the State will provide informational sessions via webinars or in public forums for stakeholders on the transition to CCO/HH Care Management and the change in authorization of HCBS from the 1915(c) authority to the 1115 Waiver authority. Web-based information sessions for all MSCs and appropriate DDRO staff is scheduled to begin no later than January 1, 2018 (see Attachment C). CCOs/HHs will assume responsibility for trainings for MSC staff and providers, with support provided, as needed, by OPWDD.

A dedicated webpage has been established on the OPWDD website at: https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations, containing materials from webinars conducted with stakeholders and providers, letters and announcements to stakeholders and providers, a frequently asked questions (FAQs) document and links to the DOH website which contains additional information.

DOH has created a webpage specific to the CCO/HHs serving individuals with I/DD at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/, as well as a webpage specific to the transition of HCBS for individuals with I/DD at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm.

Stakeholders are encouraged to register for the OPWDD stakeholder distribution list to stay informed about upcoming changes by sending in their email address to: https://opwdd.ny.gov/jointheconversation.

II. Phase I: I/DD Targeted HCBS and I/DD populations move into the 1115 Demonstration and Transition to Health Home Services – July 1, 2018

A. Transition of HCBS Services to the 1115 Waiver

1. Purpose

The transition to the 1115 Waiver will support the continuity of current services as well as increased flexibility and person-centered service delivery. Over time, OPWDD will develop new approaches to service delivery and value-based payment strategies within I/DD Specialized Managed Care Plans.

2. Overview of Phase I - HCBS Services

This phase accomplishes the transition of the OPWDD Comprehensive 1915(c) Home and Community Based Services (HCBS) Waiver, funding, providers and plan of care requirements from the existing authority to the 1115 Waiver. Under the 1115 Waiver, these services will remain available solely to eligible individuals with I/DD and, therefore, will be identified in the 1115 Waiver as, “I/DD targeted HCBS services”. All services under the current OPWDD Comprehensive 1915(c) Waiver will remain available to individuals once the transition to the 1115 Waiver authority has occurred, except for Plan of Care Support Services (or PCSS). Changes to PCSS and continuity of care provisions for individuals now receiving that service are described in the section of this document describing Care Management transitions beginning on Page 17.

Except for PCSS, the transition to the 1115 Waiver is designed to have no impact on individuals, families, and the authorization of HCBS services. HCBS will be available through both the fee-for-service (FFS) and managed care delivery systems as individuals with I/DD transition into managed care over the course of the next several years. The 1115 Waiver will also become the HCBS authority for the individuals enrolled in the Fully Integrated for Duals Advantage Plan for Individuals with Intellectual and

Developmental Disabilities (FIDA-IDD). Individuals living in Intermediate Care Facilities (ICF/IIDs) will also transition to the 1115 Waiver authority. HCBS services definitions (other than for care coordination, as described below), will not initially change with the transition to the 1115 Waiver. Any future changes to provider reimbursement rates will be subject to required public notice.

3. Service and Program Changes

Comprehensive Care Management, which will include Care Management and plan of care requirements for 1115 HCBS services, will be provided by CCO/HHs, as authorized under the Health Home State Plan Amendment and the 1115 Waiver authority. Individuals who are now eligible for MSC or PCSS services will be eligible for CCO/HH services. Individuals who opt out of Care Management services provided by the CCO/HH will receive Basic HCBS Plan Support provided by the CCO, as further described beginning on Page 24 of this document. CCO/HHs will bill CCO/HH rates authorized by the State Plan, in accordance with public notice. The rate for the Basic HCBS Plan Support will be authorized by the 1115 Waiver, in accordance with public notice.

Beginning July 1, 2018, the following services previously provided under the OPWDD Comprehensive 1915(c) Waiver will be transitioned to 1115 Waiver authority. These services will be available through the FFS delivery system under the 1115 Waiver.

- Habilitation
    - Residential
    - Day
    - Community
    - Prevocational (site-based and community)
    - Pathway to Employment
    - Supported Employment
- Respite
- Adaptive Devices – Assistive Technology
- Environmental Modifications
- Basic HCBS Plan Support (replacing PCSS)
- Family Education and Training
- Services to Support Self-Direction
    - Fiscal Intermediary
    - Support Brokerage
    - Individual Directed Goods and Services (IDGS)
- Community Transition Services

- Live-In Caregiver
- Intensive Behavioral Support
- Vehicle Modifications

In addition to the OPWDD 1915(c) Comprehensive Waiver services identified above, individuals will continue to access OPWDD-specialized and other State Plan services including ICF/IID services, Day Treatment, Article 16 Clinic Services, Independent Practitioner Services for Individuals with Intellectual and Developmental Disabilities (IPSIDD) and Community First Choice Option (CFCO) services. The State will provide further guidance on the implementation of CFCO services.

Effective with the July 1, 2018 transition to the 1115 Waiver and the development of CCO/HHs, both MSC targeted case management services and PCSS will be end-dated. The transition associated with the end of these services and the initiation of CCO/HH services and Basic HCBS Plan Support under the 1115 Waiver is described in the next section of this Transition Plan (beginning on Page 17).

Effective with Federal approval and the transition to the 1115 Waiver, Federal financial participation will be available for crisis services delivered by OPWDD-approved providers of START (Systemic, Therapeutic Assessment, Resources and Treatment) services. START is a community-based program that provides crisis prevention and response services to individuals with I/DD who present with complex behavioral and mental health needs, and to their families and others in the community who provide support.

4. Continuity of Care for Individuals, Families and Providers

a. Individuals and Families

Individuals with I/DD receiving services through the OPWDD Comprehensive 1915(c) Waiver will transition to the 1115 Waiver through a series of carefully organized and communicated steps. Individuals and families will be well informed of their options and rights throughout the transition.

To ensure that this change has no immediate impact on individuals enrolled in the OPWDD Comprehensive 1915(c) Waiver and to promote a seamless transition, all existing 1915(c) plans of care known as Individualized Service Plans (ISPs) prior to July 1, 2018 will remain in place, and services will be considered authorized under the 1115 Waiver

authority. Any change in a person's OPWDD services will remain subject to NYCRR 633.12 and fair hearing rights following the transition to the 1115.

The State will continue to use all current OPWDD Comprehensive 1915(c) Waiver protocols for referral, screening, and intake into Waiver program services, including determining the ICF level of care (LOC). The Medicaid eligibility application process will also remain the same as it does today by going through the Local Departments of Social Services (LDSS).

Individual eligibility for HCBS Waiver services under the 1115 Waiver is unchanged. Individuals with I/DD who are currently in receipt of OPWDD Comprehensive HCBS at the time of transition to the 1115 Waiver will experience no interruption in care. As is the process today, the individual must continue to meet the annual level of care (LOC) requirement. In recognition of the transition activities underway in the Spring of 2018, OPWDD and DOH propose in the Transition Plan a temporary extension for the completion of the annual LOC redeterminations that are due in May through July 2018. As reflected in the timeline on Page 29, LOC redeterminations that are due in May, June or July of 2018 will be extended and must be completed no later than September 30, 2018.

After the transition to the 1115 Waiver, individuals will be eligible for I/DD HCBS Services when they meet the ICF LOC, are Medicaid enrolled, and live in a residential setting as described in Part 14 NYCRR 635-10. HCBS eligible residential settings are the individual's own or family home or an OPWDD-certified community-based residence meeting Federal HCBS setting requirements or subject to heightened scrutiny. Similarly, all individuals newly identified by providers, Local Departments of Social Services (LDSS) or local government units as being potentially eligible for HCBS after July 1, 2018, will experience no additional changes in the process for completing the supporting documentation, Medicaid eligibility application, and intake processes necessary to establish Medicaid eligibility and access services.

The State will waive deeming of income and resources (if applicable) for all medically needy children for Family of One populations under this 1115 Waiver Demonstration Amendment. This provision allows the State to continue the current practice of evaluating the eligible child's income and resources and not the family's income and resources when establishing financial eligibility for Medicaid. To meet maintenance of effort requirements with respect to Medicaid eligibility, as the State transitions to the 1115 Waiver authority OPWDD's Developmental Disabilities Regional Offices (DDROs) will continue to assist individuals/families in obtaining Medicaid eligibility via their LDSS and HCBS eligibility through the DDRO.

Children enrolled in OPWDD Care At Home (CAH) Waiver are not included in the transition to CCO/HHs. The State continues its efforts to forge a future cross-system opportunity that will integrate services across all the Waivers that exclusively serve children (Children's Medicaid System Transformation). All children enrolled in the OPWDD 1915(c) Comprehensive Waiver will be transitioned to the 1115 Waiver and will be given an option to choose a CCO/HH.

ICF-IIDs will also transition into the 1115 Waiver and will continue to be paid at the current rate described in the State Plan. Individuals living in ICF-IIDs will continue to receive services in accordance with their comprehensive functional assessment.

b. Providers

It is anticipated that all providers that are certified for the delivery of OPWDD Comprehensive 1915(c) HCBS services will be designated as I/DD HCBS providers under the 1115 Waiver effective July 1, 2018. Requests from entities that want to be newly established as I/DD HCBS Services providers under the 1115 Waiver and are not currently an approved OPWDD provider, will follow existing application processes as described at: https://opwdd.ny.gov/opwdd_services_supports/service_providers/how_to_become_a_service_provider.

The Early Alert procedures currently in place within OPWDD to oversee provider fiscal, governance and compliance practices will remain in place during and after the transition to the 1115 Waiver. Any provider currently under review by the Early Alert Committee will remain in this status until the entity complies in full with OPWDD's recommendations and provides evidence to show that issues of concern have been corrected and a system has been put in place to prevent recurrence. As is now the practice, if a provider is identified as having unacceptable fiscal, governance or compliance practices and the provider is unable or unwilling to make necessary changes, negative action may be taken against them by OPWDD including the transfer of services or the revocation of operating certificates, during or after the transition to the 1115 Waiver.

5. Administrative Processes, Operations and Oversight

a. HCBS Enrollment

The State will maintain the current OPWDD HCBS Eligibility Determination criteria. The criteria and assessment tools used under the OPWDD Comprehensive 1915(c) Waiver will continue to be used throughout the transition process and under the 1115 Waiver authority.

If an individual with I/DD chooses to apply for I/DD HCBS, the individual must first meet the following criteria for OPWDD HCBS enrollment, as determined by the DDRO:

- Have an intellectual or developmental disability in accordance with the definition found in New York State Mental Hygiene Law Section 1.03 (22),
- Medicaid eligibility,
- Eligibility for ICF LOC,
- Reside in an appropriate living arrangement or obtain residence in an appropriate setting prior to enrollment. Individuals must reside in their own or family home, Family Care home, Community Residence (CR), or Individualized Residential Alternative (IRA).

The CCO/HH will continue to work with the DDRO regarding the processing of HCBS eligibility determinations as is current practice for Medicaid Service Coordination (MSC) agencies. On July 1, 2018, the State will continue to work with the local government unit, LDSS and provider referral processes to identify individuals with I/DD newly in need of HCBS. OPWDD will work with CCO/HHs regarding the streamlining of eligibility processes under the 1115 Waiver.

For individuals with I/DD who are enrolled in Medicaid and newly in need of HCBS, a referral will continue to be made directly to the individual's local OPWDD DDRO. The DDRO will continue to perform the following responsibilities as the OPWDD system transition to CCO/HHs:

- OPWDD HCBS Eligibility Determination and discussion of the available OPWDD HCBS providers within the individual's/family's region to choose from for the delivery of HCBS.
- Make the OPWDD HCBS Eligibility Determination using the targeted and functional criteria established for the Developmental Disability LOC population.
- For individuals with I/DD who are not yet Medicaid eligible, the DDRO will continue to refer individuals with I/DD who do not have Medicaid eligibility and need services to their LDSS to assist with applying for Medicaid prior to pursuing HCBS service enrollment.

DOH and OPWDD will provide extensive communication through Administrative Directive Memorandum (ADM), General Information System (GIS), desk aids and frequently asked questions (FAQs) as guidance to the LDSS on the new policies and processes associated with the termination of the 1915(c) Waiver program and transition to 1115 Waiver authority.

The LDSS will continue to be responsible for establishing Medicaid eligibility for individuals with I/DD or referring community eligible applicants, as appropriate, to the New York State of Health (New York's health benefits exchange). Medicaid eligibility rules will remain unchanged by this transition.

b. Provider Billing and Payment

The State will ensure systems for eligibility, enrollment, cost reporting, and claims payment to support the transition by developing population identifiers on State eligibility systems to support Medicaid managed care enrollment and ensure access to services. The State will also develop changes to claims and billing systems to authorize FFS reimbursement, ensure defined allowable scope of benefits, and to monitor expenditures.

During the initial transition to the 1115 Waiver, the existing rates and fees paid for State Plan and HCBS Waiver services will continue. Future changes will be subject to public notice requirements.

Existing Information Technology provider and program identifiers and reporting codes associated with HCBS services in the OPWDD Tracking and Billing System (TABS) will remain largely unchanged with the initial transition to the 1115 Waiver. MSC and PCSS program codes will be closed for further enrollments effective July 1, 2018 as is further described in the Section of this document describing the transition of Care Management services.

c. Oversight

For services under the jurisdiction of OPWDD, the current oversight, incident reporting requirements and quality standards for State and voluntary-operated State Plan and HCBS services will not change with the transition to the 1115 Waiver. OPWDD is modifying its current regulations to refer to the 1115 Waiver, as appropriate. With this minor change, the current regulatory framework continues to apply to services under the jurisdiction of OPWDD and includes the following regulations:

- 14 NYCRR 701 – Justice Center Criminal History Information Checks
- 14 NYCRR 633 – Protection of Individuals Receiving Services
- 14 NYCRR 635 – General Quality Control and Administrative Requirements
- 14 NYCRR 624 – Reportable Incidents and Notable Occurrences
- 14 NYCRR 625 – Events and Situations
- 14 NYCRR 681 - Intermediate Care Facilities for Individuals with Intellectual and Disabilities
- 14 NYCRR 636 Person Centered Planning (for matters related to Habilitation services)

The OPWDD Division of Quality Improvement will continue its surveillance and survey of programs and services under the auspice of OPWDD. Any future changes will be subject to advance public notice, and engagement and training of provider agency staff will be provided. OPWDD is actively seeking input on regulatory streamlining of operations and oversight to enhance access to, and operations of, services.

6. Proposed Timeline Associated with Phase I/HCBS Services

The timeline below outlines the major elements associated with the transition of I/DD services to the 1115 Waiver. Dates will be adjusted, as needed.

Proposed Phase I Timeline – HCBS Services	
Target Date	**Action**
6/7/2017	Tribal Notifications to amend MRT 1115 Waiver to include I/DD services
6/14/2017	Federal Public Notice of intent to submit Amendment to transition HCBS services & I/DD population
6/15/2017	Publication of the OPWDD Commissioner's Policy Paper on Managed Care
7/24/2017	OPWDD/DOH joint message to State partners regarding 1115 Draft Waiver Amendment
7/25/2017	1115 Draft Waiver Amendment published for 30-Days

8/31/2017	Final 1115 Waiver submission for IDD population & publication of Response to 1115 Waiver public comments
11/2/2017- 12/6/2017	Regional forums regarding CCO/HH implementation planning and 1115 transition
12/5/2017	Transition Plan posted to web/ for Public Comment through 1/5/2018
12/13/2017	Series of twice-monthly informational webinars for MSCs presented by OPWDD and NYSDOH begin
1/1/2018 – 1/15/2018	Guidance Document for CCO/HH Training Requirements and Curricula Recommendations for Care Managers released by OPWDD and NYSDOH
2/14/2018 & 2/28/2018	WebEx sessions begin with Service Coordinators regarding the transition to 1115 Waiver and the 6/1 mailing to enrollees
3/26/2018	Submission to CMS of 1915c Amendment to transition 1915c Waiver to 1115 Waiver
5/31/2018	Notice sent to all 1915(c) enrollees regarding continuity of care and the 7/1/18 transition to the 1115 authority
7/1/2018	1915c authority transitions to 1115 Waiver
ongoing	Joint Advisory Council meetings
ongoing	Commissioner's Transformation Panel
ongoing	Developmental Disability Advisory Committee
ongoing	Medicaid Managed Care Advisory Review Panel (MMCARP)

B. Care Management Transitions to Health Homes – July 1, 2018

1. Purpose

The purpose of the activities associated with this phase include the transition of MSC and PCSS to comprehensive, holistic Care Management CCO/HH model authorized under the proposed State Plan Amendment.

2. Overview of Phase I – CCO/HH Services

To ensure the expertise of existing MSC Service Coordinators are incorporated into the CCO/HH model, this phase will accomplish transitioning the service of care coordination now provided by MSC agencies to the Health Home model (i.e., CCO/HHs), transition current MSC Service Coordinators and the individuals now receiving MSC or PCSS under the 1915(c) Waiver to the CCO/HHs under the authorization of the 1115 Waiver and State Plan Amendment.

Health Home Care Managers, including MSC Service Coordinators who transition to Health Home, will be responsible for developing a person-centered, individual and family-driven, comprehensive care plan that includes all the medical, behavioral health (mental health and substance use) and community and social supports and services, including HCBS authorized under the 1115 Waiver. The CCO/HHs will be responsible for working with individuals and their families to develop and oversee the enhanced Individualized Service Plans, called Life Plans. See Attachment E for additional information on Life Plans.

All individuals receiving MSC will have the opportunity to transition to Health Home Care Management provided by a CCO/HH. Individuals receiving MSC or PCSS and choosing not to enroll in CCO/HH Care Management will receive Basic HCBS Plan Support (i.e., a care plan that includes only HCBS services and is developed in accordance with HCBS care planning requirements and authorized under the 1115 Waiver). The Basic HCBS Plan Support will be provided by the CCO/HH. This Basic HCBS Plan Support is an 'opt out' service for individuals who choose not to receive the *comprehensive* Care Management provided by the CCO/HH under the Health Home model. More information regarding Basic HCBS Plan Support appears below in Part V of this section.

More details on the development and composition of CCO/HHs is available at:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/hhidd_application_part_1.pdf.

3. Service and Program Changes

a. Health Home Core Services

The Health Home State Plan requires that six Health Home core services be provided by designated CCO/HH providers. Under the provisions of the State Plan and Health Home standards and requirements developed by the State in accordance with the State Plan, CCO/HHs will deliver core services in a manner that meets the person-centered needs of individuals with I/DD, the Valued Outcomes of OPWDD and the programmatic objectives of the People First Transformation. The six core services are:

1. **Comprehensive Care Management**
   This service includes the creation, execution, and updates of an individualized, person-centered plan of care for each enrollee (the Life Plan). The Life Plan is the individual's care plan that is electronic and supported by a care planning information system and addresses all service needs. The goal of initial and ongoing assessment and Care Management services is to integrate primary, behavioral and specialty health care and community support services in a manner that addresses all clinical and non-clinical needs, promotes wellness and management of chronic conditions in pursuit of optimal health outcomes and supports enrollees' wishes. See Attachment E for additional information regarding the Life Plan.

2. **Care Coordination and Health Promotion**
   This service includes the education and engagement of an individual in making decisions that promote his/her maximum independent living skills and lifestyle choices that achieve the following goals: good health, proactive management of chronic conditions, early identification of risk factors, and appropriate screening for emerging health problems. Materials are adapted to each individual's comprehension level, and Care Managers will provide the support necessary for the individual to understand and implement care coordination and health promotion practices.

3. **Comprehensive Transitional Care**
   This service includes the facilitation of services for the individual and his/her family and/or representative when the individual is transitioning between levels of care (including but not limited to hospital, nursing facility, ICF/IDD, rehabilitation facility, community based group home, family or self-care and for teenagers transitioning

out of residential schools) or when an individual is electing to transition to a new Health Home provider.

4. **Individual and Family Support**
   This service includes the coordination of information and services to support enrollees and enrollees' family and/or representative to maintain and promote quality of life, with a focus on community living options. Access and linkages to supports for families is included.

5. **Referral to Community and Social Support Services**
   This service includes providing information and assistance to engage and refer enrollees and enrollee support members (including family members and/or representatives and others) to community based resources (regardless of funding source), that can help meet the needs identified on the enrollee's person-centered Life Plan. The service is also intended to include activities that connect and monitor an individual's community activities and opportunities, develop relationships with others, and foster independence and integration, including employment.

6. **Use of Health Information Technology (HIT) to Link Services**
   The CCO/HHs are required to meet the HIT standards in the delivery of the Health Home core services. This includes an electronic Life Plan.

a. Regional Designation of CCO/HHs

The State's goal is to provide CCO/HH services statewide, including a choice of CCO/HH in regions wherever possible. The final Application was released on September 30, 2017, and potential applicants were required to submit completed applications by November 30, 2017. A copy of the Application is available at the following link: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/. The State anticipates CCO/HHs will be designated on or before February 28, 2018.

Interested applicants were asked to submit initial information regarding their organizational structure and the MSC agencies with which they plan to establish formal relationships. The name and contact information and the potential service area for each emerging CCO/HH is available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/letters_of_interest.htm.

4. Continuity of Care Provisions for Individuals, Families, Medicaid Service Coordination (MSC) Service Coordinators and MSC Providers

a. Individuals and Families

The enrollment process to transition to CCO/HHs from MSC and PCSS is designed to ensure that Care Management under MSC and PCSS provided to individuals with I/DD today are not disrupted and there is continuity of care between the person receiving services and his/her current service coordinator/provider. Upon affiliation with a designated CCO/HH, today's MSC Service Coordinators may begin to reach out to individuals and families and educate them on the benefits of enrolling in a CCO/HH. This process is expected to begin on April 1, 2018, with the expectation that consents to enroll in CCO/HH are completed by June 30, 2018. A detailed timeline is included on Page 28 and in Attachment D. Individuals will have the choice of CCO/HH. Individuals who opt out of Health Home care coordination services will receive Basic HCBS Plan Support from a CCO/HH of their choice.

Individuals will be able to request a different CCO/HH prior to being enrolled in the CCO/HH and at any time following initial enrollment. To ensure there is no disruption of services during the transition process, once a CCO/HH is selected, a request to select a different CCO/HH submitted between June 15, 2018 and July 31, 2018 will be processed and effective September 1, 2018.

Once enrolled in a CCO/HH, individuals can request a different Care Manager at any time. CCO/HH applicants must establish a process for requesting a change in Care Manager and must inform enrollees of this process. Eligible individuals not currently enrolled in an MSC program have the option to enroll with a CCO/HH of their choice.

b. MSC Service Coordinators

CCO/HH Care Managers must meet the following qualifications:

- A Bachelor's degree with two years of relevant experience, or
- A License as a Registered Nurse with two years of relevant experience, which can include any employment experience and is not limited to Care Management/service coordination duties, or
- A Master's degree with one year of relevant experience.

CCO/HH Care Manager qualifications will be waived for existing MSC Service Coordinators who apply to serve as Care Managers in CCO/HHs.

This will facilitate continuity of care for the individuals receiving service coordination and ensure an adequate number of needed Care Managers.

In accordance with CCO/HH requirements and State standards, CCO/HHs will be required to provide Health Home core services training for all current MSC Service Coordinators who transition to the Health Home program. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC agency or CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018. It is anticipated that most MSC Service Coordinators will transition to CCO/HHs, and any additionally needed training will be provided by the CCO/HHs with support, as needed, by OPWDD. The CCO/HH will be responsible for ensuring that all "grandfathered" MSCs are adequately trained for Care Management responsibilities within one year of contracting with an MSC agency unless a longer timeframe is approved as part of the readiness review.

CCO/HHs are required to ensure that all CCO/HH Care Managers are qualified to provide and meet the standards and requirements of CCO/HH Care Management and deliver the six core Health Home services. All CCO/HHs must ensure Care Managers are trained in skill building areas identified in the CCO/HH Application and can employ the skills aligned with each area in the delivery of Health Home Care Management. The CCO/HH Application is available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/. In January 2018, the State provided CCO/HHs with guidance on skill standards, learning objectives, training development resources and any OPWDD mandated trainings. All CCO/HH applicants must submit their training plans for review to the State for meeting these requirements during the readiness review period.

In addition to structural and systemic readiness activities for CCO/HHs, additional information will be provided to assist the Care Managers serving individuals with I/DD and families during the transition. The State will work closely with the agencies to assure that MSC Service Coordinators, and ultimately Care Managers, have the tools necessary to help families transition into CCO/HH. A series of informational sessions for MSC Service Coordinators and Supervisors began in December (see Attachment C).

c. MSC Provider Agencies

To ensure a smooth transition, during the first year of operations CCO/HHs, with appropriate firewalls and supervisory structures in place, may provide I/DD Health Home Care Management services through a contract or may directly employ Care Managers. CCO/HHs will be responsible for developing an infrastructure that supports the effective delivery of person-centered Care Management services and is consistent with State standards and requirements. They will need to define the supervisory structure and qualifications that will support that infrastructure. After one year of operation, all Care Managers (including former MSC Service Coordinators) providing Care Management under a designated CCO/HH must be directly employed by the CCO/HH and may not provide HCBS, with the exception of Care Managers who are affiliated with an MSC agency that is operated by a federally recognized Tribe.

5. Administrative Processes, Operations and Oversight

a. Education & Choice with the Transition to CCO/HH Services

CCO/HH Care Management is an optional benefit, and individuals have the right to choose a CCO/HH or to opt out. The State is developing CCO/HH consent forms, as well as consumer information regarding CCO/HHs and enrollment consent forms. The forms will be used to effectuate enrollment and the sharing of information among service providers and the team engaged in implementing the individual's Life Plan.

Following the initial designation of CCO/HHs by the State, anticipated to occur no later than February 28, 2018, MSC Service Coordinators will begin talking with individuals and families about the transition to CCO/HH. By this time, the MSC Service Coordinator and MSC agency will have completed its affiliation with one of the CCO/HHs. The MSC Service Coordinator, who will transition to the role of a CCO/HH Care Manager, will assist individuals and families with information and the signing of consent forms in preparation for the enrollment in CCO/HH services effective July 1, 2018. These discussions are anticipated to occur between April 1, 2018 and June 30, 2018. CCO/HH Care Managers will explain the transition in general terms. All CCOs/HHs will be engaged in training and technical assistance that will include the standards and requirements for delivering CCO/HH Care Management in accordance with the State Plan and State guidance, as well as requirements and training concerning the use of health information technology (HIT), electronic Care Management records, and other CCO/HH systems. All CCO/HHs and Care Managers will be trained on the

requirements for developing care plans that include HCBS and State Plan services.

Under the State's Transition Plan, there will be a choice of CCO/HHs available across the State.

OPWDD will prepare, and the CCO/HH will distribute through its affiliated MSC agencies, informational letters to all individuals receiving MSC and PCSS, informing them of the benefits of CCO/HH services. This letter will specify with which CCO/HH their current MSC provider agency has affiliated. In addition, this letter will explain the option to receive HH services from alternative CCO/HHs in the region or to elect to opt out of Health Home services and, instead, receive Basic HCBS Plan Support as described on Page 24 of this Plan. As part of the responsibilities of MSC, Service Coordinators will be responsible for ensuring an individual has received the CCO/HH informational letter. The MSC Service Coordinator will talk with the individual and family about what the transition means for the individual and what choices are available for the person relative to his/her need for Care Management.

Once a CCO/HH is selected, the individual will sign a consent form and, at that point, can indicate the providers with which information can be shared. The individual will be given a copy of the enrollment form and the enrollment will become effective July 1, 2018.

To initiate and bill for Health Home services, Care Managers will be required to complete the Health Home Services Checklist, Attachment A, which is designed to assist Care Managers in ensuring the necessary actions items are completed to initiate a smooth transition into Health Home services for the individuals they serve. The purpose of completing the Checklist is to educate enrollees and their families on Health Home services and to understand the current service needs of enrollees and their families. This process is essential to the successful delivery of Health Home core services and will confirm continuity of care and identify additional areas for needed services. These tasks must be completed in partnership with the Health Home enrollee and his/her designated representative, in either a face-to-face meeting or telephone conversation, and must occur between April 1st and July 31, 2018. An enrollee may change CCO/HHs at any time.

The enrollee's Individualized Service Plan (ISP) will remain current until the initial comprehensive person-centered planning meeting is held to establish the enrollee's Life Plan. In addition to obtaining the current ISP and any

other available assessment or supporting documentation, the Care Manager must also complete the following activities:

- Confirm and identify the members of the Interdisciplinary Team (IDT), in which the primary I/DD providers (i.e. residential, day, and community habilitation providers) are mandatory members.
- Confirm and identify all providers responsible for providing care to the enrollee. These providers will include, but are not limited to, providers of medical and behavioral health services and specialists, I/DD services, Long Term Supports and Services, and social and community services.
- Schedule the date, time and location of the care planning meeting and identify the IDT members who will be participating.

The team must be comprised of the individual and/or his/her family member and/or his/her representative, the Care Manager, primary providers of I/DD services and other providers as requested by the enrollee and/or their family member and/or representative.

b. Procedures for Individuals Who Opt Out of Health Home Services

Individuals with I/DD who wish to receive HCBS services but are opting out of CCO/HH services will instead receive Basic HCBS Plan Support. Basic HCBS Plan Support will be authorized under the 1115 Waiver and will provide the necessary development and management of HCBS services in a person's HCBS care plan. Attachment B outlines the differences between HH Care Management and Basic HCBS Plan Support. Individuals will have the choice of receiving CCO/HH Care Management from a CCO/HH in their region, or opting out and receiving Basic HCBS Plan Support that will be provided by the CCO. As with CCO/HH services, the Basic HCBS Plan Support provided by the CCO may contract with existing MSC agencies for up to a year (July 1, 2018 – June 30, 2019) for the delivery of the Basic HCBS Plan Support.

Basic HCBS Plan Support will only provide the following essential functions to ensure the person's continued access to HCBS services:

- Developing and monitoring HCBS plans of care, known as Life Plans, for individuals with I/DD who opt out of Health Home;
- Educating individuals about their freedom of choice of available CCOs/HHs; and
- Performing annual LOC HCBS redeterminations for individuals with I/DD who opt out of CCO/HH Care Management.

In addition, it is anticipated that as the CCO which is providing Basic HCBS Plan Support develops a relationship with the member and the family, there will be the opportunity to develop interest in the receipt of the more comprehensive CCO/HH Care Management provided under the Health Home model. The CCO providing Basic HCBS Plan Support must comply with the requirements for person-centered planning described in 14 NYCRR 636-1 regarding care plan development and monitoring, freedom of choice, and the annual LOC redetermination process, including required assessment tools used during redetermination, ongoing care coordination and/or monitoring. The State will also provide access and training on systems to make CCO/HH referrals, as necessary and monitor access to care.

The payment for Basic HCBS Plan Support will be made to the CCO on a quarterly basis, in the amount of $243.40/quarter (see Attachment B).

c. Readiness and System Operations

DOH and OPWDD sought Applications from qualified parties interested in becoming designated CCO/HHs to serve individuals with I/DD per the timetable on Page 28.

As a first step in the Application process, the State released "Part I" of the draft CCO/HH Application to serve individuals with I/DD for stakeholder review and comment from June 30, 2017 to August 11, 2017 on the DOH website at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/.

The Final Application includes an additional section "Part II." Part II is the CCO/HH Application to serve individuals with I/DD. Qualified parties interested in becoming designated as a CCO/HH serving individuals with I/DD are required to complete and submit the Application. The State provided access to an electronic version of Part II of the Application. All Applicants will be required to electronically submit the Application, the Health Home Network Partner List, and other requirements.

Applications are being reviewed by a team of State staff from DOH and OPWDD. In reviewing Applications, the review team will consider the comprehensiveness of the Application. Areas of review and focus include: the comprehensiveness of the Applicant's network of providers, including the inclusion of qualified Care Managers and current MSC Service Coordinators and providers' expertise in providing physical, behavioral health and community supports services to the individuals with I/DD; the

demonstrated ability to meet the standards and requirements of the Health Home, including the delivery of the six core services; and the demonstrated ability to promote inclusion and cultural competence by establishing sufficient partnerships with entities serving various cultural groups in the region in which the CCO/HH will be designated to operate.

Based on the Applicant's demonstrated level of comprehensiveness and competency, a CCO/HH will be "initially designated" beginning no later than March 2018, to serve individuals with I/DD, subject to the completion and review by the State of readiness activities and any other requirements identified by the State team. Upon completion and approval of those activities by the State, the CCO/HH will be formally designated and may begin operations.

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 MSC or HCBS Waiver services to individuals with I/DD, and are in good standing with the State. In addition, the CCO/HH must establish an advisory body that reports to the CCO/HH leadership and is made up of individuals served by the CCO/HH and their family members and/or representatives.

Additional information regarding the CCO/HH Application, readiness review process, and designation process is described in Part I of the CCO/HH Application. Part I of the Application (https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/) provides stakeholders and qualified parties interested in becoming designated by the State as a CCO/HH with important information about the Health Home Care Management program, including:

- The important role designated CCO/HHs will have in providing person-centered, integrated Care Management to the I/DD community and their option to have a leadership role in the development and implementation of I/DD Specialized Managed Care Plans;
- The anticipated schedule for CCO/HH designation, readiness and implementation activities;

- How the existing Health Home model, including Health Home eligibility criteria, will be tailored to meet the unique needs of individuals with I/DD; and
- State requirements and standards for serving individuals with I/DD in Health Homes and delivering the six core Health Home services, including:
    - Comprehensive assessments for the I/DD population to identify medical, behavioral, and social and community services;
    - Using a Life Plan to create and implement the Health Home person-centered plan and comprehensive planning process required by the Health Home model;
    - Health Home HIT and other systems requirements;
    - Per member, per month (PMPM) rates for CCO/HH;
    - Care Manager and network requirements; and
    - Performance management and quality oversight.

d. Provider Billing and Payment

The State will provide technical guidance to entities that have submitted CCO/HH Applications and meet the minimum requirements outlined in section A of Part II of the CCO/HH Application. This information will detail how to obtain a Medicaid Provider Identification Number and describe other important information for becoming a provider of HH services.

For individuals transitioning from MSC to CCO/HH services, the most recent DDP2, completed within the last 24 months and filed in the OPWDD Tracking and Billing System (TABS), will be used to calculate the individual's HH payment tier on a monthly basis for the CCO/HH. In the rare case where two DDP2s are filed on the same date, the most recent DDP2 will be used. The DDP2 will be applied to the CCO/HH tier on a prospective basis. Enrollments into eMedNY will be effectuated, and once the data is uploaded into eMedNY, the appropriate Restriction/Exception (R/E) codes will be applied to ensure compliance with current billing protocol.

e. Oversight

OPWDD CCO/HHs will be subject to ongoing performance monitoring and management. CCO/HHs will be required to undergo a re-designation process, based on key performance measures identified by the State and unique to individuals with I/DD; designations are active for up to three years. In the interim years, case reviews, site visits, routine calls, data and standards compliance reviews and monthly Health Home discussions with OPWDD and DOH will occur. Additionally, the State requires Health Homes

to report, review, track and address complaints and critical incidents in accordance with published guidance.

Underperforming Health Homes, in accordance with severity of underperformance, will be subject to remediation measures up to and including revocation of CCO/HH authority. Remediation measures could include the submission of performance improvement plans, and routine review of policies and procedures, network guidance and Health Home operations.

6. Proposed Timeline Associated with Phase I Actions/Health Homes

The anticipated schedule for the implementation of CCO/HHs for individuals with I/DD is as follows:

Proposed Phase I Timeline	
Target Date	**Action**
June 30, 2017	Draft I/DD Health Home Application Released
August 11, 2017	Due Date to Submit Comments on Draft Health Home Application to Serve Individuals with I/DD
August 4, 2017	Due Date to Submit Letter of Interest
October 6, 2017	Final Health Home Application to Serve Individuals with I/DD Released
November 30, 2017	Due Date to Submit Health Home Application to Serve Individuals with I/DD
December 2017 Through June 30, 2018	State Webinars, Training, and Other Readiness Activities
February 28, 2018	Initial approval of CCO/HHs is announced, including listing of MSC affiliated providers. Readiness and preparatory enrollment activities begin.

Proposed Phase I Timeline	
Target Date	**Action**
March 15, 2018 to March 28, 2018	Initial CCO/HH designation/informational letter distributed to all individuals receiving MSC and PCSS informing them of benefits of CCO/HH services.
April 1, 2018 to June 30, 2018	Health Home and Network Partner Readiness Activities.
April 1, 2018 to June 30, 2018	MSC Service Coordinator conducts outreach/discussions with individuals and families, Care Managers begin preliminary enrollment activities. CCO/HH enrollment choices and processing occur, although the effective date for enrollment is no earlier than July 1, 2018.
May 1-September 30, 2018	For individuals transitioning to the CCO/HH, with an annual LOC redetermination due in June or July 2018, there will be a grace period for completion of the redetermination – these must be completed no later than September 30, 2018.
July 1, 2018	Effective date for CCO/HH enrollment for members transitioning from MSC and PCSS, date to begin CCO/HH Care Management for new individuals.
July 1, 2018	CCO/HH Enrollments processed into eMedNY. Data is uploaded into eMedNY, and the appropriate R/E codes will be applied to ensure compliance with current billing protocol.
July 1, 2018 to July 1, 2019	The individual, family and Care Manager convene the IDT and transition the current Individualized Service Plan (ISP) to a Life Plan.

III. Phase II and III: Voluntary and Mandatory Managed Care Enrollment

A. Purpose

The State's system of services for people with I/DD must change to better integrate services, promote the better use of resources to meet growing and changing needs, improve system flexibility and become truly person-centered. The development of managed care that is grounded in the tradition of specialized I/DD services will better support the needs of the population as it ages, ensure better access to cross-system care, and promote value based payment strategies that will drive continued improvement in I/DD services.

As the State is working toward the development of specialized managed care options for individuals with I/DD, it is recognized that today there are over 23,000 individuals with I/DD in New York State who have opted to enroll in Mainstream Managed Care for access to other Medicaid-funded acute health care services. The goal is to offer continuity of care for individuals and families for both HCBS services and for those 23,000 people who have already voluntarily enrolled in an existing Managed Care Plan.

In cases where an individual already is enrolled in an existing Mainstream Managed Care Plan, either individually or as part of the family's health benefits plan, the individual will be able to access cross-system services including OPWDD specialized services through their existing Mainstream Managed Care Plan. For individuals remaining in Mainstream Managed Care, I/DD Targeted HCBS will be reimbursed through FFS until the I/DD contract amendments are effective with the Mainstream Managed Care Plans.

In all cases, whether an individual is now enrolled in a Mainstream Managed Care Plan, newly enrolls in an existing Mainstream Managed Care Plan or enrolls in a newly established I/DD Specialized Managed Care Plan, the Care Management will be provided by CCO/HHs. Thus, the CCO/HHs established in Phase I will either apply to become I/DD Specialized Managed Care Plans or existing Mainstream Managed Care Plans will contract with CCO/HHs for the delivery of Care Management functions. In addition to newly created Specialized Plans, Dual Eligibles (Medicare-Medicaid enrollees) will continue to have access to either of the existing I/DD dual managed care opportunities in the downstate area, the FIDA-IDD and the ArchCare Program of All-Inclusive Care for the Elderly (PACE) service.

Individuals with I/DD and who have both Medicaid and Medicare coverage will have the following options:

- Receive their Medicare acute health benefits through traditional FFS Medicare, and enroll in the I/DD Specialized Managed Care Plan for coverage of those services that are only covered by Medicaid – including HCBS services; or
- Receive their Medicare acute health benefits through a Medicare Advantage product and enroll in the I/DD Specialized Managed Care Plan for coverage of those services that are only covered by Medicaid – including HCBS services.
- Alternatively, these individuals may enroll in a Dual Advantage product that offers all Medicare and Medicaid benefits through one plan (e.g., the FIDA-IDD).

B. Overview of Phase II and III

The final phases of the 1115 Waiver implementation will focus on the development of Specialized Medicaid Managed Care Plans with a focus on I/DD services. The goal is the creation of a model of care that enables qualified Specialized I/DD Managed Care Plans (in this document referred to as "Specialized Managed Care Plans") throughout the State to meet the needs of individuals with I/DD. The State anticipates the release of a qualification document to certify I/DD experienced, provider-led I/DD Specialized Managed Care Plans. In addition, Mainstream Medicaid Managed Care Plans may qualify to operate a separate line of business, by demonstrating the capacity and expertise to offer the specialized I/DD services. The transition of the I/DD population to managed care will initially occur on a voluntary enrollment basis with the establishment of I/DD Specialized Managed Care Plans.

C. Service and Program Changes

The 1115 Waiver is designed to initiate managed care operations for the I/DD population to support the development of Value Based Payment (VBP) strategies. At the same time, there are important protections that are built into the transition process to ensure that individuals, families, providers and Managed Care Plans are all prepared for operations in the managed care system that will meet the needs of individuals with I/DD.

Care Managers who work within the I/DD managed care environment, will first gain experience working in a comprehensive care planning environment with a CCO/HH while in FFS, beginning in 2018. In addition to this opportunity to prepare and develop the workforce prior to engaging in managed care, there are four important elements that are built into the 1115 Waiver application that support the readiness of all stakeholders to participate in managed care:

- Individuals and families will have a period of time of voluntary enrollment in managed care, prior to the State implementing any mandatory enrollment.
- Medicaid Managed Care Plans will be able to gain experience in managing the HCBS benefit before they will be 'at risk' for any HCBS services. (This is sometimes called 'pay and report' -- where a plan authorizes services, receives the FFS Medicaid rate from the State for HCBS services, which it will pass through to HCBS providers.)
- During the voluntary enrollment period, the OPWDD DDROs will work in collaboration with Managed Care Plans to ensure plans are prepared to manage the HCBS benefit.
- Providers of HCBS will be guaranteed the Medicaid payment rate from Managed Care Plans for a period-of-time.

The proposed Medicaid Managed Care implementation for individuals with I/DD is as follows:

- 2018: Early Adopter Plans may begin operation as a Mainstream Managed Care plan that provides health care services, but does not include I/DD specialized services in the benefit package. There are no change in the current enrollment exemptions. Enrollment is voluntary for the I/DD population.
- 2019: Voluntary enrollment into I/DD Specialized Managed Care Plans. These may be Early Adopter Plans with an expanded benefit package that includes I/DD benefits. These may also include other newly created Specialized Plans that did not begin operations as a Mainstream Managed Care Plan. We begin assessing the outcomes of managed care for individuals with I/DD prior to implementing mandatory enrollment.
- 2020: Voluntary enrollment is expanded statewide. Begin review of Mainstream Medicaid Managed Care Plans to offer I/DD Specialized plan line of business and readiness for all Mainstream Medicaid Managed Care Plans that were not Early Adopter I/DD Specialized plans in 2019, and other I/DD Specialized Managed Care Plans.
- 2021: Downstate mandatory enrollment will proceed in a region when the State confirms that there is choice of plans in a community that can support the needs of individuals with I/DD and promoting a Value Based Payment (VBP) methodology that furthers the transformation outcome of the Commissioner's Transformation Panel.
- 2022: Remainder of State mandatory enrollment will proceed in a region when the State confirms that there is sufficient choice of plans that are capable of supporting the needs of individuals with I/DD and promoting a VBP methodology that furthers the transformation

outcome of the Commissioner's Transformation Panel.

- 2023: I/DD residential services become a part of the capitation rate for Downstate I/DD Specialized Managed Care Plans and Mainstream Managed Care Plans. I/DD Targeted HCBS move to some form of risk basis within I/DD Specialized Managed Care Plans and Mainstream Managed Care Plans.
- 2024: I/DD residential services become a part of the capitation rate for the Rest of State I/DD Specialized Managed Care Plans. I/DD targeted HCBS move to some form of risk basis within I/DD Specialized Managed Care Plans and Mainstream Managed Care Plans.

D. Continuity of Care Provisions for Individuals, Families and Providers

1. Individuals and Families

In addition to the timeframes above, which guarantee payment to providers, the continuity of care provisions identified below are in place to ensure that a person's current care plan remains in place when he or she enrolls in a Managed Care Plan. These protections remain in place after the period when HCBS services are included in the capitation rate.

- With respect to a person receiving non-residential HCBS services operated, certified, funded, authorized or approved by the OPWDD, the Managed Care Plan must pay the current provider of non-residential services at the rates established by the State for ninety days, to ensure continuity of care.
- With respect to a person living in a residential facility operated or certified by OPWDD, the Managed Care Plan must offer a contract with the provider of residential services at the rates established by the State for so long as such individual lives in that residence pursuant to an approved plan of care.
- Plans must allow FFS individuals with I/DD newly enrolling in the Managed Care Plan to continue with their current provider for a current behavioral health episode of care for up to 24 months, regardless of that provider's participation with the Managed Care Plan.

There are important design elements related to enrollment education, grievance and appeal rights and independent ombudsman services that support individuals and families. These elements are described in the following section (Page 36).

2. Providers

The protections above guarantee that, at a minimum, the provider is paid the established Medicaid Rate. A provider may waive these provisions to participate in advanced-level VBP strategies at an earlier date. The individual will always have a choice of provider within the Managed Care Plan's network and, hence, none of the provider protections described above diminish a person's rights to request a change in the services described in his or her Life Plan and/or a change in service provider. I/DD HCBS services operated by a Federally recognized Tribe will continue to be paid, at a minimum, the established Medicaid rate. All medical providers for the Managed Care Plans must comply with the Americans with Disabilities Act (ADA), as required by law.

E. Administrative Processes, Operations and Oversight

1. Voluntary Individual Enrollment

Under the 1115 Waiver, beginning in July 2018, individuals with I/DD who were previously exempt from enrollment in Mainstream Managed Care may continue to enroll voluntarily in a plan and will receive HCBS from the FFS system. While gearing up for approval and enrollment into an I/DD Specialized Managed Care Plan, the State will provide technical assistance to OPWDD HCBS providers regarding contracting with Managed Care Plans prior to the transition of the OPWDD service system to managed care.

The transition of the I/DD population to managed care will occur initially on a voluntary enrollment basis, beginning in 2018, and be phased in throughout the State. Beginning in 2018, individuals with I/DD may enroll in available Early Adopter Plans that offer health care services and do not include I/DD services. In 2019, individuals with I/DD who were previously excluded (or exempt) from enrollment in Medicaid Managed Care based on a developmental or intellectual disability, will be able to voluntarily enroll in a Specialized Managed Care Plan and receive both State Plan as well as OPWDD HCBS from the Medicaid Managed Care delivery system. Those individuals who enrolled previously in Mainstream Medicaid Managed Care will be offered the choice to transfer to a Specialized Managed Care Plan. Individuals with I/DD who are otherwise exempt from enrollment in a Mainstream Managed Care Plan prior to 2021 for downstate residents and 2022 for individuals residing in the rest of the state will continue to have the option of enrolling in a Mainstream Managed Care Plan or receiving Medicaid benefits from the Medicaid FFS delivery system.

2. Mandatory Enrollment

Beginning in 2021 (implementing downstate prior to the rest of the state), the transition to mandatory managed care will proceed in a region when the State confirms that there is a sufficient choice of I/DD Specialized Managed Care Plans in a community that can support the needs of individuals with I/DD and promoting a VBP methodology that furthers the transformation outcomes of the Commissioner's Transformation Panel.. Voluntary enrollment in a Specialized Managed Care Plan will continue until two or more Managed Care Plans are available, offering individuals a choice in plans. At that time, mandatory enrollment into a Managed Care Plan will begin for individuals with I/DD unless they are otherwise exempt or excluded from mandatory enrollment. Native Americans with Medicaid coverage may enroll in Medicaid Managed Care Plans but are not required to do so. This exemption from mandatory enrollment for Native Americans will continue.

Individuals identified as required to enroll in a Managed Care Plan will be given prior written notice. An initial notification letter will inform the individual that the way services are received will soon change and that he/she will need to enroll in a Managed Care Plan. This initial notification will occur 30 days prior to a mandatory notice being sent to the individual. The notice will include an informational brochure about managed care, available Managed Care Plans, and contact information for the State's enrollment broker.

Mandatory notices will be sent to individuals indicating they have 60 days to choose a Managed Care Plan and enroll. The notice will include an enrollment packet, available Managed Care Plans in their region and the enrollment broker contact information. Additional reminder notices will be sent 45 and 30 days to individuals who are scheduled to transition to a plan and have not yet chosen a plan. If the individual does not choose a plan within 60 days, one will be auto-assigned for him/her using the State's approved auto-assigned algorithm. The Plan auto-assignment algorithm will include, but is not limited to, geographic accessibility and the Plan's affiliation with individuals' current providers.

F. Oversight, Enrollee Protections and Enrollment Education in Managed Care

During both the voluntary and mandatory enrollment periods, the current regulatory framework continues to apply to services under the jurisdiction of

OPWDD and includes the regulations identified above (Page 14). The OPWDD Division of Quality Improvement will continue its surveillance and survey of programs and services under the auspice of OPWDD.

In accordance with existing law and regulation, the State will ensure individuals receive timely and adequate notice whenever a determination is made regarding Medicaid eligibility, HCBS eligibility, or Health Home eligibility, fully explaining all appeal and fair hearing rights. Everyone will receive similar beneficiary protections under Medicaid managed care, including the right to file complaints, timely and adequate notice, and the right to appeal and to ask for a fair hearing if the managed care plan denies a requested service, or approves less than the requested amount of a service, and, in the case of reduction, suspension or termination of current services, the right to have benefits continue while the managed care appeal or fair hearing is being decided.

Individuals and families will be provided conflict-free advice and assistance from New York Medicaid Choice (currently a contract provided by Maximus Inc.). New York Medicaid Choice provides unbiased assistance and education related to enrollment and plan options through a call center and at various locations throughout New York State with in-person meetings and presentations. There are unique protocols now in place to assist individuals with enrollment in the FIDA-IDD, and these protocols will be evaluated and expanded to assist with the enrollment into new managed care options.

If an individual is dissatisfied with his or her Managed Care Plan, he or she can file a complaint. The complaint can relate to:

- The Managed Care Plan or any of its employees, providers, or contractors, or
- The Managed Care Plan´s services, determination of benefits, or the health care treatment received through the plan.

Appeals, complaints and grievances may be made verbally or in writing. Each Managed Care Plan must have a process for addressing grievances and complaints and these are described in a Member Handbook. A complaint may also be submitted directly to the State and there is more information at the following website:
https://www.health.ny.gov/health_care/managed_care/complaints/

New York State maintains a contract with the Independent Consumer Advocacy Network (ICAN) program to provide direct assistance to all Medicaid

long-term care recipients in navigating their coverage and in understanding and exercising their rights and responsibilities in managed care. ICAN has trained health counselors who answer a toll-free telephone hotline to answer questions about Medicaid Managed Care Plans. ICAN currently has a specialized counselor assisting people with I/DD with issues related to services available for the Fully Integrated Duals Advantage Plan (FIDA-IDD). The contract will be reevaluated and updated to reflect changing enrollment of the I/DD population into managed care.

G. Development of Specialized Managed Care Plans

The State will conduct a desk review, followed by on-site readiness reviews, to ensure that the required components of serving individuals with I/DD have been met by the applicant. The readiness review process will address each Specialized Managed Care Plan's capacity to serve the enrollees, including but not limited to, adequate network capacity, staff hiring plans including job description, training schedule and materials, policies and procedures, practice guidelines, and operational readiness to provide intensive levels of support. Onsite readiness reviews will be conducted in Spring of 2019. A team comprised of State agency staff will visit each Specialized Managed Care Plan and review the organization's preparedness for the transition.

A list of OPWDD HCBS providers for individuals with I/DD will be provided to I/DD Specialized Managed Care Plans to facilitate network development and the contracting process under the FFS model prior to the OPWDD service system transition to managed care.

Specialized Managed Care Plan Applicants will be notified of their status (qualified, conditionally qualified pending corrective actions, etc.) at least three months in advance of enrolling individuals. The State will monitor corrective actions and work with conditionally qualified I/DD Specialized Managed Care Plans to ensure qualification standards and requirements are met during the three-month period prior to implementing enrollment. Plans that remain conditionally qualified at implementation will continue to be monitored and may be subject to additional conditions and safeguards ensuring enrollee access to services.

The State oversees Managed Care Plans using a combination of desk reviews and on-site reviews guided by a survey tool. Plan reporting will be expanded to include key metrics related to individuals with I/DD and HCBS benefits affected by this transition. The State will continue to monitor timely access to care standards by incorporating the requirements set forth by this

transition in ongoing monitoring and surveillance activities.

Each Managed Care Plan undergoes a Public Health Law Article 44 operational review. An on-site, comprehensive operational survey is conducted every two years, beginning one year after certification. In the off year of the comprehensive operational survey, a targeted survey is conducted to assess implementation of a Plan of Correction (or citations found during the operational survey), as well as the review of new or revised policies or organizational changes. These surveys are completed to comply with statutes, regulations, provisions within the Medicaid Managed Care Model Contract, and standards outlined in Medicaid qualification documents. Surveys include desk reviews of written material, which may include review of networks, policies and procedures, staff qualifications, and on-site reviews, which may include review of claim systems, and interviews with staff at various levels. If deficiencies are cited, the Medicaid Managed Care Plan is required to implement a corrective action plan, which is re-evaluated during the next survey. The State also conducts periodic focused surveys, including but not limited to: network capacity assessment; evaluations of access and availability of the provider network; testing of member services phone lines; review of provider directory information and accuracy; and compliance with fair hearing directives.

The following areas will be incorporated into the Readiness requirements:

- I/DD Specialized Managed Care Plans will have sufficient member services support to respond to questions related to HCBS for individuals with I/DD and provider network participation. The State expects member services staff to be adequately trained and any additional staff needed to support the volume of calls to be hired.
- To begin authorization of new services, I/DD Specialized Managed Care Plans will be ready to accept Life Plans from a CCO. For those individuals newly enrolling into Specialized Managed Care Plans, prior to sharing the individual's Life Plan with the Specialized Managed Care Plans, the CCO must obtain consent to share the individual's Life Plan with the Specialized Managed Care Plan.
- I/DD Specialized Managed Care Plans will have all operational systems in place prior to enrolling individuals to ensure continuity of care provisions for transitioning members, to accept enrollments with new identifiers for HCBS-eligible individuals with I/DD, and pay HCBS claims and to collect data and report on issues daily.
- Three months in advance of enrolling individuals, I/DD Specialized Managed Care Plans will:
    - contract with (or amend contracts with) providers prior to enrolling individuals and begin claims testing with providers.
    - Test encounter data submissions and participate with the State

in the provision of training to providers relating to claims submissions, network status, credentialing, etc. as contracts are executed.

H. Quality Review of Managed Care

1. State's Quality Strategy

As the Managed Care program evolves to bring forward specialized I/DD plans, strong adherence to the Transformation Panel's goals and protections will be the cornerstone of the State's Quality Strategy. Accompanying the health-related measures, such as Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction survey, monitoring of plan's work to achieve person-centered goals and outcomes will be a focal point in establishing plan reporting requirements. Wellness, elimination of care fragmentation and individual attainment of goals will be measured by the National Core Indicators (NCI) and the Council on Quality and Leadership Personal Outcome Measures (NCI CQL POMs) and plan reported data to ensure this complex population is being appropriately served.

As part of the federal 1115 Waiver Authority, New York must develop and maintain a State Quality Strategy for assessing and improving the quality of health care and services furnished by managed care organizations (§1932(c)(1) of the Act). This Quality Strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. The New York State Quality Strategy has evolved over time because of programmatic changes, member health needs, clinical practice guidelines, Federal and State laws, lessons learned, and best practices.

The New York State Quality Strategy recognizes that as I/DD Specialized Managed Care Plans develop and operationalize, additional managed care objectives must be considered as part of the State's Quality Strategy for the Medicaid Managed Care Program (Quality Strategy). As per Waiver requirements, the State is required to update the Quality Strategy upon any major changes to the Medicaid Managed Care program, making revisions available for public comment. Within 90 days of the 7/1/2018 amendment effective date, the State's Quality Strategy will be revised and submitted to CMS, reflecting changes in the transitioned care and services. Incorporated within the 90 days, will be a 30-day public comment period.

2. Plans' Performance Improvement Projects (PIPs)

All Managed Care Plans must establish PIPs that:

- Use objective measurements
- Assess clinical and nonclinical areas
- Implement system interventions to improve care
- Evaluate effectiveness

I/DD Specialized Managed Care Plans will be required to conduct one PIP annually using a report template that reflects CMS requirements for a PIP. With the expected implementation of 7/1/18, the initial selection of a PIP topic will take place prior to 1/1/20. Measurement data will be reported by 1/1/21. The DOH and the External Quality Review Organization (EQRO) support these collaborative efforts.

3. External Quality Review Organization (EQRO)

An independent, External Quality Review Organization (EQRO) evaluates and reports on the quality, timeliness of, and access to, care and services provided by Medicaid Managed Care Plans. The EQRO conducts analysis and evaluation of aggregated information on quality, timeliness, and access to the services provided to Medicaid recipients. Required activities of the EQRO include an assessment of plan's strengths and weaknesses, and recommending quality improvement projects. As phases II and III are implemented, the EQRO reports will be a valuable resource for improvement in the I/DD service system and a resource to stakeholders.

I. Proposed Timeline Associated with Phase II Actions

The timelines for voluntary and mandatory enrollment are described in prior sections of this Transition Plan. The table below identifies the target dates for the preparation, and where appropriate, public comment periods, for key policy documents related to the implementation of managed care for the I/DD population.

Proposed Phase II & III Timeline	
Target Date	**Action**
January 1, 2018	Entities seeking Early Adopter status apply for NYS HMO certification or amendment of HMO Certificate of Authority for comprehensive health services plan, and qualification as comprehensive Medicaid managed care plan
August 1, 2018	Draft qualification document for I/DD Specialized Managed Care Plans released for public comment
November 1, 2018	FINAL qualification document for I/DD Specialized Managed Care Plans released – Round 1 Early Adopters
December 1, 2018	Early Adopter Plans may be approved as a Mainstream Managed Care Plan. (Health care benefits only – these plans will later become a Specialized Managed Care Plan; at this date there are no specialized I/DD benefits.) Voluntary enrollment for I/DD population
January 1, 2019	Managed Care OPWDD Transition Policy & Related Guidance published in Draft for Public Comment
March 1, 2019	Finalize Managed Care OPWDD Transition Policy & Related Guidance Finalized
March 1, 2019	Early Adopter I/DD Specialized Managed Care Plan Qualification Application Due if certified HMO/HMO application submitted)
June 1, 2019	Early Adopter successful applicants certified and qualified

Attachment A

Initiating Health Home Services: Care Manager Checklist

The checklist below is designed to assist Care Managers in ensuring the necessary actions items are completed to initiate a smooth transition into Health Home services for the individuals they serve. The purpose of completing these tasks is to educate enrollees and their families on Health Home services and to understand the current service needs of the enrollee and their family. The following activities are essential to the successful delivery of Health Home core services and will confirm continuity of care and identify additional areas for needed services.

These tasks must be completed in partnership with the Health Home enrollee and his/her designated representative, in either a face-to-face meeting or telephone conversation, and must occur between April 1, 2018 and July 31, 2018. Enrollment in the CCO/HH is effective: (enter date)

Step One: Information Gathering

Upon enrollment into the Care Coordination Organization/Health Home (CCO/HH), the Care Manager must complete the following steps for everyone on their case load:

☐ Obtain the enrollee's current Individualized Service Plan (ISP). This plan will remain effective until the initial comprehensive person-centered planning meeting is held to establish the enrollee's Life Plan.

☐ Obtain available OPWDD assessment information, including the DDP2 and CAS summaries, from the OPWDD IT system (Choices)

☐ Confirm and identify the members of the Interdisciplinary Team (IDT), in which the primary I/DD providers (i.e. residential, day, and community habilitation providers) are mandatory members.

☐ Confirm and identify all Providers responsible for providing care to the enrollee. These providers will include but are not limited to medical, behavioral health, specialists, I/DD services, Long Term Services and Supports, and social and community services.

☐ Schedule the date, time and location of the Life Plan review meeting and the IDT members who will be participating.

Date of Person-Centered-Planning Meeting: Click or tap to enter a date.

Step Two: Care Coordination Organizations/Health Homes (CCO/HHs) are required to provide the following six Health Home Core Services. The tasks referenced below are examples of core service activities that must be completed during the initial transition period to CCO/HH. Care Managers will be responsible for educating and identifying areas of service need for enrollees and their families.

Comprehensive Care Management

☐ Inform enrollee and their family of the care manager's responsibility to create, document, execute and update the individualized, person-centered plan of care.

☐ Identify enrollee's current service needs, providers, supports, goals, and engagement actives.

Care Coordination and Health Promotion

☐ Educate enrollee and their family on engagement and decision-making to promote independent living, as well as education on wellness promotion and prevention programs

☐ Coordinate and arrange for the provision of current additional needed services and ensure treatment adherence.

Comprehensive Transitional Care (note: CCO/HH services may be billed to eMedNY within 30 days of discharge from a hospital or institutional setting.)

☐ Notify enrollee and their family of the established networks with local practitioners, health facilities including emergency rooms, hospitals, and residential/rehabilitation settings.

☐ Is the enrollee currently residing in a health facility? (i.e. hospital or residential/rehabilitation setting? ☐ Yes ☐ No

If yes, are the appropriate procedures currently in place to ensure timely access to follow-up care post discharge? ☐ Yes ☐ No

Enrollee and Family Support

☐ Educate enrollee and their family on support and self-help resources to increase knowledge, engagement, self-management and to improve adherence to prescribed treatment.

Currently, does the enrollee and family require additional education and support services?

☐ Yes ☐ No

Referral to Community and Social Supports

☐ Advise enrollee and their family of available community-based resources and explain the care manager's role in managing appropriate referrals, access, engagement, follow-up and coordination.

Currently, does enrollee require additional community-based resource support?

☐ Yes ☐ No

Use of Health Information Technology (HIT) to Link Services

☐ Inform enrollee and their family of the purpose and utilization of HIT.

☒ Has the enrollee signed a consent to share personal information? ☐ Yes ☐ No

X_____

Care Manager Signature & Date

X_____

Individual/Family Signature & Date

Attachment B

Health Home Comprehensive Care Management and Basic HCBS Plan Support

The chart below outlines the key program design standards and the requirements for Health Home Care Management and Basic HCBS Plan Support within CCO/HHs.

Health Home Standards	Basic HCBS Plan Support (Opt Out) Standards
Care Manager Responsibilities – • Reach out to individuals and families to educate them on the benefits of enrolling in a Health Home • Complete the Health Home Services Checklist, to initiate Health Home Services, educating and identifying areas of service need for enrollees and their families • Developing a person-centered comprehensive care plan (Life Plan) and coordinate annual LOC	**HCBS Care Manager Responsibilities –** • Develop and monitor Basic HCBS Plan Support Life Plans for individuals with I/DD who opt out of Health Home services • Educate individuals about their freedom of choice of available CCO/HHs • Perform annual LOC redeterminations, for individuals with I/DD that opt out of CCO/HH Care Management
Care Manager Qualifications – • A Bachelor's degree with two years of relevant experience, OR • A License as a Registered Nurse with two years of relevant experience, which can include any employment experience and is not limited to Care Management/service coordination duties, OR • A Master's degree with one year of relevant experience • Grandfathering of current MSC Service Coordinators	**HCBS Care Manager Qualifications –** • A Bachelor's degree with two years of relevant experience, OR • A License as a Registered Nurse with two years of relevant experience, which can include any employment experience and is not limited to Care Management/service coordination duties, OR • A Master's degree with one year of relevant experience • Grandfathering of current MSC Service Coordinators
Care Manager Training – • CCO/HHs will be required to provide Health Home core services training. • CCO/HHs must ensure Care Managers are trained in skill building areas. • CCO/HHs must ensure Care Managers are trained on the requirements for developing care plans that include HCBS and State Plan Services.	**HCBS Care Manager Training –** • Expectation is that all CCO/HH Care Managers will be trained in HH services. For individuals they serve who are enrolled in Basic HCBS Plan Support, they will adjust activities accordingly.
Health Home Services – • Use of Health Information Technology – to link services, and enhance communication between providers • Coordinate and Provide access to chronic disease self-management support to individuals and families	**Basic HCBS Plan Support Services –** • Coordinate and arrange provision of services

Health Home Standards	Basic HCBS Plan Support (Opt Out) Standards
• Coordinate access to mental health and substance abuse services • Establish continuous quality improvement program – to collect and report on data that permits an evaluation of increased coordination of care • Coordinate and arrange provision of services • Support adherence to treatment recommendations • Monitor and evaluate individual's needs • Identify community based resources	
Billing and Payment – • For individuals transitioning from MSC to CCO/HH services, the most recent DDP2 completed within the last 24 months and filed in TABS will be used to calculate the individual's HH payment tier, on a monthly basis. • The Monthly fee ranges between $317 - $598 (Upstate) and $337 - $637 (Downstate).	**Billing and Payment –** • Opt Out Fee = $243 Proposed payment schedule 1/quarter (4 times/calendar year)
Consent to Enroll – • A signed consent form will effectuate enrollment and the sharing of information among service providers and team engagement in implementing the individual's Life Plan.	**Consent to Enroll –** • An individual must consent to enroll in Basic HCBS Plan Support.
Lack of Decision – • For an individual without a decision-maker or where a decision has not been made, OPWDD will notify the person that OPWDD will make a decision on their behalf based on a set of criteria. Criteria will include review of current services to ensure continuity of care.	**Lack of Decision –** • For an individual without a decision-maker or where a decision has not been made, OPWDD will notify the person that OPWDD will make a decision on their behalf based on a set of criteria. Criteria will include review of current services to ensure continuity of care.
Life Plan Requirements – • Developed using an Integrated Information Technology or IT (electronic) system that allows for prompt real-time notification(s), regarding any changes to the individual's plan, to those providers in the individual's network. • Integrates all preventive and wellness services, medical and behavior healthcare, personal safe guards and habilitation to support each participant's personal dreams	**Life Plan Requirements –** • Does not require the use of an IT (electronic) system • Integrates HCBS services only • Understandable and personal plan, with its required attachments, for implementing decisions made during a person-centered planning process • The Basic HCBS Plan Support Life Plan is not required to include personal outcome measures.

Health Home Standards	Basic HCBS Plan Support (Opt Out) Standards
• Understandable and personal plan for implementing decisions made during person-centered planning; incorporating all service and habilitation plan(s), individual safeguards, and Individual Plans of Protective Oversight in one comprehensive document. • The CCO/HH Life Plan identifies the Personal Outcome Measure(s) that best fit with the goal and valued outcome as determined by the individual, Care Manager and/or the IDT. • The CCO/HH Life Plan includes, as applicable, a Special Considerations section to provide specific information in instances where an individual makes an informed choice not to follow specific medical or treatment advice that may still need to be considered when providing supports and services to assist the person in achieving his/her valued outcome. • The CCO/HH Life Plan is required to be accessible to the individual and his/her family/representative with appropriate consideration for language and literacy, either electronically and/or via mail, based on the individual's preference.	• The Basic HCBS Plan Support Life Plan is not required to include a special considerations section. • The Basic HCBS Plan Support Life Plan is required to be accessible to the individual and his/her family/representative with appropriate consideration for language and literacy, via mail.

Attachment C

CCO/HH Informational Sessions for MSC Staff

Below are Planned Topics for Information Sessions Scheduled to begin in December 2017 and continue through the Transition Period

Topic (Presentation order may change)	Summary
People First Care Coordination – What MSCs Need to Know	An introduction to the MSC Informational Series providing an overview of the transition to CCO/HH Care Management and the role of the MSCs
What is CCO/HH Comprehensive Care Management and How is it Different from the Work of Today's MSCs?	An explanation of what CCO/HH Care Management is with specific information about how it is different than the current work of MSCs. Information will include the key differences between coordination of I/DD only services and the expanded role of Care Managers
What is CCO/Health Home?	An overview of the transition process, including: What is a CCO/HH? How does it provide coordination services? How does it differ from Managed Care?
What is a Life Plan and How Does It Compare to an Individualized Service Plan?	An introduction to Life Planning elements with comparison to Individualized Service Plans
What Does an MSC Need to Do to Help Individuals Transition to CCO/HH?	A summary of details that MSCs need to know, or do, to help individuals and families transition to CCO/HH
Behavioral and Medical Care Coordination: How is it Different than Medicaid Service Coordination?	A summary of the expanded role of Care Managers, based on the Guidelines and Learning Objectives
An Introduction of the CCOs for NYS	Announcement of the CCOs and what MSCs need to know about the organizations

Topic (Presentation order may change)	Summary
Voices from the Field – MSCs Talk about Care Coordination	A panel of MSCs share their experiences as Care Managers
How CCO/HH Impact Interactions with the Front Door?	Guidance on how the Front Door will be impacted by CCO/HH
Cultural and Language Competency – CCO/HH Care Management For All	Ensuring that Care Managers support all cultures, ethnicities and languages in the shift to Care Coordination

Attachment D

Health Home Implementation Timeline/Transition Plan for Individuals

Overview:

- This Transition Plan describes the timeline and activities for the transition of individuals currently receiving Medicaid Service Coordination to Health Home services on 7/1/18.
- Prior to beginning any outreach to the people on their caseload, Medicaid Service Coordinators must receive training in Health Home services (suggestion that weekly training times leading up to HH Implementation be offered via WebEx or other public forum in partnership with the State and Designated CCO/HHs).
- Training for all MSC providers and DDRO staff who will be involved in the CCO/HH enrollment process is scheduled to begin no later than January 1, 2018 and continue through February or until training is completed for all.
- It is also necessary for CCO/HHs to participate in State implementation and operational trainings.

Timeline	Actions
Initial designation of CCO/HHs **2/28/18**	Care Coordination Organizations/Health Home applications are received and reviewed, including the listing of MSC affiliated providers. CCO/HHs are contingently designated and readiness activities begin.
Initial CCO/HH Designation / Informational Letter **3/15/18 – 3/28/18**	As part of the responsibilities of Medicaid Service Coordination, service coordinators will be responsible for ensuring an individual has received the HH informational letter, notifying them of the benefits of HH services and the July 1, 2018 transition. Based on the defined affiliation of the individual's MSC provider, confirmed via the application process, the letter will specify the CCO/HH that is affiliated with the individual's current MSC provider. The Medicaid Service Coordinator will talk with the individual about what the transition means for the individual and what choices are available for the person relative to their need for coordination.
MSCs begin discussions with individuals/families **4/1/18 – 6/30/18**	The current service coordinator reviews with the individual the designation/information letter and begins discussing the individual's affirmative choice of CCO/HH and facilitates obtaining a signed consent form. Discussion with the individual/family must include the following key messages: • What is a CCO/HH? • What will change for the individual once enrollment occurs? • When will enrollment into the CCO/HH begin? • What happens if the individual does not choose or consent to CCO/HH services?

CCO/Health Home Enrollment Activities Begin **4/1/18 – 7/31/18**	Care Managers (i.e., MSC Service Coordinators prior to 7/1 transition) must contact each new enrollee no later than June 30th to complete the Checklist. For individuals transitioning from the MSC program, the current care plan along with the Checklist will identify and confirm: • Members of the interdisciplinary team (IDT), including primary I/DD providers • The person's providers and contact information • Consent form to share information electronically • A scheduled Life Plan meeting with the IDT at the location chosen by the person and informed by the comprehensive assessment process
Data is uploaded into eMedNY **7/1/18 -**	Once the individual affirmatively chooses to enroll into a CCO/HH for HH services, and consent is received, data is uploaded into eMedNY and the appropriate R/E codes will be applied to ensure compliance with current billing protocol.
Enrollment Confirmation Letters (Medicaid Notice of Enrollment) **6/15/18 –**	For all enrollments approved and processed into eMedNY system, CCO/HHs will send a welcome letter to individuals confirming enrollment into the CCO/HH, including the start date, contact information for the CCO/HH, and any other pertinent information required by law and/or regulation.
Comprehensive Assessments for all transitioning members completed **7/1/18 – 7/1/19**	Care Managers will complete the comprehensive assessment process at the time of their annual care plan review, but no later than 7/1/19.

Attachment E

Life Plan Template and Comparison to ISP

Individualized Service Plan (ISP)	Care Coordination Organization/Health Home Life Plan	Basic HCBS Plan Support Life Plan
The ISP does not require the use of an IT (electronic) system.	The Care Coordination Organization/ Health Home (CCO/HH) Life Plan is **required to be** a person-centered service plan that is **developed using an Integrated Information Technology or IT (electronic) system** for preparing, implementing and monitoring the electronic life plan.	The Basic HCBS Plan Support Life Plan does not require the use of an IT (electronic) system.
ISPs are not required to use an integrated IT system to connect all providers with real-time notifications and updates.	The integrated IT system will allow for prompt real-time notification(s), regarding any changes to the individual's plan, to those providers in the individual's network.	The Basic HCBS Plan Support Life Plan is not required to use an integrated IT system to connect all providers with real-time notifications and updates.
The ISP is required to document HCBS Services and other community and social supports.	The CCO/HH electronic Life Plan will be required to integrate all preventive and wellness services, medical and behavior healthcare, personal safe guards and habilitation to support each participant's personal dreams in a state-of-the-art document.	The Basic HCBS Plan Support Life Plan only requires the integration of HCBS services.
The ISP is an understandable and personal plan, with its required attachments for implementing decisions made during a person-centered planning process.	The CCO/HH Life Plan is an understandable and personal plan for implementing decisions made during person-centered planning; incorporating **all service and habilitation plan(s), individual safeguards, and Individual Plans of Protective Oversight in one comprehensive document.**	The Basic HCBS Plan Support Life Plan is an understandable and personal plan, with its required attachments for implementing decisions made during a person-centered planning process.
The ISP is not required to include Personal Outcome Measures.	The CCO/HH Life Plan identifies the Personal Outcome Measure(s) that best fit with the goal and valued outcome as determined by the individual, Care Manager and/or the IDT.	The Basic HCBS Plan Support Life Plan is not required to include personal outcome measures.

The ISP is not required to include a special considerations section.	The CCO/HH Life Plan includes, as applicable, a Special Considerations section to provide specific information in instances where an individual makes an informed choice not to follow specific medical or treatment advice that may still need to be considered when providing supports and services to assist the person in achieving his/her valued outcome.	The Basic HCBS Plan Support Life Plan is not required to include a special considerations section.
The ISP is required to be accessible to the individual and his/her family/representative, with appropriate consideration for language and literacy, via mail.	The CCO/HH Life Plan is required to be accessible to the individual and his/her family/representative with appropriate consideration for language and literacy, either electronically and/or via mail, based on the individual's preference.	The Basic HCBS Plan Support Life Plan is required to be accessible to the individual and his/her family/representative with appropriate consideration for language and literacy, via mail.

Attachment E – Life Plan Template

[INSERT NAME]

Date of Birth: xx/xx/xxxx

Life Plan / ISP

Member Address:

Phone:

Medicaid #:

Medicare #:

Enrollment Date:

Plan Effective Dates:

Willowbrook Member:

CCO

Address:

Phone:
Fax:

Provider ID:

Meeting History		
Plan Review Date	Reason For Meeting	Member Attendance

SECTION I

ASSESSMENT NARRATIVE SUMMARY

This section includes relevant personal history and appropriate contextual information, as well as skills, abilities, aspirations, needs, interests, reasonable accommodations, cultural considerations, meaningful activities, challenges, etc., learned during the person-centered planning process, record review and any assessments reviewed and/or completed.

My Home:	
My Work:	
My Health and My Medications:	
My Relationships:	

SECTION II

OUTCOMES AND SUPPORT STRATEGIES

This section includes measurable/observable personal outcomes that are developed by the person and his/her IDT using person-centered planning. It describes provider goals and corresponding staff activities identified to meet the CCO goal/valued outcome. It captures the following information: goal description, valued outcomes, action steps, responsible party, service type, timeframe for action steps and Personal Outcome Measures. Evidence of achievement must be reflected in monthly notes from assigned providers.

CQL POMS Goal/ Valued Outcome	CCO Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Action Step Labels: (G) = Goal, (S) = Support, (T) = Task

Section III

Individual Safeguards/Individual Plan of Protection (IPOP)

Compilation of all supports and services needed for a person to remain safe, healthy and comfortable across all settings (including Part 686 requirements for IPOP). This section details the provider goals and corresponding staff activities required to maintain desired personal safety.

Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Section IV

HCBS Waiver and Medicaid State Plan Authorized Services

This section of the Life Plan includes a listing of all HCBS Waiver and State Plan services that have been authorized for the individual.

Authorized Service	Provider/Facility	Effective Dates	Unit	Comments

Section V			
All Supports and Services; Funded and Natural/Community Resources *This section identifies the services and support givers in a person's life along with the needed contact information. Additionally, all Natural Supports and Community Resources that help the person be a valued individual of his or her community and live successfully on a day- to-day basis at home, at work, at school, or in other community locations should be listed with contact information as appropriate.*			
Name	**Role**	**Address**	**Phone**

Signatures:

Care Manager: _____ Date: _____

Person: _____ Date: _____

Advocate: _____ Date: _____

**Signatures are required for the finalization of an individual's Life Plan; however, the signature page of the Life Plan may be formatted differently within the CCO/HH's information technology system. The above list is not a comprehensive list of potential signatories.