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ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner of Health, DOH

KERRY A. DELANEY, J.D.
Acting Commissioner, OPWDD

DRAFT
New York State
Medicaid Managed Care Organization
I/DD System Transformation Requirements and Standards to Serve Individuals with Intellectual and/or Developmental Disabilities in Specialized I/DD Plans – Provider Led (SIPs-PL)

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Introduction

The New York State Department of Health (NYSDOH) and the Office for People With Developmental Disabilities (OPWDD) are accepting applications to qualify specialized Managed Care Organizations (MCOs) to manage the delivery of cross-system services, including OPWDD specialized services and other Medicaid funded acute health care services for individuals with intellectual and/or developmental disabilities (I/DD). The availability of an expanded array of services for the I/DD population within Medicaid Managed Care (MMC) is a key component of both the Medicaid Redesign Team (MRT) Waiver and recommendations from OPWDD's Commissioner's Transformation Panel. These changes will fundamentally restructure and transform the health care delivery system for individuals with I/DD enrolled in Medicaid. The goal is the creation of a model of care that enables qualified Plans, called Specialized I/DD Plans – Provider Led (SIPs-PL), formed by experienced providers of developmental disability (DD) services throughout the State, to meet the needs of individuals with I/DD. Any savings achieved due to more efficient service utilization will be invested back into the OPWDD service system.

This document contains the New York State Medicaid MCO I/DD system transformation requirements and standards for operating a SIP-PL. It includes a description of the multi-phase system transformation, as described in Section 1.2, that will be implemented to support the needs of individuals with I/DD and promote a Value Based Payment (VBP) methodology that furthers the transformation outcomes of both the MRT and OPWDD's Commissioner's Transformation Panel.

This document establishes the special requirements for "Early Adopter" plans for developing and operating a SIP-PL. The term "Early Adopter" was first introduced in the Commissioner's Policy Paper on Managed Care and refers to I/DD-led organizations that are first approved to operate an Article 44 Medicaid Managed Care Plan (MMCP). Organizations that have not obtained Article 44 licensure and apply to become a SIP-PL, will need to complete a SIP-PL application which will include elements from the MMC application. This comprehensive application is forthcoming.

SIP-PL Legal Authority

Section 364-j of the New York State Social Services Law (SSL) authorizes the Commissioner of NYSDOH, in cooperation with the Commissioner of OPWDD, to establish Managed Care programs under the medical assistance program (Medicaid). Section 4403 Subdivision 8 and Section 4403-g of the New York State Public Health Law (PHL) authorizes the Commissioners of NYSDOH and OPWDD to jointly designate and oversee contracts to manage the DD, behavioral health and physical health needs of individuals with I/DD enrolled in Medicaid.

Reserved Rights

The State reserves the right to amend or modify the requirements and standards contained within this document.

Anticipated Timelines

The OPWDD Transformation Plan consists of a set of initiatives beginning with enrollment into Care Coordination Organization/Health Homes (CCO/HHs) effective July 1, 2018, with a trajectory to Managed Care enrollment into SIPs-PL, beginning in 2019. Depending on the timeframes for acquiring the necessary approvals, the implementation dates included in this

requirements and standards document will be modified accordingly. Revised timeframes will ensure there is sufficient time for the SIP-PL applicants to respond to the requirements and standards and begin implementation with the Centers for Medicare and Medicaid Services (CMS) approvals in place.

The State anticipates off-site desk reviews will begin in April 2019, followed by on-site readiness reviews to ensure that the required components of serving individuals with I/DD have been meet by all SIP-PL applicants. The readiness review process will address each applicant's capacity to serve individuals with I/DD including but not limited to, on-site reviews of operational readiness to provide intensive levels of support, adequate network adequacy, provider training, claims testing, policies and procedures, practice guidelines, and recruitment and training based on NYSDOH and OPWDD guidelines. The State reserves the right to conduct additional readiness review activities if needed.

Table 1: Anticipated Timeline for Requirements and Standards

Key Events	Anticipated Date
Release of DRAFT Medicaid MCO I/DD system transformation requirements and standards to serve individuals with I/DD in SIPs-PL document for public comment	August 2018
Public comments on draft document due to State	October 3, 2018
Release of Final OPWDD Managed Care Requirements and Standards and Application (with information for submission of applications)	November 2018
Deadline for SIP-PL Applications to the State	February 2019
Distribute Readiness Review Information Request	March 2019
State conducts off-site desk reviews of SIP-PL applicant's readiness information	April 2019
State conducts on-site readiness reviews	May 2019
State announces approved SIPs-PL	June 2019
SIPs-PL begin to enroll individuals with I/DD downstate voluntarily	August 2019
SIPs-PL begin to enroll individuals with I/DD in the rest of State voluntarily	2020
Expansion to mandatory enrollment begins for individuals with I/DD beginning downstate and moving to rest of State	2021-2022

Inquiries related to the Medicaid MCO I/DD System Transformation Requirements and Standards:
Upon final approval of this document, applicants will have the opportunity to submit inquiries and request clarification through a dedicated mailbox.

Medicaid Managed Care Organization I/DD System Transformation Requirements and Standards

1.0 Vision

New York State established the MRT in 2011 to improve health outcomes, control Medicaid costs in a sustainable way, and provide Care Management for all Medicaid enrollees by aligning incentives for the provision of high quality, integrated, and coordinated services. A key feature of the MRT initiatives is to transform the healthcare delivery system from a Fee-For-Service model to a community-based Managed Care model. In 2015, OPWDD's Commissioner convened a panel, comprised of stakeholders including providers, families, advocacy groups, and state and local government representatives, to discuss and provide recommendations to the Agency on transforming the way health care is provided to individuals with I/DD. The panel was asked to shape clear and actionable recommendations to guide OPWDD's path moving forward. The OPWDD Commissioner's Transformation Panel offered a set of sixty-one (61) recommendations designed to improve access to services and assist in ensuring a smooth transition to a Managed Care service delivery model for the I/DD population. OPWDD is committed to helping individuals with I/DD live richer lives and creating stronger, person-centered services.

OPWDD's goal is to meet the needs of individuals and families in the most comprehensive way possible, and promote the achievement of quality outcomes and improvement across the service delivery system. VBP is a strategy used by New York State's Medicaid program and other payers to incentivize quality outcomes and a higher performing system of services and health care. As OPWDD transitions to Managed Care, MCOs contracting with New York State will incorporate VBP.

The expansion, tailoring, and implementation of the Health Home Care Management model to serve individuals with I/DD is the first phase and foundation for the transition to Managed Care. This transition will also assist in implementing many of OPWDD's Commissioner's Transformation Panel recommendations which were designed to bring more choice and flexibility to the provision of comprehensive Care Management and assessment, as well as other services. The CCO/HH model provides a strong, stable, person-centered approach to holistic service planning and ensures the delivery of integrated quality care that supports the needs of individuals with I/DD. It is expected that existing DD providers and CCO/HHs will develop the capacity to transition from the provision of Care Management services to SIPs-PL or enter into agreements with existing MMCPs to provide Care Management to individuals with I/DD. The final design for SIPs-PL and the transition of OPWDD Home and Community-Based Services (HCBS) and its service population to Managed Care will be described in amendments to the Comprehensive HCBS Waiver and the MRT 1115 Waiver. Both Waiver actions are subject to approval by CMS.

New York State's experience in the implementation of MMC has shown that provider availability, including specialists, is greatly increased over Fee-For-Service availability. OPWDD is confident this will be the case in the SIPs-PL. Potential SIP-PL applicants will be given information about the providers that most frequently serve the I/DD population and will be encouraged to contract with these providers. Consistent with OPWDD's Commissioner's Transformation Panel Recommendations, SIPs-PL must demonstrate prioritization opportunities for Self-Direction by supporting people to understand their options and make choices in their lives whenever possible.

1.1 Overview of Current OPWDD Service Systems

Currently, OPWDD serves over 100,000 Medicaid enrolled individuals with I/DD. Although most Medicaid specialized I/DD services are paid through Fee-For-Service, over 25,000 individuals with I/DD are already enrolled in a type of Medicaid MCO.

During the transition to Managed Care, the current oversight, incident reporting requirements and quality standards for OPWDD state and voluntary-operated State Plan and HCBS services will not change significantly. OPWDD is modifying its current regulations to refer to the 1115 Waiver and the services delivered by CCO/HHs, as appropriate. 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/or Developmental Disabilities (ICF/IID)
- 14 NYCRR 636 – Person Centered Planning (for matters related to Habilitation services)

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

1.2 Transforming the Service Delivery System for Individuals with I/DD

The OPWDD MRT Redesign Plan consists of a set of system transformation initiatives that will be implemented via the Health Home State Plan Amendment (SPA), the Comprehensive HCBS Waiver, and an amendment to the MRT 1115 Waiver. The 1115 Waiver Amendment, among other things, authorizes the creation of a model of care that enables qualified SIPs-PL, throughout the State to meet the needs of individuals with I/DD.

This section reviews transformational changes taking place within the service delivery systems for individuals with I/DD:

1. CCO/HH Care Management for individuals with I/DD
2. Transition of the OPWDD population into MMC through the concurrent 1115/1915c Waiver authority providing access to Demonstration services
3. Transition of OPWDD HCBS Waiver and State Plan services to Managed Care

CCO/HH Care Management for Individuals with I/DD

In April 2018, the State received CMS approval to expand the Health Home model to serve individuals with I/DD through CCO/HHs beginning in July 2018. The CCO/HH Care Management service model is tailored for individuals with I/DD who are enrolled in Medicaid. CCO/HH Care Managers provide person-centered Care Management that integrates and addresses the need for DD, physical and behavioral health care, transitional Care Management, and access to community and social supports. The objective of CCO/HH services is to improve the outcomes for individuals with I/DD.

Effective July 1, 2018, CCO/HHs began serving individuals who chose to receive comprehensive Care Management. Individuals who opted out of CCO/HH Care Management were enrolled into Basic HCBS Plan Support provided by CCOs. CCO/HH Care Management is a critical component of both the MRT and OPWDD's Commissioner's Transformation Panel. CCO/HHs will not only provide comprehensive, integrated, individual and family focused Care Management, but they will also ensure the efficient and effective implementation of the transition of the I/DD population to Managed Care.

Transition of the OPWDD population into MMC through the concurrent 1115/1915(c) Waiver authority providing access to Demonstration services

Development of SIPs-PL

The State's primary goal is to ensure robust, cross-system service coordination by entities that have experience with I/DD service delivery and which meet all requirements for operating as a comprehensive SIP-PL. The SIP-PL will operate pursuant to New York State law. SIP-PL applicants must have a demonstrated history of providing and/or coordinating health and long-term care (LTC) services to individuals with I/DD.

The State's intent is to first determine the sufficiency of qualified SIPs-PL established through the SIP-PL qualification process, before accepting applications from non-provider led MMCPs (Specialized I/DD Plans – Mainstream (SIP-M)) choosing to operate a Specialized I/DD Plan as separate line of business. If there is insufficient participation of SIPs-PL to meet the needs of the I/DD population, the State will develop criteria that will be used to qualify SIPs-M to provide coverage for I/DD services. In all cases, whether an individual is now enrolled in a MMCP, newly enrolls in an existing MMCP or enrolls in a newly established SIP-PL, the Care Management will

be provided by CCO/HHs or by Care Managers employed directly by the SIP-PL with the State's approval. [1]

Enrollment and Choice

Beginning no earlier than August 1, 2019, enrollment into SIPs-PL will occur in the following order:

1. SIPs-PL begin to enroll individuals with I/DD downstate voluntarily (2019)
2. SIPs-PL begin to enroll individuals with I/DD in the rest of State voluntarily (2020)
3. Mandatory enrollment begins for individuals with I/DD beginning downstate and moving to rest of State (2021-2022)

Individuals who continue to be excluded from enrollment in a MCO or who are exempt and choose not to enroll (after mandatory enrollment begins) will continue to receive benefits via the CCO/HH program and the Fee-For-Service delivery system.

Individuals eligible to enroll in SIPs-PL include individuals enrolled in the OPWDD Comprehensive HCBS Waiver, individuals living in ICF/IIDs, and other Medicaid-enrolled individuals who are also eligible for OPWDD services, and non-I/DD family members of SIP-PL enrollees. This includes those individuals already enrolled in a MMC program who choose to transfer to a SIP-PL. In addition to individuals listed as excluded from enrolling into a MCO in the MRT Waiver, the following are also not eligible for SIP-PL enrollment:

- Individuals enrolled in Developmental Centers (DC), and/or
- Individuals who are eligible for and/or enrolled in a Health and Recovery Plan (HARP)

Table 2: Current I/DD Waiver, ICF/IID and other I/DD populations

Waiver	Federal Fiscal Year (FFY) 2015
OPWDD Comprehensive Waiver (#NY-0238)	75,483
OPWDD ICF/IID Residents	6,700
Other I/DD	26,300
Total	**108,483**
Note: These counts include approximately 20,000 individuals already in MMC.	

[1] This provision recognizes that certain, existing Article 44 license holders (the Fully Integrated Duals Advantage Plan – for individuals with I/DD (FIDA/IDD)) who already have a Care Management function in place that meets the specialized, comprehensive service expectations of the CCO/HH.

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

1. Enroll in a SIP-PL for comprehensive services with Medicaid coverage of co-insurance deductible and coordination of benefits, including HCBS services.
2. Receive their Medicare acute health benefits through a Medicare Advantage Product and enroll in the SIP-PL for coverage of those services that are only covered by Medicaid – including HCBS services.
3. Alternatively, these individuals may enroll in a Dual Advantage product that offers all Medicare and Medicaid benefits through one plan (e.g., the FIDA-I/DD).

The SIP-PL may not conduct outreach/marketing activities directly to individuals in an effort to encourage enrollments. Passive (indirect outreach) will be allowed as outlined in Appendix D of the Medicaid MMC Contract and includes brochures, posters, billboards, etc. Education, choice counseling and enrollment/disenrollment of I/DD individuals and families must be non-biased and will be completed by the State's contracted enrollment broker.

New York State has contracted with an enrollment broker to assist in implementation of the MMC and Managed Long Term Care (MLTC) programs. The broker, New York Medicaid Choice, is responsible for informing individuals about their Managed Care options, educating them about covered benefits, how Managed Care works, their rights and responsibilities as an enrollee, and assisting individuals and families/caregivers with enrolling into a health plan of their choice. The enrollment process for SIPs-PL will also be through New York Medicaid Choice. The State will provide New York Medicaid Choice with detailed information regarding DD, physical and behavioral health care benefits, including HCBS benefits and complete provider network information for all SIPs-PL.

Initially, enrollment into SIPs-PL will be voluntary and individuals will be allowed to disenroll or switch plans at any time for any reason. For individuals choosing to disenroll or switch plans, the SIP-PL will be responsible for working with the Local Department of Social Services (LDSS) and OPWDD's Developmental Disabilities Regional Offices (DDROs) to transition the individual's Life Plan back to the Fee-For-Service program or to another health plan.

Beginning in 2021, with available choice of plans, provider systems in place, and standards established for the transition to mandatory enrollment, the process of mandatory Managed Care enrollment for individuals with I/DD will be effectuated. The State will remove the exemptions from Managed Care enrollment for individuals with an I/DD diagnosis as defined in New York State Mental Hygiene Law.

Please see Attachment K (Chart of Populations, Enrollment Strategies, and Benefits) for detailed information regarding eligibility for enrollment into SIPs-PL, as well as benefits for the I/DD population by phase.

Transition of OPWDD HCBS Waiver and State Plan Services to Managed Care
All SIPs-PL will offer a capitated State Plan benefit package consistent with MMC benefits, as well as provide non-risk I/DD residential services and OPWDD HCBS Waiver services, as defined in Attachment G. For dual-eligibles, SIPs-PL must also coordinate the benefit package

with Medicare and pay Medicare cost-sharing. Dual-eligibles will have a choice of providers for Medicare benefits and will not be required to remain in the SIP-PL network to receive those benefits.

Upon approval to provide services to the I/DD population, SIPs-PL will provide the OPWDD HCBS Waiver services* below, in addition to OPWDD residential services (except for DCs, Small Residential Units (SRUs) and OPWDD specialty hospitals) through a non-risk arrangement to individuals enrolled in the OPWDD Comprehensive Waiver and according to the individual's Life Plan as defined in Attachment J. Community-based ICFs will also be included in the SIP-PL benefit package. Initially, these services will be subject to levels zero (0) through two (2) VBP and will be paid via a Fee-For-Service pass through, at the State Medicaid rate, with opportunities for shared savings for the achievement of quality outcomes. No later than twenty-four (24) months after the implementation of mandatory enrollment, the OPWDD HCBS Waiver services and OPWDD residential services will be placed in capitated premium rates.

These protections 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 SIP-PL may, subject to the State's review and approval, enter into shared savings or incentive payment arrangements with providers to incentivize access to and coordination of care and to provide improved outcomes resulting from the integration of I/DD, physical and behavioral health services.

OPWDD HCBS Waiver services operated by a Federally recognized Tribe will continue to be paid, at a minimum, the established Medicaid rate. All medical providers for the SIP-PL must comply with the Americans with Disabilities Act (ADA), as required by law.

***Non-Risk OPWDD HCBS Waiver Services**

1. Habilitation
    a. Residential
    b. Day
    c. Community (Community First Choice Option - CFCO)
    d. Prevocational (site-based and community)
    e. Supported Employment
    f. Pathway to Employment
2. Respite
3. Adaptive Devices — Assistive Tech (CFCO)
4. Environmental Modifications
5. Family Education and Training
6. Services to Support Self Direction
    a. Fiscal Intermediary
    b. Support Brokerage
    c. Individual Directed Goods and Services (IDGS)
7. Community Transition Services (CFCO)
8. Live-in Caregiver
9. Intensive Behavioral Services
10. Vehicle Modifications (CFCO)

Individuals enrolled in the OPWDD Comprehensive Waiver, and who are eligible for Medicaid under community eligibility rules, will be eligible for CFCO services under the State Plan. Individuals eligible for Medicaid under Family of One institutional rules, who also meet CFCO eligibility, will be eligible for the CFCO services** below.

****CFCO Services**

1. Assistive Technology
2. Community Transitional Services
3. Durable Medical Equipment/Medical Supplies
4. Environmental Modifications
5. Community Habilitation
6. Home Delivered/Congregate Meals
7. Home Health Care (Aide)
8. Moving Assistance
9. Personal Care
10. Consumer Directed Personal Assistance Services (CDPAS)
11. Personal Emergency Response Services (PERS)
12. Vehicle Modifications

In addition to the OPWDD 1915(c) Comprehensive HCBS Waiver services identified above, individuals will continue to access CFCO and OPWDD-specialized State Plan services including ICF/IID services, Day Treatment, Article 16 Clinic Services, Independent Practitioner Services for Individuals with I/DD (IPSIDD).

Additional information on OPWDD's 1915c Comprehensive HCBS Waiver can be found at the following link:

https://opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_waiver_services.

2.0 Definitions

Basic HCBS Plan Support: A service provided by a CCO and authorized under the Basic HCBS Plan Support SPA for those individuals who do not wish to access Health Home Care Management. The Basic HCBS Plan Support service focuses on HCBS services, and the Life Plan is developed and maintained in accordance with HCBS care planning requirements.

Behavioral Health (BH): Mental health and/or Substance Use Disorder (SUD) benefits and/or conditions.

Care Coordination Organization (CCO) or Care Coordination Organization/Health Home (CCO/HH): A CCO is an entity delivering both Health Home Care Management and Basic HCBS Plan Support services to eligible individuals with I/DD. CCO/HH is used to refer to the organization and its Health Home operations.

Caregiver/legal guardian: The adult or adults who have the legal decision making and consent authority for a child, youth, or adult receiving care/services. This may include the parent(s), OPWDD, LDSS etc.

CCO/HH Care Management: A Care Management service model for individuals enrolled in Medicaid with I/DD needs. CCO/HH Care Managers provide person-centered, integrated physical and behavioral health Care Management, transitional Care Management, and community and social supports to improve health outcomes of high-cost, high need Medicaid enrollees.

As defined and implemented by the Medicaid State Plan, CCO/HH Care Management includes six (6) core functions, and the provision of required care plans for HCBS. The six (6) core functions include:

1. Comprehensive Care Management
2. Care Coordination and Health Promotion
3. Comprehensive Transitional Care
4. Enrollee and Family Support
5. Referral to Community and Social Supports
6. Use of Health Information Technology to Link Services

CCO/HH SIP-PL Liaison: This liaison between CCO/HHs and individuals and families/caregivers seeking authorization of services necessary to support individuals with I/DD in community-based settings.

Community First Choice Option (CFCO) services: An optional set of services under Medicaid that was authorized in the Affordable Care Act (ACA) that allows states to expand and enhance State Plan home/community-based attendant services and supports to individuals in need of long term care for help with everyday activities and health-related tasks that can be performed by an aide or direct care worker. Benefits include Assistive Technology, Community Habilitation, Skill Acquisition, Maintenance and Enhancement, Community Transitional Services, Durable Medical Equipment/Medical Supplies, Environmental Modification, Home Delivered/Congregate Meals, Home Health Care, Homemaker/Housekeeper, Personal Care/Consumer Directed Personal Assistance Program, Personal Emergency Response Services, Transportation, and Vehicle Modification. These enhanced services and supports are for eligible individuals who need assistance with everyday activities due to a physical, developmental or behavioral disability. These services and supports address activities of daily living, instrumental activities of daily living and health-related tasks through hands-on assistance, supervision and/or cueing. Medicaid recipients must meet HCBS setting requirements and institutional Level of Care (LOC) criteria, as well as other eligibility criteria, to be eligible for CFCO services. CFCO services must be provided pursuant to a Person-Centered Service Plan. More information is available at https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm

Coordinated Assessment System (CAS): An assessment tool specifically tailored to capture the unique health and support needs of individuals with I/DD in New York State. The CAS is being implemented in phases and the DDP2 will continue to be the assessment tool used until the CAS is implemented Statewide.

Centers for Medicare and Medicaid Services (CMS): A Federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with State governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance exchanges.

Conflict-Free Care Management (CFCM): Federal Home and Community-Based Settings rule, 42 CFR 441.301(c)(1)(vi), effective March 2014 requires that "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan."

Cultural Competency: An awareness and acceptance of cultural differences, an awareness of individual cultural values, an understanding of how individual differences affect those participating in the helping process, a basic knowledge about the individual's culture, knowledge of the individual's environment, and the ability to adapt practice skills to fit the individual and/or their family/caregiver's cultural context.

Demonstration Service: Healthcare related services under the 1115 Waiver that are not otherwise eligible expenditures under the Medicaid State Plan. Demonstration services are included under the 1115 MRT Waiver for Managed Care enrollees and will be expanded to individuals with I/DD enrolled in SIPs-PL. New York's Systemic, Therapeutic, Assessment, Resources, and Treatment (NYSTART), a new demonstration service for individuals with I/DD and behavioral health needs, will be available.

Department of Health (NYSDOH): The New York State governmental department responsible for public health and oversight of licensed health care facilities and MCOs. The NYSDOH is the single state agency responsible for the Medicaid program. Additional information on NYSDOH can be found at: http://www.health.ny.gov

Developmental Center (DC): An institution operated by OPWDD that serves individuals with I/DD and provides comprehensive residential services and active treatment.

Developmental Disability Regional Office (DDRO): OPWDD's regional offices that determine individual eligibility, conduct intake processes and assist with the coordination and oversight of services within their geographic region. Refer to Attachment C for a list of counties associated with each DDRO.

Dual-Eligible: Individuals who qualify for and are in receipt of medical coverage from both Medicare and Medicaid benefits.

Early Adopter Plan: Voluntary Early Adopters/ MCOs are entities that are controlled by not for profit organizations with extensive experience coordinating care and delivering I/DD services in New York State. Voluntary Early Adopter plans begin operation as MMCPs that provide comprehensive health care services, but do not include I/DD specialized services in the benefit package. Enrollment will be voluntary for the I/DD population.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Provides comprehensive and preventive health care services for children under the age of twenty-one (21) who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.

Family: Family is defined as the primary caregiving unit and is inclusive of the wide diversity of primary caregiving units in our culture. Family is a birth, foster, adoptive or self-created unit of people residing together, with significant attachment to the individual, consisting of adult(s) and/or child(ren), with adult(s) performing duties of parenthood/caregiving for the person even if the person is living outside of the home.

Family of One: A commonly used phrase to describe a child that becomes eligible for Medicaid through use of institutional eligibility rules for certain medically needy individuals. These rules allow children to meet Medicaid financial eligibility criteria as a "family of one," using the child's own income and disregarding parental income.

Foster Care Liaison: The SIPs-PL direct contact for Care Managers and service providers that support children in Foster Care. The Foster Care Liaison will be responsible for monitoring access for children in Foster Care.

Federally Qualified Health Center (FQHC): Community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. Federally Qualified Health Centers may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Centers for Residents of Public Housing.

Health Maintenance Organization (HMO): A MCO that operates under Article 44 of the Public Health Law and the Insurance Law and must be certified by NYSDOH. Operation and structure of these organizations is further defined in NYCRR Title 10 Part 98.

Healthcare Effectiveness Data and Information Set (HEDIS): The set of performance measures used in the Managed Care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

Home and Community-Based Services (HCBS): Home and community-based services (HCBS) provide opportunities for individuals to receive services in their own home or community rather than institutions or in other isolated settings. These services include HCBS services contained within the MMC benefit package, as well as the OPWDD HCBS Waiver services defined in Attachment G.

Home Setting or Community Setting: The setting in which a person primarily resides or spends time, that is not a hospital, nursing facility, Intermediate Care Facility (ICF), or psychiatric nursing facility.

I/DD Clinical Director: The individual designated by the SIP-PL who is responsible for services provided to individuals with I/DD. This individual shall hold a New York State clinical license in a behavioral health field and have at least seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) and five (5) years working with individuals with I/DD providing clinical services. Knowledge of New York State systems serving individuals with I/DD is required. This position must be located in New York State. SIPs-PL with more than 20,000 enrollees, the percent of effort must be full-time. SIPs-PL with less than 20,000 enrollees, the percent of effort may be less than full-time.

I/DD Dental Coordinator: The individual designated by the SIP-PL who is responsible for dental services provided to individuals with I/DD. This individual must be licensed to practice dentistry in New York State; and shall have a minimum of five (5) years of experience providing dental services for individuals with I/DD. This position may be filled on a consultant or part time basis.

Intellectual and/or Developmental Disability (I/DD): I/DD as defined by OPWDD: is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader Willi Syndrome, or autism; is attributable to any other condition found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such persons; is attributable to dyslexia resulting from a disability described above; originated before the person turns twenty-two (22) years old; has continued or can be expected to continue indefinitely; and constitutes a substantial handicap to such person's ability to function normally in society. (See also Intellectual Disability).

Intellectual Disability: A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers a range of everyday social and practical skills. (See also definition of Intellectual and/or Developmental Disability)

Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID): An OPWDD certified residential facility that provides comprehensive services and supports.

Level of Care (LOC): See Attachment A for a description of HCBS eligibility criteria for LOC population.

Life Plan: The Life Plan replaces the Individualized Service Plan (ISP) document and Plan of Care (POC) and meets all the regulatory requirements for a person-centered plan. The Life Plan documents all services the individual receives and is designed to integrate preventive and wellness services, medical and behavior healthcare, personal safeguards and habilitation to support the individual's desired personal outcomes in an electronic document

Local Department of Social Services (LDSS): Each County has an LDSS that provides or administers the full range of publicly funded social services and cash assistance programs. In New York City, these departments are named the Human Resources Administration (HRA) and Administration for Children's Services.

Long Term Supports and Services (LTSS): Health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community-based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, AIDS Adult Day Health Care Program, Personal Care Services, and institutional services including long term placement in Residential Health Care Facilities.

Managed Care Organization (MCO): A Health Maintenance Organization (HMO), Prepaid Health Services Plan (PHSP), Managed Long Term Care Plan (MLTC), HIV Special Needs Plan (HIV SNP), Health and Recovery Plan (HARP), Specialized I/DD Plan – Provider Led (SIP-PL) and Specialized I/DD Plan – Mainstream (SIP-M) certified under Article 44 of the Public Health Law.

Medicaid: Also known as Medical Assistance, Medicaid is a joint Federal and State program that helps with medical costs for people with low incomes and limited resources and/or high cost medical conditions.

Medicaid Managed Care (MMC): A health care delivery system organized to manage cost, utilization, and quality. MMC provides for the delivery of Medicaid health benefits and often additional services through contracted arrangements between State Medicaid agencies and MCOs that accept a set per member per month (PMPM) capitated payment for these services.

Medicaid Managed Care Plan (MMCP): A HMO or PHSP certified under Article 44 of the Public Health Law to provide comprehensive health services to an enrolled population eligible for Medicaid, also known as Mainstream Medicaid Managed Care.

Medical Director: The individual designated by the SIP-PL who has overall accountability for services for all enrollees, including I/DD services coming under plan responsibility as described in this document. This position must be reflected in the SIP-PL organizational chart and the identified individual must hold a New York State license as a board-certified physician. The Medical Director shall have a minimum of five (5) years of experience working with individuals with I/DD in Managed Care settings or clinical settings (at least two (2) years must be in a clinical setting). If the SIP-PL Medical Director does NOT have the stated knowledge and experience in the I/DD population and services, the SIP-PL must also identify an additional Medical Director for services for individuals with I/DD. Allocation for this additional position, if necessary, must be at a minimum of .5 Full Time Equivalent (FTE). SIPs-PL may submit a request to waive the minimum allocation of time with appropriate documentation for review and approval by the State.

Medical Necessity: New York law defines “medically necessary medical, dental, and remedial care, services, and supplies” in the Medicaid program as those “necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law” (N.Y. Soc. Serv. Law, § 365-a).

Medicare: The Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD).

New York Systematic, Therapeutic, Assessment, Resources and Treatment (NYSTART): NYSTART is a community-based program delivered by OPWDD-approved providers 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. NYSTART augments the current service system through linkage agreements and capacity building and does not replace existing services.

Office for People With Developmental Disabilities (OPWDD): The New York State agency responsible for coordinating services for more than 130,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. OPWDD provides services directly and through a network of approximately 650 not for profit service agencies. Supports and services, including Medicaid funded long-term care services, such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the State. In addition to these Medicaid services, OPWDD also provides New York State-funded family support services. https://www.opwdd.ny.gov

Personal Outcome Measures (POMs): Developed by the Council on Quality and Leadership (CQL), POMs are a list of twenty-one (21) personal outcomes designed to measure if the individual is supported in a way that achieves the outcomes that are most important to them.

Person-Centered Care: Services that are person-centered, person-guided, and reflect the person's goals and emphasize shared decision-making approaches that empower individuals and families, provide choice, and minimizes stigma.

Plan of Care (POC): The written plan that describes the type, level and duration of services and care necessary to treat the assessed needs for individuals. (See Life Plan).

Preventive Care: The care or services rendered to avert disease/illness and/or its consequences. There are three (3) levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than treatment programs.

Provider Agreement: Any written contract between the SIP-PL and a participating service provider to provide medical care and/or services to SIP-PL enrollees.

Quality Assurance Reporting Requirements (QARR): MCOs are required to submit quality performance data each year. Demographic information analyzed in this report includes individual's sex, age, race/ethnicity, Medicaid aid category, cash assistance status, language spoken, behavioral health conditions including serious mental illness (SMI) and substance use disorder (SUD), and region of residence. The QARR are largely based on measures of quality

developed and published by the National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set (HEDIS®)

Qualified Intellectual Disabilities Professionals (QIDPs): A professional who has at least one (1) year of experience working directly with individuals with I/DD; and is one (1) of the following: (i) A doctor of medicine or osteopathy. (ii) A registered nurse. (iii) An individual who holds at least a bachelor's degree in a professional category specified in 42 CFR 483.430.

Quality Management (QM): A system that documents processes, procedures, and responsibilities for achieving quality practices and objectives. It is a proactive approach rather than reactive, identifying and resolving issues before they occur. An effective QMP not only evaluates the ability of the Health Home and Care Management agencies to provide quality services to individuals, but also the impact of the services on individual health outcomes.

Regional Planning Consortium (RPC): Regional behavioral health planning consortiums are comprised of each Local Government Unit (LGU) in a region, and representatives of mental health and substance use disorder service providers, child welfare system, peers, families, Health Home leads, and Medicaid MCOs. The RPC works closely with State agencies to guide behavioral health policy in the region, problem solve regional service delivery challenges, and recommend provider training topics.

Single Case Agreement (SCA): An agreement between a non-contracted provider and the MMCP in which the provider is reimbursed for services regarding an individual's case.

Specialized I/DD Plan – Provider Led (SIP-PL): A specialized MCO led by provider organizations in the OPWDD system that have a history of serving New Yorkers with I/DD.

Specialized I/DD Plan – Mainstream (SIP-M): A MMCP offering a specialized I/DD plan as a separate line of business.

Start-up date: The date the SIPs-PL will begin providing health services described in this document.

Utilization Management (UM): The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable MMCP.

Value Based Payment (VBP): A strategy that is used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by Fee-For-Service payments to payments that are more closely related to both quality and cost outcomes, linking provider payments to improved performance by holding health care providers accountable for both the cost and quality of care they provide.

Valued Outcomes (Habilitation Goals): The destination or valued end result that an individual wants to pursue or, achieve. It can be long–term desires or simple day-to-day choices. They are individualized, clearly stated, and not vague. The Valued Outcomes must be listed in the

individual's Life Plan in the Valued Outcomes section. They are linked to other services that the individual receives, and there must be at least one (1) Valued Outcome listed in the Valued Outcome Section of the Life Plan and for each Waiver habilitation service that the individual receives.

3.0 Performance Standards

1. SIP-PL Early Adopter applicants must demonstrate that the health plan meets the qualifying criteria in this document to manage the delivery of 1115 Demonstration and Medicaid-covered services for all enrollees and additional benefit package services for all enrolled individuals with I/DD. The State expects that upon transition of the DD benefits and services, SIPs-PL will continue to operate under contracts with the State, meeting all requirements in the MMC Model Contract unless otherwise stated in this document.

2. The SIP-PL is required to develop a governance model that addresses the needs of the expanded OPWDD benefit and the I/DD population.

3.1 Organization Capacity

The SIP-PL must meet the following minimum requirements:

1. The SIP-PL must be controlled by one (1) or more not for profit organizations with a history of providing or coordinating health and long-term care services to individuals with I/DD. Experience coordinating care for individuals with I/DD will be evaluated based on the experience of the organization's leadership in overseeing and operating entities that deliver Care Management, ICF/IID and/or HCBS Waiver services. The expectation is that the leadership of the SIP-PL (board members and officers) will have extensive experience in coordinating care for individuals with I/DD.
2. Applicants must be in good standing with OPWDD.
3. The SIP-PL or its business associates may not have current, unsatisfied charges or orders related to administration of services outstanding against it by any State or the Federal government.
4. The SIP-PL or its business associates may not have had a contract to manage services discontinued, cancelled or non-renewed by any State or the Federal government for lack of performance or non-performance within the prior three (3) years.
5. If needed for statewide coverage, MMCPs may apply for consideration to serve the I/DD population to operate as a Specialized I/DD Plan- Mainstream (SIP-M) prior to implementation of mandatory enrollment of individuals with I/DD beginning in 2021.
6. The SIP-PL may contract with a delegated manager through a Management Services Agreement (MSA) to oversee and/or administer the I/DD and/or HCBS benefits, provided the delegated manager meets all requirements and standards in this document applicable to functions contractually delegated to the manager. The delegated manager can be an Independent Practice Association (IPA) that provides management services or another

management contractor. Any contract (including all amendments) delegating management functions in accordance with 10 NYCRR 98-1.11(j), must be approved by the State.

7. The SIP-PL must demonstrate processes and procedures to accommodate the service needs of individuals with I/DD.
8. To accommodate additional responsibilities, the SIP-PL must expand or establish service center operations in New York State by the start-up date.
9. The SIP-PL shall provide and/or manage the functions listed below. Unless otherwise noted, functions shall be available during business hours (8:00 am to 6:00 pm) in the New York State service center location. Functions allowed out-of-state must be provided in the United States, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.
    a. Seven (7) days a week, three hundred and sixty-five (365) days a year live toll-free line to provide information and referral on I/DD benefits and services. This function may be operated out-of-state with the approval of New York State. The SIP-PL must demonstrate that the member service line staff has knowledge of:
        i. Covered Services
        ii. New York State Managed Care Rules
        iii. Approved Utilization Management Criteria
        iv. Provider Networks
    b. Twenty-four (24) hour, seven (7) days a week, three hundred and sixty-five (365) days a year person staffed toll-free line to provide crisis referral.
    c. The SIP-PL must demonstrate the efficacy of the linkage between the crisis line and local crisis responders, including DD service providers for crisis intervention, State Plan services, and NYSTART.
    d. The SIP-PL must modify their staff training programs and provider contracting to include New York State specific rules.
    e. The SIP-PL must demonstrate an adequate number of trained staff to ensure that network development, clinical management, and provider relations activities are sufficient to accomplish the transition goals described in this document.
    f. The SIP-PL must demonstrate an adequate number of trained staff to accomplish necessary provider contracting and credentialing/re-credentialing. The SIP-PL is responsible for training providers on how to become credentialed and re-credentialed in their Plan. This function may be located out-of-state.
    g. The SIP-PL must have provider relations staff with access to claims and payment reporting platform(s).
    h. Per Federal guidelines, the SIP-PL must have sufficient staff available to respond to prior authorization requests for post stabilization services within one (1) hour (twenty-four (24) hours a day). This service may be provided out-of-state but staff must have knowledge of:
        i. Covered Services
        ii. New York State Managed Care Rules
        iii. Approved Utilization Management Criteria
        iv. Provider Networks

i. The SIP-PL must provide I/DD clinical and medical management as specified in this document.
j. The SIP-PL must provide education and training on topics required in this document.
k. The SIP-PL must have sufficient resources to assist with Quality Management initiatives, financial oversight, reporting and monitoring, and oversight of any subcontracted or delegated functions related to the I/DD population.

10. The SIP-PL must have a reasonable strategy and sufficient internal resources, including staff and infrastructure, to review functional assessments, OPWDD HCBS eligibility determinations, and Life Plans, including those developed by CCO/HHs.

11. The SIP-PL is responsible for the provision of Care Management for all enrollees. Care Management provided by the SIP-PL must comport with the person-centered planning requirements in the MMC Model Contract.

    a. Individuals who newly enroll in the SIP-PL and are in receipt of services from a CCO may continue to receive Health Home or Basic HCBS Plan Support Care Management from the CCO. In all cases, the enrollee will have a single Life Plan, and the SIP-PL and CCO must collaborate to maintain the individual's plan.
    b. The SIP-PL will provide coverage of Health Home services for non-I/DD enrolled family members (adults and children) who are eligible to receive Health Home Care Management.
    c. For individuals with I/DD who choose not to receive services from a CCO, individuals enrolled in an ICF, and for family members who do not qualify for Health Home services, the SIP-PL must demonstrate having person-centered planning capacity in one (1) of two (2) ways:
        i. Delegate Care Management functions to the CCO; or
        ii. Provide Care Management directly. The SIP-PL directly delivering person-centered planning services shall be subject to character and competency review of staff and SIP-PL leadership, as well as an assessment of staff qualifications (e.g., staff who are QIDPs).

12. The SIP-PL shall establish its mechanisms to monitor service quality, develop quality improvement initiatives, and solicit feedback/ recommendations from key stakeholders to improve quality of care and individual outcomes through the involvement of consumer and other stakeholder advisory boards.

13. The SIP-PL shall establish an Advisory Committee that reports to the governing board to advise and assist the SIP-PL in identifying and resolving issues related to the management of developmental disability, physical and behavioral health benefits for individuals with I/DD. The committee shall include:
    a. Individuals with I/DD who are served in the OPWDD system and their family/caregivers,

b. DD service providers, and
c. Other stakeholders as appropriate

14. Representatives of the Advisory Committee shall have expertise in I/DD service delivery and familiarity with the service needs of adults and children with I/DD, including medically fragile individuals, and individuals with behavioral health needs. The committee representatives should be chosen to reflect the entire geographic service area of the SIP-PL.
15. The SIP-PL must have an established information technology (IT) platform that provides electronic support to comply with requirements in this document.

3.2 Personnel

1. The purpose of these staffing requirements is to ensure that SIPs-PL have the required DD, physical health, behavioral health, pharmacy, utilization management, quality management, and Care Management experience to meet the needs of individuals with I/DD, including any special needs they may have.
2. The SIP-PL retains governing responsibility per 10 NYCRR Part 98. If the SIP-PL delegates certain management functions, the SIP-PL and its delegated managers must work as an integrated team with involved State agencies, CCO/HHs, providers, and Regional Planning Consortiums (RPCs) regardless of the SIPs-PL organizational structure.
3. The SIP-PL shall establish and maintain an organizational culture, leadership approach, and administrative structure that supports a partnership amongst Plans, providers, local government units (LGUs), DD service systems, individuals, family members and advocates, and embraces the State's vision for the OPWDD delivery system as described in this document.
4. This section establishes minimum requirements for key personnel, managerial staff, and operational staff to accommodate the administration of the expanded benefits for the I/DD population.
    a. Key staff have overall accountability for ensuring access to high quality and timely care for the individuals they serve and are required to participate in the RPC. At a minimum, the SIP-PL Medical Director and I/DD Clinical Director shall participate directly or through a delegate who has knowledge of the DD system of care and possesses the authority to make decisions on behalf of the SIP-PL.
    b. Managerial staff have day-to-day responsibility for the management of I/DD services within the SIP-PL.
5. The SIP-PL shall have DD, physical, and behavioral health resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the training, education, experience, orientation, and credentials, as applicable, to perform assigned job duties.

6. The SIP-PL must meet the needs of all SIP-PL enrollees including service delivery and staffing requirements for children as defined in the MMC Organization Children's System Transformation Requirements and Standards. Full implementation of these requirements will be based on enrollment thresholds being met.
7. SIP-PL applications must contain specific details on how functions will be assigned to responsible parties and how the SIP-PL will ensure these functions are achieved in ways that ensure effective services are provided to individuals with I/DD and/or chronic medical, and/or behavioral health needs.
8. The SIP-PL shall orient and train all staff, including delegated managers as appropriate, to job functions, requirements, and standards articulated in this document, including training on the requirements of the New York State OPWDD service system.
    a. The SIP-PL shall develop and implement a training plan which at a minimum incorporates the topics listed in Attachment D. This plan is subject to the State's review and approval.
    b. All SIP-PL staff must be trained prior to performing work under the standards articulated in this document.
    c. SIPs-PL are strongly encouraged to consider including individuals and/or family members/caregivers in the development and delivery of training and education.
    d. Knowledge checks and competency testing must be incorporated into training plans, and periodic staff reassessments (annually at minimum) are required.
9. Unless specified in Attachment C, positions are not required to be full-time or located in New York State. Staff allocation and qualifications must be sufficient to meet the requirements in this document.
10. The SIP-PL shall maintain current organizational charts and written job descriptions that are consistent in format and style for each functional area. Organizational charts shall clearly demonstrate how required functions will be assigned. If applicable, the organizational chart should also clearly show how the SIP-PL will oversee delegated managers.
    a. Organizational charts and job descriptions for key personnel and managerial staff must be submitted for review and approval by the State.
    b. The SIP-PL must develop and maintain a staffing plan that describes how staff training will be completed and staffing levels will be maintained to ensure the successful accomplishment of all duties outlined in this document.
11. Key Personnel Requirements: The SIP-PL must fill the following key leadership functions to oversee the delivery of services to individuals with I/DD. These roles are mandatory positions and must be filled by separate individuals. See Attachment C.
    a. Required I/DD positions for all SIPs-PL
        i. Medical Director: The SIP-PL shall identify a Medical Director to have overall accountability for all services delivered, including DD services coming under the SIP-PL responsibility as described in this document. This position must be reflected in the SIP-PL organizational chart, and

the identified individual must hold a New York State license as a board-certified physician. The Medical Director shall have a minimum of five (5) years of experience working with individuals with I/DD in Managed Care or clinical settings (at least two (2) years must be in a clinical setting) and must meet the experience requirements as reflected in Attachment C. If the SIP-PL Medical Director does NOT have the stated knowledge and experience in the I/DD population and services, the SIP-PL must also identify an additional Medical Director who meets the I/DD experience requirements. Allocation for this additional position, if necessary, must be at a minimum of .5 FTE. The SIP-PL may submit a request to waive the minimum allocation of time with appropriate documentation for the State's review and approval. This position must be located in New York State.

ii. I/DD Clinical Director: The SIP-PL must designate an I/DD Clinical Director responsible for services provided to individuals with I/DD. This position must be reflected in the SIP-PL organizational chart and the identified individual must have appropriate managerial experience. The individual shall hold a New York State clinical license in a behavioral health field and have at least seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) and five (5) years working with individuals with I/DD providing clinical services. Knowledge of New York State systems serving individuals with I/DD is required. This position must be located in New York State.

iii. I/DD Dental Coordinator: The SIP-PL must designate an I/DD Dental Coordinator who is responsible for dental services provided to individuals with I/DD. This individual must be licensed to practice dentistry in New York State. The individual shall have a minimum of five (5) years of experience providing dental services to individuals with I/DD. This position may be filled on a consultant or part time basis.

b. Additional Key Personnel Positions Required when SIP-PL enrollment exceeds 10,000 enrollees

i. Behavioral Health Medical Director: SIPs-PL whose enrollment exceeds 10,000 enrollees must also identify a Behavioral Health Medical Director to have overall accountability for behavioral health services for SIP-PL enrollees. This individual must hold a New York State license as a physician and shall have a minimum of five (5) years of experience working in a Managed Care or clinical settings (at least two (2) years must be in a clinical setting). The Behavioral Health Medical Director shall have appropriate training and expertise in general psychiatry and/or addiction disorders (e.g., board certification in general psychiatry and certification in addiction

medicine or certification in the subspecialty of addiction psychiatry). This individual must be located in New York State. The Behavioral Health Medical Director is not required for SIPs-PL with less than 10,000 enrollees.

c. Additional Personnel Positions Required when SIP-PL enrollment of children under the age of twenty-one (21) exceeds 2,500 enrollees

i. Foster Care Liaison: The SIP-PL is expected to have an interagency Foster Care Liaison able to meet the criteria/requirements as outlined in the MMC Organization Children's System Transformation Requirements and Standards document. The responsibilities for this position may be included within another position.

12. Changes in SIP-PL Key Personnel: The SIP-PL shall verbally inform NYSDOH and OPWDD immediately and provide written notice within seven (7) days after the date of a resignation or termination of all key personnel identified in this document. The notification must include the name of the contact person that will be performing the key personnel duties in the interim. In addition, the SIP-PL shall submit a written plan for replacing key personnel, including expected timelines. If key personnel will not be available for work as required in this document for a continuous period exceeding thirty (30) days, or are no longer working full-time in the key position, the SIP-PL shall notify NYSDOH and OPWDD within seven (7) days after the date of notification by the key personnel of the change in availability or change in full-time employment status. New York State must review the character and competency of individuals serving in all key staff positions and maintains the right to review and approve individuals filling these positions.

13. Required Functions of Key Personnel: The Medical Director, I/DD Clinical Director, I/DD Dental Coordinator and when applicable, the Behavioral Health Medical and/or Clinical Directors shall be involved in the following functions, as they relate to the provision of services to individuals with I/DD enrolled in the SIP-PL:
    a. Provision of clinical oversight and leadership to utilization management and Care Management staff working with the I/DD population.
    b. Development, implementation, and interpretation of clinical-medical policies and procedures that are specific to the DD benefits and services or can be expected to impact the overall health, and wellbeing of individuals with I/DD.
    c. Ensuring strong collaboration and coordination between DD, physical and/or behavioral health care across the utilization management and Care Management staff.
    d. Clinical peer review recruitment and supervision of SIP-PL staff.
    e. Collaboration with Provider Relations staff to ensure an adequate provider network via required provider credentialing guidelines.
    f. DD and behavioral health provider quality profile design and data interpretation.
    g. Development and implementation of the I/DD and behavioral health sections of the quality management/utilization management plan

h. Participation on the I/DD and behavioral health committees for quality management/utilization management.
i. Administration of I/DD and behavioral health quality management/utilization management and performance improvement activities, including grievances and appeals.
j. Attendance at regular (at least quarterly) SIP-PL leadership and other I/DD and/or Behavioral Health Medical Director meetings.
k. Ensuring strong collaboration and coordination between other I/DD and behavioral health serving systems, including the CCO/HHs and the education system.
l. Attendance at Regional Planning Consortium meetings.

14. Managerial Staff: The SIP-PL shall develop and maintain overall management and staffing to achieve the goals listed throughout this document. The SIP-PL shall employ managerial personnel to oversee and provide the functions listed below.
    a. All managerial staff must demonstrate knowledge of the needs, services and benefits for individuals with I/DD.
    b. Managerial staff must have knowledge of or experience related to working with individuals with I/DD and their families/caregivers using the person-centered planning process, and collaborating with DD and other service systems, including but not limited to the behavioral health service system, local, State and Federally-funded non-Medicaid service providers (e.g., community resources and the education system).
    c. Ideally, the SIP-PL should employ Manager(s) with experience working with individuals with I/DD in behavioral health settings and, when possible, experience working with individuals with I/DD and other chronic medical, and/or behavioral health needs.
    d. Managers should have knowledge of service delivery consistent with evidence-based and promising practices for individuals with I/DD.
    e. Managerial staff must also have knowledge of HCBS and related regulatory requirements including:
        i. Timeframes for completion of the comprehensive assessment and the Life Plan;
        ii. Procedures and State guidelines for approving HCBS services recommended in a Life Plan;
        iii. Effective and efficient monitoring of the individual's progress, frequency of HCBS, including identification of any deviations from approved Life Plans; and
        iv. Coordination across departments responsible for compliance with HCBS requirements, including but not limited to, reporting related to HCBS assurances and sub-assurances.
        v. Coordination in engaging their entire organization by encouraging individuals, board members, management and staff to work together in a person-centered environment with the goal of promoting and achieving Valued Outcomes for the individuals served.

15. The SIP-PL is required to create the following Managerial Staff Positions:

    a. CCO/HH SIP-PL Liaison: SIPs-PL are responsible for ensuring there is a coordinated approach and effective communication between CCO/HHs and individuals and/or their families/caregivers. The CCO/HH SIP-PL Liaison must support the staffing and functions outlined in this document and in the MMC Model Contract and act as a liaison between CCO/HHs and families seeking authorization of services necessary to support individuals with I/DD in community-based settings. This position may not be delegated.
    b. For each department and position listed below, the SIP-PL shall ensure a sufficient staffing plan that includes adequate managerial resources with the expertise to meet the needs of individuals with I/DD who have chronic medical and/or behavioral health needs, including each HCBS-eligible population. Positions and functions may be combined to the extent that the staff allocation and qualifications are sufficient to meet the requirements in this document, subject to the State's approval. In addition, for each of the departments and positions listed below, Plans shall ensure adequate experienced staff to meet the needs of individuals with I/DD and behavioral health needs.

        i. Comprehensive Care Management
        ii. Utilization Management
        iii. Network Development
        iv. Member Services
        v. Provider Relations
        vi. Training
        vii. Quality Management
        viii. Information Systems
        ix. Governmental/Community Liaison
        x. CCO/HH SIP-PL Liaison

16. In addition to the key and managerial staff, the SIP-PL shall have adequate qualified operational staff to meet the responsibilities contained within this document. For each department, the SIP-PL shall ensure staff expertise to meet the needs of individuals with I/DD as appropriate to their job function, as described within this document.

    a. Member services staff, claims staff, utilization management staff, and I/DD clinical peer reviewers, may work at sites within the United States but outside of New York State. Other operational staff must work at sites located within New York State. Refer to Attachment C for a summary of personnel requirements.

17. The SIP-PL shall have staffing and structure necessary to support individuals with chronic medical, I/DD, and/or behavioral health needs who also need assistance with performing daily activities, including the individuals receiving OPWDD HCBS who have met the level of care eligibility determination (LCED) criteria. The SIP-PL shall have clinical leadership, peer review, and utilization management staff with appropriate clinical expertise to support the needs of the LCED population.

3.3 Member Services

1. The SIP-PL shall provide and/or manage the Member Services call center operations listed below and according to the requirements found in Section 12 of the MMC Model Contract.

    a. The SIP-PL must provide a person-staffed Member Services toll-free phone line to respond to inquiries, conduct triage, make referrals and follow-up on questions or concerns related to the benefits and services for the I/DD population seven (7) days per week/three hundred and sixty-five (365) days per year. Unless otherwise stated, these operations must be available from 8am - 6pm, with 24 hours per day/7days a week availability for crisis referrals.
    b. Member Services call center operations may be located out-of-state provided staff are adequately trained on all New York State requirements.
    c. The SIP-PL shall staff the Member Services call center with a sufficient number of trained representatives to meet call responsiveness expectations reflected in the SIP-PL Member Services policies and procedures and to competently respond to Member Services calls.
    d. The SIP-PL must demonstrate that the Member Services call center staff have knowledge of the benefits and program requirements for the I/DD population.

2. The SIP-PL must have Member Services policies and procedures to reflect the following:

    a. Authorization requirements for I/DD benefits and services.
    b. Requirements for responding promptly to individuals and family members/caregivers and for supporting linkages to other DD-serving systems, including but not limited to the LDSS, DDROs, NYSTART, CCO/HHs, State or Federally funded non-Medicaid services (e.g., community supports and the education system), and the New York State Justice Center. Member services staff shall not be required to make direct linkages by phone to such systems.
    c. Protocols for assisting and triaging individuals who may be in crisis by accessing a clinician qualified to assess the individual's needs. The transfer to the clinician must take place without placing the caller on hold. (The qualified clinician will assess the crisis and provide a warm transfer to the crisis provider, call 911, refer the individual for services or to his or her provider, and/or resolve the crisis over the telephone as appropriate). The SIP-PL must demonstrate the efficacy of linkages between the Member Services call center and local crisis responders, including DD service providers for crisis intervention State Plan services and NYSTART.

3. As directed by the State, the SIP-PL shall submit Member Handbooks for review and approval. The SIP-PL Member Handbook must meet all requirements outlined in the MMC Model Contract and include information on the I/DD benefits and services, including where and how to access them and related authorization requirements.

3.4 Service Delivery Network Requirements/Access to Care

1. The SIP-PL service areas shall consist of the county or counties listed in the Plan's MMC Contract with the State.
2. The SIP-PL shall contract with enough providers to meet the minimum network standards outlined in this document that will ensure access to covered benefits and services as described in Attachment F.
3. In addition to the provider network requirements in the MMC Model Contract, the SIP-PL is required to accommodate the service delivery needs of individuals with I/DD as defined in the Life Plan and informed by the person-centered comprehensive assessment process.
4. The SIP-PL is required to contract with OPWDD certified providers of I/DD Specialty Services within the SIP-PL service area. This list of providers will be provided to SIPs-PL as available. As the State analyzes capacity, based on provider designation process, the State may require SIPs-PL to contract with additional providers certified to provide the HCBS/SPA services.
5. The SIP-PL is required to contract with CCO/HHs serving individuals with I/DD in the SIP-PL service area. The SIP-PL network must include a sufficient number of CCO/HHs for any enrollees eligible for CCO/HH services.
6. The SIP-PL must develop and expand their networks based on the anticipated needs of individuals with I/DD. SIPs-PL are required to contract with OPWDD certified providers who have expertise in supporting individuals with I/DD, to ensure that individuals with I/DD receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of the individual or seek authorization from the Plan for out-of-network providers when participating providers cannot meet the individual's needs.
7. The SIP-PL must authorize services in accordance with established timeframes in the MMC Model Contract.
8. For all benefits included in the SIP-PL benefit package, the SIP-PL must ensure access to that service. This includes coverage of, and payment for, covered services for which the SIP-PL does not have an available provider and emergency services, including emergency services provided within the United States or its territories.
9. The SIP-PL must assure access to all behavioral health services in the MMC benefit package. However, network adequacy standards will initially recognize the existing provider capacity and current behavioral health service providers for individuals with I/DD. Once enrollment in a SIP-PL reaches 10,000, the existing MMC behavioral health network capacity requirements must be met.

10. OPWDD is committed to continuing transformation goals related to self-direction. The SIP-PL benefit package includes the self-direction benefit. While the SIP-PL will oversee the benefit, the self-direction program rules will not change, and will operate in Managed Care as it does in the Fee-For-Service program.

11. The SIP-PL must meet the minimum appointment availability and network standards for each service type identified in Tables 3 and 4 below. If contracting with required providers does not meet the minimum network standards, the SIP-PL must attempt to secure contracts with additional providers to meet the applicable standard. If a provider is unwilling to contract with the SIP-PL, the SIP-PL must offer Single Case Agreements.

Table 3. Minimum Network Standards by Service Type

Service	Urban Counties	Rural Counties[2]

Habilitation
· Residential
· Day
· Community
· Prevocational
  o Site Based
  o Community
· Supported Employment
· Pathway to Employment
	At least 2	At least 2 in region

Respite	At least 2	At least 2 in region
Adaptive Devices — Assistive Tech (CFCO)	At least 2	At least 2 in region
Environmental Modifications	At least 2	At least 2 in region
Family Education and Training	At least 2	At least 2 in region
Services to Support Self Direction · Fiscal Intermediary · Support Brokerage · Individual Directed Goods and Services	At least 2	At least 2 in region

[2] New York State Public Health Law defines a rural county as any county having a population of less than 200,000.

Community Transitional Services (CFCO)	At least 2	At least 2 in region
Live-in Caregiver	At least 2	At least 2 in region
Intensive Behavioral Services	At least 2	At least 2 in region
Vehicle Modification (CFCO)	At least 2	At least 2 in region
OPWDD Certified Clinics	All in county	All in county (or region)

1. The SIP-PL shall comply with the appointment availability standards and definitions in the MMC Model Contract. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.
2. Table 4 illustrates how appointment availability standards apply to each specialized service type.

Note: In addition to the required core provider types (as listed on the Health Commerce System (HCS); and although HCBS services will be paid on a non-risk basis until such time no later than two (2) years, SIPs-PL are obligated to have a sufficient network of designated HCBS providers qualified to meet the needs of individuals in the subpopulations enrolling in MMC under this transition. In many areas, the minimum standards below may not be adequate to meet the individual's need for access. Where minimum network standards in Table 3 are not adequate to meet the individuals' need for access and/or to meet appointment access standards in Table 4, the SIP-PL will be required to exceed the minimum network standards in Table 3 to ensure access to care. The State reserves the right to modify the minimum network standards in accordance with the MMC Model Contract. Regions are aligned with DDRO regions. Refer to Attachment E: Network Development in rural Counties for additional information.

Table 4. Appointment Availability[3] Standard by Service Type

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge
OPWDD Outpatient Clinic		Within 24 hours	Within 1 week	Within 5 business days of request

[3] Availability for HCBS services is the point in time when the network provider contacts the individual to begin the habilitation planning process.

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge
Intensive Behavioral Services		Within 72 hours of request	2–4 weeks	Within 24 hours
Vehicle Modifications			Within 2 weeks of request	Within 5 business days of request
Live-in Caregiver			Within 2 weeks of request	Within 5 business days of request
Community Transition Services			Within 2 weeks of request	Within 5 business days of request
Family Education and Training			Within 5 business days of request	Within 5 business days of request
Pathway to Employment			Within 2 weeks of request	
Prevocational Services			Within 2 weeks of request	
Supported Employment			Within 2 weeks of request	
Services to Support Self-direction		Within 72 hours of request	Within 5 business days of request	
Habilitation: Day, Community, and Residential	Within 24 hours	Within 72 hours of request	Within 2 weeks of request	

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge
Adaptive Devices and Assistive Tech		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request
Environmental Modifications		Within 24 hours of request	Within 2 weeks of request	Within 24 hours of request
Respite		Within 24 hours of request	Within1 weeks of request	Within 24 hours of request

3.5 Continuity of Care

The SIP-PL must meet continuity of care for services under OPWDD auspices. Continuity of care provisions to ensure that an individual's current Life Plan remains in place while the individual is transitioning and enrolling in a SIP-PL. The individual will always have a choice of provider with the SIP-PL network and, hence, none of the provider protections and continuity of care provisions described below diminish an individual's right to request a change in the services described in his or her Life Plan and/or a change in service provider.

1. With respect to an individual receiving non-residential HCBS services operated, certified, funded, authorized or approved by OPWDD, the SIP-PL must pay the current provider of non-residential services at the rates established by the State for ninety (90) days, to ensure continuity of care.

2. With respect to an individual living in a residential facility operated or certified by OPWDD, the SIP-PL 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 Life Plan.

3. The SIP-PL shall execute Single Case Agreements (SCAs) with non-participating providers to meet clinical needs of individuals with I/DD when in-network services are not available. The SIP-PL shall monitor the use of SCAs to identify high-volume, non-participating providers for contracting opportunities and to identify network gaps and development needs. The SIP-PL must pay at least the fee-for-service fee schedule for twenty-four (24) months following enrollment for all SCAs.

4. The SIP-PL must allow individuals to continue with their care providers, including medical and behavioral health, for a continuous Episode of Care. This requirement will be in place for the first twenty-four (24) months following enrollment. It applies only to Episodes of Care that were ongoing during the transition period from Fee-For-Service to Managed Care

5. To preserve continuity of care, individuals with I/DD enrolled in the SIP-PL will not be required to change CCO/HHs at the time of the start-up-date. The SIP-PL will be required to pay on a single case basis for individuals with I/DD enrolled in a CCO/HH when the CCO/HH is not under contract with the SIP-PL.

6. SIPs-PL that contract with clinics holding a state integrated license shall contract for the full range of services available pursuant to that license, subject to the agreement of the clinic. In the event a contracted clinic refuses to contract with the SIP-PL for all services provided pursuant to the clinic's license, the SIP-PL must notify the State and must demonstrate a good faith effort to negotiate a contractual arrangement with the clinic for the full range of services available pursuant to the clinic's license.

3.6 Network Monitoring

1. The SIP-PL must have a process for regularly monitoring the contracted network's adequacy, developing strategies to ensure uninterrupted services to individuals, and ensuring that major components of their current network delivery system are not adversely affected by the transition to Managed Care.

2. The SIP-PL must develop a detailed network plan for review and approval that must be updated annually and submitted to the State upon request. The network plan shall include, but is not limited to the following components:
    a. An analysis of network adequacy derived from data on enrollment, utilization, prevalent diagnoses, individual demographics, access and availability survey results for the covered benefits, out-of-network utilization (i.e., SCAs), outcomes (when available), grievances, appeals, individual and family satisfaction, and provider issues that were significant or required corrective action during the prior year.
    b. An explanation of how the network meets the needs of the expanded population and provides access to the covered benefits.
    c. Identification of any current material gaps in the DD network and specialty service providers needed to provide access to covered benefits, priorities for network development for the coming year and a work plan with goals, action steps, timelines, and measurement methodologies for addressing the gaps and priorities.

3. OPWDD certification of providers will suffice for the SIP-PL credentialing process. When contracting with OPWDD certified providers, the SIP-PL may not separately credential individual staff members in their capacity as employees of these programs. The SIP-PL must still conduct program integrity reviews to ensure that provider staff are not disbarred or excluded from Medicaid or any other Federal health care programs, or excluded from Medicaid reimbursement in any other way. The SIP-PL shall still collect and accept program integrity related information from these providers, as required in the MMC Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

4. When credentialing OPWDD-certified, OMH-licensed, OMH-operated and OASAS-certified providers, the SIP-PL shall accept the OPWDD, OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Plan credentialing process for individual employees, subcontractors or agents of such providers. The SIP-PL shall still collect and accept program integrity related information from these providers, as required in the MMC Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

5. The SIP-PL shall update and submit to the State for review and approval the SIP-PL Provider Manual to include policies and procedures that address all relevant information on DD services including HCBS and the specific provider requirements described throughout this document, State guidance, and the Federal Waiver special terms and conditions.

6. The SIP-PL shall develop a CCO/HH and provider profiling system that includes outcomes and compliance with HCBS assurances and sub-assurances. At minimum, HCBS assurances are anticipated to include the assurances and sub-assurances as listed in Attachment B. These assurances and sub-assurances may be modified by the State to more appropriately reflect the needs of individuals with I/DD.

3.7 Network Training

1. The SIP-PL shall expand its current provider training curriculum to reflect the I/DD service population and benefits. To the extent practical, provider training and the SIP-PL annual training plan should be coordinated with the CCO/HH providers and address any gaps identified by the SIP-PL or CCO/HHs related to the treatment of individuals with I/DD.
    a. An initial orientation and training shall be offered to all providers in the SIP-PL network.
    b. Training and technical assistance shall be provided to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and utilization management requirements.
    c. Training shall include processes for assessment for OPWDD HCBS eligibility (e.g., Targeting Criteria, Risk Factors, Functional Limitations) and Life Plan development and review, including Habilitation and/or Staff Action Plans and Valued Outcomes.

2. The State will collaborate with SIPs-PL to develop a uniform provider training curriculum that addresses clinical components necessary to meet the needs of individuals with I/DD transitioning to Managed Care. Examples of clinical topics include:
    a. Unique needs of the I/DD population;
    b. Person-centered treatment planning and service provision.

3.8 Utilization Management

1. SIPs-PL will use Medical Necessity Criteria (MNC) guidelines as defined in New York Social Services Law, § 365-a to determine appropriateness of new and ongoing services. The SIP-PL should view each request for authorization for a specific service level within the larger context of the individual's needs. When an individual no longer meets MNC for a specific service, the SIP-PL should work with the individual's provider to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the enrollee successfully transitions without disruption in care. While MNC is required to justify the provision of services, the State supports a person-centered approach to care in which the individual's needs, preferences, and strengths are considered in the development of the Life Plan. The SIP-PL must make every effort to implement the goals contained in the individual's Life Plan by providing alternatives where the desired service does not meet MNC guidelines.
    a. The SIP-PL should also have processes for reviewing claims and authorization requests to determine if an individual with I/DD, who is not currently enrolled in a CCO/HH or in a 1915(c) waiver, should be referred for CCO/HH or HCBS Waiver services.
    b. The SIP-PL should have processes for reviewing claims and authorization requests to determine if a non-I/DD family member should be referred for Health Home or HCBS Waiver services.

2. SIPs-PL shall establish utilization review protocols that comport with the State's Medicaid medical necessity standards, Federal and State parity requirements, the MMC Model Contract, and other related standards that may be developed by NYSDOH and OPWDD for the I/DD services described in this document.

3. SIPs-PL that choose not to conduct prior authorization or concurrent review for specific ambulatory levels of care must provide the State with their data-driven plan to identify and work with providers who are outliers. The SIP-PL must do the same for services in which prior authorization is not permitted.

4. SIPs-PL shall develop and implement utilization management protocols for DD, medical, behavioral health, long term supports and services (LTSS), pharmacy and HCBS benefits, including policies, procedures and guidelines that comply with the following requirements:
    a. Utilization management protocols, MNC guidelines, and admission criteria and service authorization criteria must be consistent with State guidance.
    b. Utilization management protocols and guidelines, as well as any subsequent modifications to the protocols and guidelines, shall be submitted to the State for review and approval prior to adopting.
    c. Utilization management protocols for DD services shall include a process to accelerate access to necessary services commiserate with an individual's need. Necessary services authorized under these guidelines will be provided in accordance with a set threshold amount that will be established by the State. Utilization management protocols for self-direction will follow State guidelines and budgeting standards.

d. The SIP-PL review process for HCBS shall include review and approval of Life Plans inclusive of HCBS Waiver services.
    i. HCBS Waiver services must be managed in compliance with the CMS HCBS Final Rule (CMS 2249-F and CMS 2296-F) and any applicable State guidance.
    ii. The SIP-PL must ensure that the Life Plan was developed in a person-centered manner, compliant with the Final Rule and State guidance, meets individual needs, and includes goals and outcomes.
    iii. The SIP-PL must ensure that HCBS services the individual receives are included in the Life Plan and authorized pursuant to that Life Plan.
    iv. The SIP-PL shall develop a data driven approach to identify service utilization patterns that deviate from any approved Life Plan, conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the Life Plan.
e. To begin authorization of new services beginning with the effective date of enrollment, the SIP-PL must be ready to accept Life Plans from CCO/HHs as of that date. For newly enrolled individuals, the CCO/HH must obtain the individual's consent prior to sharing the Life Plan with the SIP-PL.

5. The SIP-PL shall educate utilization management staff in the application of utilization management protocols, clearly articulating the criteria to be used in making utilization management decisions and describing specific Care Management functions. This includes the requirements in the MMC Model Contract regarding individuals with I/DD. The SIP-PL shall ensure that all utilization management staff who are making service authorization decisions and/or conducting Care Management have been trained and are competent in working with the specific area of service they are authorizing.

6. The SIP-PL shall ensure consistent application of review criteria regarding requests for initial and continuing stay authorizations. At a minimum, on an annual basis, all staff performing initial and continuing stay authorizations and denial reviews shall participate in inter-rater reliability testing to assess consistency in the application of utilization management guidelines. Staff performing below acceptable thresholds for inter-rater reliability shall not be allowed to make independent authorization decisions until such time that they can be retrained, monitored and able to demonstrate performance that exceeds the acceptable threshold. The inter-rater reliability testing, including test scenarios and processes, shall be customized to address all medical, DD, behavioral health, and HCBS services subject to prior authorization or concurrent review, as defined throughout this section.

7. The SIP-PL shall establish criteria to identify quality issues, other than medical necessity, that result in referral to a clinical peer reviewer for review and consultation. The SIP-PL must develop a reasonable method and have systems in place including appropriate utilization management documentation audits.

8. The SIP-PL shall be part of the discharge planning team and establish protocols to ensure that discharge planning is comprehensive. Protocols shall include, but are not limited to:
    a. Identifying comprehensive discharge plans that address not only treatment availability, but also community supports necessary for achievement of milestones and community integration, including but not limited to: educational concerns (inclusive of special education), family and social supports and interactions, stable housing, financial support, medical care, transportation, employment/vocational training and a crisis intervention/prevention plan;
    b. Identifying and reducing barriers to access and/or engagement with post-discharge ambulatory appointments, medication, and other treatment(s);
    c. Confirming post-discharge appointment availability and adherence. In the absence of adherence, the SIP-PL must offer appointment options;
    d. Procedures for concurrent review for enrollees requiring extended care in inpatient classified settings due to insufficient response to treatment and/or placement limitations, to ensure services are authorized at the appropriate care level so that services are not inappropriately denied.

9. The SIP-PL shall comply with State Medicaid guidance including Managed Care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review.

10. The SIP-PL shall utilize information acquired through quality management/utilization management activities to make annual recommendations to the State on the continuation or adoption of different practice guidelines and protocols, including measures of compliance, fidelity, and outcomes. The identification of evidence-based or promising practices shall consider cultural and developmental appropriateness. The SIP-PL shall comply with the MMC Model Contract in implementing practice guidelines.

11. In general, denials, grievances, and appeals of health and behavioral health services must be peer-to-peer. A peer is defined in Public Health Law Section 4900(2)(a)(i-iii). Further, the following standards shall apply to SIP-PL staff conducting utilization management reviews for the SIP-PL:
    a. A physician with five (5) years' experience serving the I/DD population must review all denials for services for an individual with I/DD and such determinations must take into consideration the needs of the family/caregiver.
    b. A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of twenty-one (21).
    c. A physician certified in addiction treatment must review all inpatient LOC/continuing stay denials for SUD treatment.

    Denials of Habilitative Services must be reviewed by a licensed professional who is also qualified as a QIDP. Information on QIDP qualifications can be found in 42 CFR 483.430.

3.9 Clinical Management

1. Over the next several years, the State will work with the Plan Associations and MMCPs to develop steps, including comprehensive reporting requirements to ensure that individuals with I/DD and their families have appropriate access to primary and specialty health care services, behavioral health services, and habilitative services, and receive high quality treatment and services by knowledgeable and informed providers including medical professionals, clinicians, and program staff to achieve integration in primary care and other settings. Key areas of consideration shall include:
    a. Compliance with Federal mandates for conducting and reporting I/DD Screening: The American Academy of Pediatrics Practice Guidelines and the Federal and State EPSDT schedules indicate routine developmental surveillance should be conducted during each well-child visit. Developmental surveillance and screening for specific disorders starting during infancy is critical to early identification and intervention with developmental disorders. Information should be obtained using standardized instruments, parental and professional observations, and clinical judgment. Concerns raised by developmental surveillance should result in screening or referral for diagnostic evaluation.
    b. Improve access to services to Promote Maternal and Child Health in order to identify disabilities earlier, especially for non-English speaking individuals: OPWDD serves individuals and families from many ethnic and cultural backgrounds, so it is critical to ensure that families have greater understanding of the importance of doctor/hospital visits and that individuals and families can communicate better about their disabilities.
    c. Promoting integration through activities such as:
        i. Reducing barriers to primary and specialty health care services among individuals with I/DD caused by social and economic disparities, geographic isolation, transportation challenges, limitations in communication skills, and cultural differences among others. Transportation, communication, and other problems commonly experienced by individuals with I/DD only increase the challenges faced by providers. Individuals with I/DD may need assistance in filling out medical forms, making medical care decisions, securing transportation to and from appointments, and finding a qualified medical professional with the training to work effectively with them.
        ii. Providing opportunities to promote healthy lifestyle practices and prevent diseases by increasing providers' knowledge regarding the distinctive needs of individuals with developmental disabilities. Individuals with I/DD have been found to experience more serious health problems than the general population including but not limited to seizures, diabetes, sensory problems (e.g., visual and auditory impairments), serious dental problems, cardiac problems, obesity and gastrointestinal problems. Some syndromes are associated with increased risk for physical problems. For example,

Down syndrome is associated with auditory impairment, cataracts, impaired cardiac functioning, early onset dementia symptoms, and thyroid disorders that can result in psychiatric symptoms. Physical illnesses can often be overlooked in individuals with I/DD due to difficulties in reporting symptoms. Individuals with severe communication difficulties may find it difficult to articulate their health needs, and, without adequate support and education, may not recognize ill health. Ensuring that providers are well-versed in understanding the challenges that individuals with I/DD may have with advocating for, and understanding, their medical/behavioral health care needs is critical to health promotion and disease prevention.

iii. Promoting wellness and prevention programs by assisting and providing individuals with resources that address topics which include but are not limited to exercise, nutrition or smoking cessation.
iv. Trauma Informed Care strategies and models
v. Monitoring the use of psychotropic and other medications with individuals with I/DD. This is critical as care for individuals with I/DD who have multiple conditions is often fragmented (e.g., different specialists may be managing seizures, a gastrointestinal disorder, and self-injurious behaviors), resulting in potential for adverse drug interactions or chronic drug toxicity which has a detrimental impact on overall health.
vi. Screening for Depression, dementia, and Substance Use Disorders

2. The SIP-PL shall develop their DD, physical and behavioral health integration requirements to include the following:
    a. The SIP-PL shall deliver orientation and ongoing training to educate its clinical, medical and program staff about co-occurring I/DD and medical disorders and/or behavioral health disorders and integrated clinical management principles. This staff training is critical as individuals with I/DD are at risk to receive fewer routine health examinations, immunizations, behavioral health assessments, prophylaxis and treatment, and have fewer opportunities for physical exercise. Providers may omit screening individuals with I/DD for dietary and nutritional status, exercise habits, oral diseases, substance use/abuse, and depression and other mental illnesses, cancer, abuse or neglect, domestic violence, or occupational hazards. Routine preventive services including periodic oral prophylaxis and restoration, cancer screening, immunizations, and early intervention in emerging psychiatric symptoms, may not be recommended or provided. Nutrition and weight control; exercise; oral health; family planning; safe sex; strategies for protection from rape, domestic violence, and sexual abuse; maintaining treatment regimens; avoiding medication errors; recognizing and seeking care for emerging disorders; and age-related changes in, and

risks to, health status and other educative and self-care skills may also be neglected as a focus of treatment.

b. The training objective is to strengthen the knowledge, skills, expertise, and coordination efforts within the respective outreach, utilization management, clinical management, pharmacy, and provider relations workforce. The SIP-PL shall develop and implement a training plan, which at a minimum shall incorporate the topics listed in Attachment D.
c. The SIP-PL shall provide initial and ongoing training for staff which must include education on commonly under-recognized health problems among individuals with I/DD such as:
    i. Gastrointestinal problems
    ii. Vision Concerns
    iii. Chronic/Recurrent Infections
    iv. Dental / Oral Care
    v. Respiratory Diseases
    vi. Musculoskeletal Conditions
    vii. Neurological Conditions
d. Preventive screening, such as:
    i. Oral Health Evaluations
    ii. Immunizations (Tuberculosis, Influenza, Pneumococcal, etc.)
    iii. Sensory Screening (vision, hearing)
    iv. Mobility Screening (gait, fall risk, bone density, etc.)
    v. Endocrine Screening
    vi. Obesity Screening
    vii. Neurologic Disorders Screening (seizure, tardive dyskinesia for those individuals on long term antipsychotic treatment)
    viii. Cancer Screening
    ix. Laboratory (liver function tests, complete blood counts, urinalysis, etc.)
    x. Medication Regimen Review
    xi. Mental and Behavioral Screening (depression, dementia, etc.)
e. The SIP-PL shall develop its business rules regarding screening, referral, and co-management of high risk individuals with I/DD and other medical and/or behavioral health conditions. The protocols shall be expanded to include processes to facilitate appropriate sharing of clinical information among providers, CCO/HHs, DDROs, and other involved agencies (i.e., LDSS, OMH and NYSDOH) as needed for coordinated care. Given their health care needs, individuals with I/DD often require a complex array of services from multiple providers. Business rules should address strategies to reduce fragmented and uncoordinated care and increase incentives, resources, or mechanisms for integrated care coordination.

3. The SIP-PL shall include the Medical Director in the pharmacological management and emerging technologies for individuals with I/DD.

4. The SIP-PL shall develop and implement a defined pharmacy management program for drug classification to include the following areas for individuals with I/DD:
    a. Specialized pharmacy management policies for I/DD providers, primary care providers, and other specialty provider types which include, but are not limited to:
        i. Drug use evaluation;
        ii. Drug therapy guidelines;
        iii. Drug utilization review;
        iv. Diagnosis-related drug use evaluation
        v. Polypharmacy
        vi. Metabolic and cardiovascular side effects of psychotropic medications for children and adults with I/DD.
    b. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost stratified by age and diagnoses.
    c. Monitoring of pharmacological classes of medications with emphasis on psychotropic, anti-infective, anticonvulsants, and opioid pharmaceuticals.
    d. Protocols to monitor the use of psychotropic medications with individuals meeting any of the following criteria:
        i. Individuals with I/DD under the age of six (6) taking any psychotropic medications;
        ii. Individuals with I/DD who are on more than one (1) medication from the same class (antidepressants, antipsychotics, attention-deficit/hyperactivity disorder medications, anxiolytics/hypnotics, mood stabilizers); or
        iii. Individuals with I/DD who are on three (3) or more psychotropic medications
    e. Therapeutic equivalents for medications requiring prior authorization or formulary exceptions.

5. The SIP-PL shall develop clear guidance to promote physical and behavioral health integration for individuals with I/DD. Considerations include:
    a. Provider access to rapid consultation from psychiatrists who are knowledgeable about treating individuals with I/DD and co-morbid behavioral health conditions;
    b. Provider access to education and training; and
    c. Provider access to referral and linkage support for child, adolescent, and adult at-risk patients.

6. The SIP-PL must meet the following additional requirements for individuals with I/DD accessing HCBS:
    a. The SIP-PL shall provide Care Management through CCO/HHs and, at the discretion of the State, other New York State-designated entities.

b. The SIP-PL shall ensure that the CCO/HH or other assigned Care Manager shall assist the individual with accessing benefits, provide the individual and family/caregiver with education and coaching to facilitate adherence to recommended treatment, develop Life Plans in accordance with applicable State and Federal regulations and guidance, and monitor individual outcomes.
c. The SIP-PL and CCO/HHs will collaborate on information sharing and care management for high need enrollees. Nothing in this requirement shall be construed to limit, in any way, the individual's right to refuse treatment.
d. When an individual is institutionalized or otherwise in a non-HCBS setting, the individual may not receive HCBS. However, the SIP-PL shall coordinate with the CCO/HH on the discharge plan, including assessing HCBS eligibility for post discharge services and supports in the community.
e. The SIP-PL shall track and promote the use of State-selected and nationally recognized clinical practice guidelines for individuals with I/DD, examples of which are listed below. The SIP-PL shall define expectations for provider utilization of evidence-based practices where appropriate and provide or enable continuing education activities to promote integration of these practices. The State will provide additional guidelines pertaining to Evidence Based Practices (EBPs).
    i. Clinical Practice Guidelines for Children with I/DD
    ii. Guidelines on Management of Dental Patients with Special Health Care Needs
    iii. Positive Behavior Intervention and Supports
    iv. Comprehensive Behavioral Treatment for Young Children
    v. Antecedent-based Interventions (ABI) with Functional Behavioral Assessment (FBA)
    vi. Behavioral Interventions/ Applied Behavior Analysis (including Differential Reinforcement, Extinction, Functional Communication Training, Reinforcement, Task Analysis and Chaining and Response Interruption/Redirection)
    vii. Cognitive Behavioral Therapy
    viii. Dialectical Behavior Therapy
    ix. Functional Communication Training
    x. Story-based Intervention
    xi. Parent Training / Parent Implemented Interventions
    xii. Peer Training Package / Peer Mediated Interventions
    xiii. Social Skills Package
    xiv. Trauma Informed Care
    xv. Good Lives Model (for use with Sex Offenders with Intellectual Disability)

3.10 Cross System Collaboration

1. SIPs-PL shall meet with NYSDOH and OPWDD on I/DD and Managed Care issues at a frequency determined by the State. At the State's discretion, the DDRO, and/or LDSS' may be involved in meetings that address services. SIPs-PL shall participate in meetings with the State on specific issues as determined by the State, including but not limited to issues related to individuals with I/DD or other identified special populations.
2. SIPs-PL shall meet quarterly with the DDRO in their respective regions. The DDRO will work closely with the State agencies to inform I/DD and Managed Care policy in the region and problem solve regional service delivery challenges.

3.11 Quality Management

1. SIPs-PL shall include in its quality management program the ability to address specific monitoring requirements related to the populations, benefits and services covered in this document. As defined in the MMC Model Contract, these requirements include but are not limited to the following:
    a. SIPs-PL must make a Primary Care Provider (PCP) available to all SIP-PL enrollees.
    b. SIPs-PL must have appropriate measures in place to ensure the confidentiality of all SIP-PL enrollees.
2. The Quality Management committee must include I/DD Quality Management sub-committee functions to meet the quality requirements and standards for the populations, benefits and services for individuals with I/DD as described in this document:
    a. SIPs-PL shall maintain an active I/DD Quality Management sub-committee which must include, in an advisory capacity, individuals, family members/caregivers, and peer support specialists, and DD service providers. The Quality Management sub-committee shall be responsible for carrying out the planned quality activities under the standards within this document related to individuals with I/DD who access I/DD and/or HCBS. The Quality Management sub-committee shall be accountable to and report regularly to the governing board or its designee concerning quality management activities. The SIP-PL Quality Management director shall lead the Quality Management sub-committee and maintain records documenting attendance by sub-committee members, as well as committee's findings, recommendations, and actions.
    b. The committee's responsibilities must also include a monitoring system to evaluate quality, efficiency, and effectiveness of CCO/HHs in providing timely comprehensive high quality person-centered Health Home services.
    c. SIPs-PL may utilize existing Quality Management committee and Quality Management sub-committee structures to meet these requirements, provided that:
        i. The Quality Management committee activities (focused discussions, tracking, trending, analysis and follow-up) related physical health services for individuals with I/DD services must

be documented as a separate item in the Quality Management committee agenda and in the Quality Management committee minutes.

ii. The I/DD Quality Management sub-committee activities (focused discussions, tracking, trending, analysis and follow-up) related to I/DD and/or HCBS individuals with I/DD must be documented as separate items in the Quality Management committee agenda and in the Quality Management committee minutes.

3. SIPs-PL shall provide for Utilization Management committee and Utilization Management sub-committee functions to meet the utilization management requirements and standards for the populations, benefits and services for individuals with I/DD described in this document. The committees must be chaired by the I/DD and/or Behavioral Health Medical Directors and are charged with implementing processes to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements defined in this document. The Medical Director(s) with I/DD knowledge and experience must participate on the I/DD Utilization Management subcommittee.
    a. The Utilization Management committee looking at physical health services must include examination of service utilization and outcomes for individuals with I/DD. The Utilization Management committee shall review and analyze data and other metrics as determined by the State.
    b. The I/DD Utilization Management subcommittee shall review and analyze data in the following areas, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings.
        i. Under and over utilization of I/DD services and cost data;
        ii. Admission and readmission rates, trends, and the average length of stay for all inpatient classified LOC;
        iii. Emergency Department (ED) utilization and crisis services use;
        iv. DD prior authorization/denial and notices of action;
        v. Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization; and
        vi. Other metrics determined by the State
    c. For individuals with I/DD eligible for HCBS, the utilization management subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:
        i. Prior authorization/denial and notices of action;
        ii. HCBS utilization;
        iii. HCBS quality assurance performance measures as determined by the State and pending CMS requirements; and
        iv. Enrollment in CCO/HH

4. SIPs-PL shall ensure intervention strategies have measurable outcomes and are recorded in the utilization management/clinical management committee meeting minutes. Analyses shall be conducted separately for individuals with I/DD.

5. SIPs-PL must include in the quality management program a method for monitoring on a provider level, that policies and expectations as outlined in Section 3.5 and 3.6 are being met.

6. VBP is a strategy used by New York State's Medicaid program and other payers to incentivize quality outcomes and a higher performing system of services and health care. SIPs-PL must be actively working toward helping the State in the VBP trajectory. The foundation of the State's Quality Strategy is centered around the following goals for individuals receiving services:
    a. Improving the health outcomes for individuals with I/DD
    b. Reducing the number of individuals with I/DD being referred and diverted to institutional levels of care when they can be supported in the community (consistent with supporting living in the most integrated setting)
    c. Improving the coordination of care for individuals with I/DD
    d. Increasing access to available services
        i. SIPs-PL must have a process in place to facilitate individual choice, improve coordination of services, and emphasize health and wellness through a process that is conflict free.
        ii. The process must incentivize both quality outcomes and a higher performing system of services and health care.
        iii. The SIP-PL process must have data collection capabilities that focus/report on outcomes.

3.12 Reporting and Performance Measurement

1. The SIP-PL shall continue to submit standard reports to the State as specified in the Quality Assurance Reporting Requirements (QARR) within the timeframes provided by the MMC Model Contract. Performance measures shall be audited as per the MMC Model Contract.
2. The SIP-PL will be required to conduct an annual internal performance improvement project (PIP) on a topic affecting the populations covered in this document that reflects CMS requirements for a PIP.
3. The SIP-PL will separately track, trend, and report complaints, grievances, appeals, and denials related to the populations and services covered in this document.
4. The SIP-PL will separately track critical incident reporting related to the populations and services covered in this document.
5. The SIP-PL shall report to the State any deficiencies in performance and corrective action taken with respect to NYSDOH and OPWDD licensed, approved, certified or designated providers. This includes notification to the NYSDOH and OPWDD when a provider agency is removed from the SIP-PL network due to quality of care concerns, and the specific quality concerns and corrective action measures taken leading to dismissal.
6. The SIP-PL shall participate in consumer perception surveys for the populations covered under this document as specified by the State.
7. The SIP-PL shall comply with the Federal HCBS QARR for individuals with I/DD receiving HCBS as defined in Attachment B.

8. The SIP-PL must report on required outcome measures, as specified by the State.
9. The SIP-PL must analyze and utilize the aggregated results of CQL interviews for continuous quality improvement purposes in the SIP-PL quality assurance and improvement program and across the SIP-PL network, reporting to OPWDD annually.
    a. The SIP-PL is required to use CQL certified interviewers to conduct CQL interviews using the CQL interview methodology based upon the 21 CQL outcome measures on a representative sample of enrolled individuals annually.
        i. The SIP-PL may contract with other entities approved by OPWDD to obtain CQL certified interviewers or may obtain certification for its own staff or network provider staff. In the latter case, the SIP-PL must ensure that certification is retained and that there is an adequate number of certified interviewers to conduct the required certified interviews at least annually.
        ii. The SIP-PL will adhere to OPWDD CQL Practice Guidelines for SIPs-PL to be published on OPWDD's website including the sampling parameters.

3.13 Claims Processing

1. The SIP-PL shall have an automated claim and encounter processing system that will support the standards and requirements within this document to ensure the accurate and timely processing of claims and encounters and allow the SIP-PL to verify services provided. The SIP-PL shall offer providers an electronic payment option including a web-based claim submission system for providers to directly data enter claims to the SIP-PL.
2. The SIP-PL shall support both hardcopy and electronic submission of claims and encounters for all claim types. The SIP-PL must be able to submit electronic 835s and hardcopy explanation of provider remittance advice in the format requested by the provider.
3. The SIP-PL must support hardcopy and electronic submission of claim inquiry forms, and adjust claims and encounters in the provider preferred format (electronic or hardcopy) to process claims.
4. The SIP-PL shall have a claims processing system that supports all individuals and covered services and use all State coding guidelines.
5. The SIP-PL shall have the capability to track and pay CCO/HHs to administer Care Management for individuals with I/DD enrolled in CCO/HHs.

3.14 Information Systems and Website Capabilities

1. The SIP-PL shall have information systems that enable the paperless submission and processing of notification, prior authorization and other utilization management related requests. The paperless submission must include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic 278 authorization format and a web-based authorization submission system for providers to directly data enter authorizations to the

SIP-PL and review status. These systems shall also provide status information on the processing of said requests.

2. The SIP-PL shall maintain content on a website that meets the following minimum requirements:
    a. Secure access to provider and member portals
    b. Web-based training
    c. Standard reporting
    d. Data access as needed for the effective management and evaluation of the performance of the SIP-PL
    e. The SIP-PL shall organize the website to allow for easy access of information by individuals with I/DD, family members/caregivers, network providers, stakeholders, and the general public in compliance with the ADA. The SIP-PL shall include on its website, at a minimum, the following information or links:
        i. Detailed process to obtain crisis intervention services, crisis contact information with toll-free crisis telephone numbers
        ii. How to identify and access services, including DD, physical health, behavioral health, and HCBS services by specific program/service types.
        iii. Telecommunications device for the deaf/text telephone numbers
        iv. Information on the right to choose a qualified DD, physical health, behavioral health, or HCBS service provider. This should include descriptions of the I/DD HCBS and the process to apply for and access these services.
        v. A Provider Directory that includes DD, physical health, behavioral health, and HCBS provider names, locations, telephone numbers, service types, non-English languages spoken for current network providers in the individual's service area, providers that are NOT accepting new patients and, at a minimum, information on specialists and hospitals. All provider information must be available online to the public and to the SIP-PL staff by February 1, 2019. The online directory must be searchable by specific service/program types and populations served (e.g., dentists experienced in serving individuals with I/DD).
        vi. The SIP-PL Member Handbook and Provider Manual.
        vii. Information regarding community forums, volunteer activities, and workgroups/ committees that provide involvement opportunities for individual's receiving services, family members/caregivers, providers, and stakeholders.
        viii. Information regarding advocacy organizations, including how individuals and other family members/caregivers may access advocacy services.
        ix. Hyperlinks to the NYSDOH and OPWDD websites and other websites determined by the State.

x. Opportunities, including surveys, for individuals with I/DD in receipt of I/DD and/or HCBS benefits, family members/caregivers, network providers and other stakeholders to provide satisfaction/complaint feedback.
xi. Information on processes for filing grievances, prior authorization requests, service denial appeals and reporting incidents.
xii. Other documents as required by NYSDOH and/or OPWDD.

f. The SIP-PL shall develop a plan to implement information systems that support data-driven approaches to monitor compliance with requirements in this document, including network adequacy, and DD-specific reporting requirements. This includes but is not limited to the following:
    i. Functionality to produce required and/or ad hoc reports by population, age group and/or system affiliation (i.e., LCED, DD eligibility).
g. The SIP-PL shall have information systems that collect data elements for reporting on HCBS assurances and sub assurances, such as assessment elements, Life Plan elements, and amount, duration, and scope of services authorized and reimbursed.
h. The SIP-PL information systems shall include functionality for all required HCBS reporting including DD/LCED designation, Life Plan, qualified provider, health and welfare, and fiscal accountability monitoring for individuals with I/DD receiving HCBS including:
    i. The SIP-PL information systems must have the analytical capability to: calculate performance indicators; detect data redundancy; measure data quality; and document compliance with State and Federal regulations.
    ii. The SIP-PL information systems must be flexible enough to accommodate the requirements as stated in the State's CMS Special Terms and Conditions and accommodate changes that are identified through the quality improvement process.
    iii. The SIP-PL information systems must, at a minimum, have the capability to access and store assessment data and electronic versions of the Life Plan to serve as notification or authorization for any HCBS in the SIPs-PL claims management system.
    iv. The SIP-PL information systems must have the ability to create reports on any data and have a timely completion indicator, etc. for quality of care monitoring related to HCBS quality assurance measures.
i. The SIP-PL management information systems must have a mechanism to provide to oversight entities (State agencies) swift access to view individuals' electronic records, Life Plans, documentation of services and supporting documents.

3.15 Financial Management

1. The SIP-PL shall submit fiscal reporting for I/DD and I/DD HCBS, including medical and administrative expenditures in a format defined by the State.
2. Capitation payments made to the SIP-PL for I/DD services for individuals with I/DD and who are in receipt of Medicaid will be monitored by the State and compared to the I/DD expenditure target. SIPs-PL that fail to perform up to the requirements in this document may be subject to statements of deficiency and/or funding recoupments.
3. SIPs-PL and providers wishing to negotiate alternative payment methodologies to the provider following implementation may do so pending State approval and subject to compliance with State and Federal law.

3.16 Reserve Requirements for SIPs-PL

Reserve requirements for MCOs are intended to support the objectives of: (1) providing protection to enrollees against MCO insolvency for the potential loss of coverage and service disruption; (2) providing protection to providers of health services who may not be paid if an MCO becomes insolvent; and (3) and promoting MCO solvency against unanticipated fluctuations in cost.

The general fiscal solvency and reserve requirements for MCOs in New York State require MCOs to demonstrate that they meet both statutory reserve requirements and maintain minimum net worth. Based on the MCOs projected enrollment for an upcoming year, a review is completed to ensure that both revenue and expense projections, as well as actual and projected balance sheets, show the MCO has the capital to meet the reserve and escrow deposit requirements.

For start-up MCOs, there must be a minimum of three (3) to four (4) years of projections and initial capital must be sufficient to maintain statutory reserves, as well as funding for working capital until the MCO becomes self-sustaining. In addition to reserves, risk may also be mitigated by the use of risk corridors and stop/loss arrangements. As part of the statutory reserves, New York also requires that MCOs provide a cash escrow deposit.

The enabling statute for specialized Managed Care for the I/DD population[4] does not specify reserve requirements. The Commissioners of NYSDOH and OPWDD have established the following reserve requirements for SIPs-PL:

1. New York State Contingent Reserve requirements for services other than OPWDD services or health care should be set at 5% of net premium revenue consistent with the standard for MLTC;
2. New York State Escrow fund requirements for OPWDD services should be set initially at 3% of estimated expenditures, and possibly increased to 4% then 5% over three years;

[4] Public Health Law § 4403-g.

3. HCBS residential and non-residential services and ICF/IID will not be subject to contingent reserve requirements until these services are at risk;
4. The cost of residential services (HCBS and ICF/IID) will not be included in the calculation of contingent reserve requirements and escrow fund due to OPWDD's control on certifying and authorizing these residential services through the OPWDD DDROs, including the number, types and distribution of approved services; and
5. Escrow fund and contingent reserve requirements for the health care benefit portion of the SIP-PL (estimated at 15% of total Medicaid costs for individuals with I/DD) should be set at the same percent required of MMC, as the risk related to health care services is similar across service sectors.

Attachment A: OPWDD Level of Care (LOC) Requirements for HCBS Waiver

The OPWDD level of care instrument for the HCBS Waiver is identical to the level of care instrument used for ICF/DD. The same instrument is used for both initial evaluations and re-evaluations. A paper copy of the level of care instrument has been submitted in previous renewals and is available from OPWDD for CMS' review upon request. The level of care instrument and instructions are available on the OPWDD website at the following location: http://www.opwdd.ny.gov/opwdd_resources/opwdd_forms/home. The level of care instrument does not limit participation by individuals with certain conditions or diagnoses.

The criteria appearing in the level of care instrument are:

1. Evidence of a developmental disability,
2. Disability manifested before age twenty-two (22),
3. Evidence of a severe behavior problem (not required),
4. Health care need (not required),
5. Adaptive behavior deficit in one or more of the following areas: communication, learning, mobility, independent living or self-direction.

The applicant must have functional limitations that demonstrate a substantial handicap. For most applicants over the age of eight (8), the substantial handicap must be determined using a nationally normed and validated, comprehensive measure of adaptive behavior, administered by a qualified professional. For applicants over the age of eight (8) who have an IQ of sixty (60) or lower, the presence of a substantial handicap may be assessed and confirmed through clinical observation or interview rather than standardized testing.

For children (birth through eight (8)) with a developmental delay, but no specific diagnosis, provisional eligibility may be confirmed based on clinical judgement by use of criteria based on 20 CFR, Appendix 1 to Subpart P of Part 404 regarding SSI eligibility, and determination of functional limitations in motor development, cognition and communication or social function. Consistent with Section 200.1 (mm)(1) of New York State Education Department regulations, substantial handicap associated with delay can be documented by the results of an evaluation that indicates:

1. A twelve (12) month delay in one or more functional areas; or
2. A 33% delay in one (1) functional area, or a 25% delay in each of two (2) functional areas; or
3. If appropriate, standardized instruments are administered yielding a score of 2.0 deviations below mean in one functional area or a score of 1.5 standard deviations below the mean in each of two functional areas. Additional information on this process is contained within OPWDD policy guidance. Any future changes to these processes and requirements will be contained within OPWDD policy guidance.

Attachment B: CMS Standard Reporting and Monitoring Requirements

The home and community-based assurances and sub-assurances on the following pages are representative of CMS requirements for managed long-term services and supports. The metrics and formulas are typical for programs such as this program and are required by CMS and its quality management contractor for demonstrating compliance with these assurances and sub-assurances. The State will negotiate the metrics and calculation of those metrics with CMS and work with the SIPs-PL to streamline all requirements associated with these quality assurance requirements. The role of the State versus the Plan in reporting and monitoring has not been finalized.

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
1	Level of care (LOC): The processes and instruments described in the approved 1915(c) Waiver	An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future	The number and percent of individuals that met LOC requirements prior to receiving OPWDD HCBS Services	Data source: LOC approvals Data collection responsible party: MCO Frequency of data collection: continuously and ongoing Sampling: 100% review Data aggregation responsible party: MCO, NYSDOH and OPWDD Frequency of data aggregation and analysis: monthly
		The processes and instruments described in the approved Waiver are applied appropriately and according to the approved description to determine participant LOC.	The percent of initial LOC forms/instruments completed as required in approved demonstration. The percent of LOC determinations made by a qualified evaluator.	Data source: record reviews, on-site or utilization review Data collection responsible party: MCO Frequency of data collection: continuously and on-going Sampling: representative sample, 95% confidence interval (CI)

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
2	Participant safeguards/health and welfare: The State identifies addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints	The State demonstrates on an ongoing basis that it identifies addresses and seeks to prevent incidents of abuse, neglect, exploitation, and unexplained death	Percent of grievances filed by participants that were resolved within fourteen (14) calendar days according to approved Waiver guidelines	Data source: record reviews, on-site Data collection responsible party: MCO Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: NYSDOH and OPWDD Frequency of data aggregation and analysis: monthly
			Percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults	Data source: record reviews, on-site Data collection responsible party: MCO Frequency of data collection: continuously and ongoing Sampling: representative sample, 95% CI Data aggregation responsible party: MCO, NYSDOH and OPWDD Frequency of data aggregation and analysis: continuously and ongoing

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
			Percent of reports related to abuse, neglect and exploitation of participants where an investigation was initiated within the established timeframe Number and percent of substantiated cases of abuse, neglect and exploitation where recommended actions to protect health and welfare were implemented	Data source: Incident Report and Management Application (IRMA) Data collection responsible party: OPWDD Frequency of data collection: ongoing Sampling: 100% review Data aggregation responsible party: OPWDD Frequency of data aggregation and analysis: monthly
		The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible	Number and percent of participant critical incidents that were reported, initiated, reviewed and completed within required timeframes as specified in the approved Waiver	Data source: IRMA Data collection responsible party: OPWDD Frequency of data collection: ongoing Sampling: 100% review Data aggregation responsible party: MCO and OPWDD Frequency of data aggregation and analysis: monthly

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
		The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	Data source: R/A Database Data collection responsible party: OPWDD Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: OPWDD Frequency of data aggregation and analysis: ongoing
		The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved Waiver	Number and percent of HCBS participants who received physical exams consistent with State policy	Data source: MCO encounter data database Data collection responsible party: MCO Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: MCO Frequency of data aggregation and analysis: monthly

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
3	The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for Waiver participants	Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means	Percent of participants reviewed with a plan of care that was adequate and appropriate to their needs and goals (including health goals) as indicated in assessment(s) Percent of participants reviewed with a POC that had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s). Percent of participants reviewed with a POC that addressed the participant's goals/needs as indicated in the assessment(s)	Data source: record reviews, onsite or through utilization review unit Data collection responsible party: MCO and OPWDD Frequency of data collection: continuously and ongoing Sampling: representative sample, 95% CI Data aggregation responsible party: MCO, NYSODH and OPWDD Frequency of data aggregation and analysis: monthly

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
		Service plans are updated/revised at least annually or when warranted by changes in participant's needs	Percent of participants whose POC was updated within 365 days of the last evaluation Percent of participants whose POC was updated as warranted by changes in the participant's needs	Data source: MCO, CCO/HH database Data collection responsible party: MCO and CCO/HH Frequency of data collection: ongoing Sampling: 100% review Data aggregation responsible party: MCO and CCO/HH Frequency of data aggregation and analysis: quarterly
		Services are delivered in accordance with the service Plan, including the type, scope, amount, duration, and frequency specified in the service plan	Percent of new participants receiving services according to their POC within forty-five (45) days of approval of their POC Percent of participants who received services in the type, number, duration, and frequency specified in the POC	Data source: Life Plan, record reviews, financial records Data collection responsible party: MCO Frequency of data collection: quarterly Sampling: representative sample, 95% CI Data aggregation responsible party: MCO Frequency of data aggregation and analysis: semi-annually

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
		Participants are afforded choice between/among Waiver services and providers	Percent of participant records reviewed with a completed, signed freedom of choice form that specifies choice was offered among Waiver services and providers Percent of participants reviewed with a POC that includes the participant's and/or guardian/caregiver's signature as consistent with State and Federal guidelines	Data source: record reviews, on-site Data collection responsible party: MCO Frequency of data collection: continuously and ongoing Sampling: representative sample, 95% CI Data aggregation responsible party: MCO and NYSDOH Frequency of data aggregation and analysis: semi-annually
4		The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing Waiver services	Percent of Waiver providers providing waiver services that meet licensure and certification requirements prior to furnishing waiver services – initially Percent of Waiver providers providing Waiver services that meet licensure and certification requirements prior to furnishing Waiver services – continuously Percent of Waiver providers providing Waiver services that	Data source: MCO credentialing files Data collection responsible party: MCO Frequency of data collection: continuously and ongoing Sampling: 100% review Data aggregation responsible party: MCO Frequency of data aggregation and analysis: quarterly Note: The SIP-PL must be able to stratify the data by licensed,

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
			have an active agreement with the MCO	certified, and atypical in order to pinpoint deficiencies in MCO credentialing
		The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements	Percent of providers of waiver services that meet training requirements — non-licensed/noncertified provider, training requirements	Data source: training verification records Data collection responsible party: MCO Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: NYSDOH and OPWDD Frequency of data aggregation and analysis: quarterly Note: New York may combine PMs in this sub- assurance and the next sub- assurance. However, the SIP-PL must be able to stratify the data by licensed, certified and atypical in order to pinpoint deficiencies in MCO training.

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
		The State implements its P&Ps for verifying that provider training is conducted in accordance with State requirements and the approved Waiver	Percent of providers of Waiver services that meet training requirements — all providers, ongoing training requirements	Data source: training verification records Data collection responsible party: MCO Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: NYSDOH and OPWDD Frequency of data aggregation and analysis: quarterly
			Number of provider trainings operated by the MCO	Data source: training verification records Data collection responsible party: MCO Frequency of data collection: quarterly Sampling: 100% review Data aggregation responsible party: NYSDOH Frequency of data aggregation and analysis: quarterly

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
5	Administration and operation: The State Medicaid Agency (SMA) retains ultimate authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by contracted entities	Number and/or percent of aggregated performance measure reports generated by the MCO and reviewed by the NYSDOH that contain discovery, remediation, and system improvement for ongoing compliance of the assurances	Number and/or percent of MCO administrative and quality assurance reports approved by NYSDOH prior to implementation by the MCO	Data source: reports to NYSDOH on delegated administrative functions Data collection responsible party: MCO Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible party: MCO Frequency of data aggregation and analysis: monthly
6	Financial accountability: The NYSDOH maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i)-like participants by qualified providers The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the Waiver program	The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Waiver and only for services rendered	Percent of providers that have payment recouped for Waiver services without supporting documentation	Data source: routine Medicaid claims verification audits Data collection responsible party: MCO and OPWDD Frequency of data collection: continuously and ongoing Sampling: 90% CI Data aggregation responsible party: MCO Frequency of data aggregation and analysis: continuously and ongoing

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other States	Formula – based on CMS requirements approved in other States
			Percent of claims verified through the MCO's compliance audit to have paid in accordance with the participant's Waiver treatment plan	Data source: MCOs compliance report Data collection responsible party: MCO Frequency of data collection: quarterly, continuously and ongoing Sampling: 95% CI Data aggregation responsible party: MCO and NYSDOH Frequency of data aggregation and analysis: quarterly
		The State provides evidence that rates remain consistent with the approved rate methodology throughout the five (5) year Waiver cycle	The State pays the MCO actuarially sound rates	N/A to MCO reporting

Attachment C: Plan Staffing Requirements for SIPs-PL

Position/ Title	NYS Location Required (Yes/No)	SIPs-PL Requirements
Medical Director	Yes	• NYS license as a physician • Minimum of five (5) years of experience working with individuals with I/DD in Managed Care or clinical settings (at least two (2) years must be in a clinical setting) • Board certified • If the Plan's Medical Director does NOT have the stated knowledge and experience in the I/DD population and services, the SIP-PL must also identify an additional Medical Director who meets the I/DD experience requirements. Allocation for this additional position, if necessary, must be at a minimum of .5 FTE. SIPs-PL may submit a request to waive the minimum allocation of time with appropriate documentation for the State's review and approval.
I/DD Clinical Director	Yes	• NYS license as a clinical professional in a Behavioral Health field • Minimum of seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) and at least five (5) years working with individuals with I/DD in a clinical setting. • Knowledge of NYS systems serving individuals with I/DD required. • For SIPs-PL with more than 20,000 enrollees, the percent of effort must be full-time. For SIPs-PL with less than 20,000, the percent of effort may be less than full-time.
I/DD Dental Coordinator	No	• Licensed to practice dentistry in New York State • Minimum of five (5) years of experience providing dental services to individuals with I/DD. • May be filled on a consultant or part time basis.
Behavioral Health Medical Director ***(for SIPs-PL whose enrollment exceeds 10,000 enrollees)***	Yes	• NYS license as a physician • Minimum of five (5) years of experience working in Managed Care or clinical settings (at least two (2) years must be in a clinical setting) • Appropriate training and expertise in general psychiatry and addiction disorders (e.g., board certification in general psychiatry and certification in addiction medicine or certification in the subspecialty of addiction psychiatry).

Position/ Title	NYS Location Required (Yes/No)	SIPs-PL Requirements
Behavioral Health Clinical Director **(for SIPs-PL whose non-DD enrollment is less than 10,000 enrollees)**	Yes	• NYS license as a Behavioral Health Professional (BHP) • Minimum of seven (7) years of experience in a Behavioral Health Managed Care or Behavioral Health clinical setting, including at least two (2) years of Managed Care (preferably MMC) experience. • And, five (5) years working with individuals with I/DD providing clinical services.
Managerial Staff		
CCO/HH SIP-PL Liaison	Yes	• Experience, expertise and knowledge of the unique and complex needs of the I/DD population. • Knowledge of State and local systems serving individuals with I/DD, health homes, and specialty providers responsible for addressing the healthcare needs of serving individuals with I/DD, including the medically needy Level of Care (LOC) population.
I/DD Care Management Director	Yes	• Nurse Practitioner • I/DD Managed Care or I/DD clinical experience • Experience working with Health Homes recommended. • Experience working with community and family-based services and experience in working across I/DD serving systems recommended. • Knowledge of systems serving individuals with I/DD needs.
I/DD Utilization Management Director	No	• Non-Physician Licensed Behavioral Health Professional (NP-LBHP) • I/DD Managed Care or I/DD clinical experience • Experience working with community and family-based services recommended. • Knowledge of systems serving individuals with I/DD needs.
Member Services Director	No	• Experience in Managed Care or clinical setting. • Experience managing member service call center operations. • Knowledge of the provider system serving individuals with I/DD needs, • Knowledge of the new benefits and program requirements for individuals with I/DD.
Network Development Director	Yes	• I/DD Managed Care or I/DD clinical experience • Demonstrated experience in I/DD network development. • Knowledge of and experience with principles of I/DD integration. • Knowledge of family-centered, individual guided principles and development of Evidenced Base Practices. • Knowledge of service needs of individuals with I/DD

Position/ Title	NYS Location Required (Yes/No)	SIPs-PL Requirements
Provider Relations Director	Yes	• Experience in I/DD Managed Care or I/DD clinical setting. • Experience managing I/DD provider issues including resolving grievances, coordinating site visits, and maintaining quality of care. • Knowledge of the provider system serving individuals with I/DD needs.
Training Director	Yes	• Significant experience and expertise in developing, tracking, and executing I/DD training to the SIPs-PL own and network provider's staff. • Significant experience and expertise in developing training programs related to I/DD systems for individuals and families.
Quality Management Director	No	• Experience and expertise in quality improvement for developmental disability services programs, ideally in publicly-operated or publicly funded programs. • Experience with Managed Care delivery systems. • Familiarity with habilitation-oriented services. • Familiarity with family-centered, individual guided service delivery for children and families. • Knowledge of appropriate performance measures (including HEDIS and QARR) for individuals with I/DD.
Information Systems Director	No	• I/DD Experience and expertise in Medicaid data analytics and I/DD data systems. • Knowledge of all federal and state laws governing the confidentiality and security of protected health information, including confidential mental health information.
Governmental/Community Liaison Director	Yes	• Must be individual with significant plan leadership responsibilities. • The SIP-PL must designate representative(s) to attend relevant stakeholder, planning, and advocacy meetings to ensure that the SIP-PL is aligned with the State's vision for Managed Care I/DD service delivery and is aware of any new State or local I/DD initiatives.
Operational Staff		
Utilization Management/Care Management	UM - No CM - Yes	• Nurse Practitioner-Licensed BHP (NP-LBHP) • CASACs (must also be NP-LBHPs) for SUD reviews. • Experience in managing care for individuals with I/DD, including individuals in high-risk groups, individuals with co-occurring DD and behavioral health needs, and who may be involved in multiple services systems (education, justice, medical, and welfare; or individuals with medical fragility/complex medical conditions

Position/ Title	NYS Location Required (Yes/No)	SIPs-PL Requirements
		requiring significant medical or technological health supports. • For utilization management, authorization decisions must be made by a NP-LBHP with minimum three years of experience treating individuals with I/DD in an I/DD setting. • Knowledge and experience in health and services for individuals with I/DD, HCBS, and social service programs.
Clinical Peer Reviewers	No	• Includes panel of reviewers to conduct denial and appeal reviews, peer review of psychological testing, or complex case review and other related consultations • Peer reviewers must include: • Physicians who are board certified and have five (5) years of experience serving the I/DD population; or • For Behavioral Health services, licensed Doctoral level psychologist with experience serving individuals with I/DD. • The credential of the licensed clinician denying the care must be at least equal to that of the recommending clinician, and reviewer should have clinical experience relevant to the denial.
Quality Management Specialists	No	• Experience and expertise in quality improvement for services and programs for individuals with I/DD, ideally in publicly-operated or publicly-funded programs. • Knowledge of family-centered, individual guided service delivery for individuals and families with I/DD needs. • Knowledge of appropriate performance measures (including HEDIS and QARR) for individuals with I/DD.
Provider Relations	Yes (some staff must be in NYS)	• Experience in I/DD Managed Care or I/DD clinical setting. • Experience managing I/DD provider issues including resolving grievances, coordinating site visits, and maintaining quality of care. • Knowledge of the provider system serving individuals with I/DD needs.

Attachment D: SIPs-PL Staff Training Requirements

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
New York State's vision, mission, goals, operating principles for the service and population expansion including I/DD services for individuals with I/DD	Required (R)	R	R
Understanding existing DD services, new SPA services and HCBS for individuals with I/DD	R	R	R
Cultural competence outlining the impact of culture, ethnicity, race, gender, sexual orientation, and social class within the service delivery process	R	R	R
HCBS eligibility requirements and protocols	R	R	R
HCBS operational requirements (e.g., needs assessment (CAS), Life Plans)	R	R	R
DD services/medical integration; co-occurring I/DD and medical disorders, and integrated CM principles	R	R	R
Medical Necessity Criteria and service authorization requirements for expanded benefits and HCBS	R	R	
Network access standards for new services and HCBS	R	R	R
New information systems, data collection tools (if applicable)	R		R
Reporting and monitoring requirements (e.g., critical incident reporting, HCBS assurances)	R	R	R
Complaints, grievance, appeals	R	R	R
After hours and crisis triage protocols	R	R	R
Linkage requirements (i.e., with OMH, OASAS, OCFS, LDSS, OPWDD, DDROs and other non-Medicaid agencies serving individuals with I/DD)	R	R	R
Network participation requirements (e.g., provider qualification validation)			R
Provider training and site visits			R

Training Topics to be completed 30 days prior to go-live	Clinical Staff	Member Services	Provider Relations
Provider profiling and performance management			R
Primary Care and I/DD service integration, including but not limited to appropriate screening and early identification tools for use in medical settings	R		R
The Health Home Model & Practice — Roles and Responsibilities	R	R	R
Understanding the interaction of systems serving individuals with I/DD, and navigating and coordinating systems of care	R	R	R
Trauma Informed Practices	R		
Importance of Families and understanding how to assist families/caregivers to access services	R	R	R
Family Psychoeducation	R	R	R

Care Management Staff:
Care Management units/staff must adhere to CCO/HH training and competencies standards as delineated in the *Training Guide for Care Managers* as per the skill building areas below.

Skills-Building Areas:
The CCO/HHs are required to deliver the following 10 skill-building areas to care managers as a process to ensure consistent and targeted CCO/HH Care Management. This learning is intended to result in outcome measures informed by the person-centered planning process.

1. Values Person-Centeredness and Communication
2. Builds Relationships and Establishes Communication within Care Coordination Team and Among Providers
3. Promotes Community Orientations
4. Culturally Competent
5. Knowledge of Developmental Disabilities, Chronic Diseases, and Social Determinants of Health
6. Knowledge of Community Supports and Services, New Models of Care, and Health Care Trends
7. Understand Ethics and Professional Boundaries
8. Promotes Quality Improvement
9. Understand Health Information Technology
10. Proficient in Documentation and Confidentiality

Attachment E: Network Development in Rural Counties

Initial Network Development in Rural Counties:

1. **Rural County Definition**
   For the purpose of network development, a rural county is defined as one with a population of fewer than 200,000 inhabitants.
   Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates are rural counties.

2. **Region Definition**
   For the purpose of determining the adequacy of the Contractor's network in rural counties and for Essential I/DD Providers, a region is defined as the catchment area beyond the border of a county, which includes the other counties of the State designated DDRO region.

Regional Office-Region 1	**Counties**
Finger Lakes DDRO 620 Westfall Rd., Suite 108 Rochester, NY 14620	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Western NY DDRO 1200 East and West Rd. West Seneca, NY 14224	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans
Regional Office-Region 2	**Counties**
Broome DDRO 229-231 State St., 1st Floor Binghamton, NY 13901	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
Central NY DDRO Eligibility Department 187 Northern Concourse North Syracuse, NY 13212	Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego
Sunmount DDRO 2445 State Route 30 Tupper Lake, NY 12986	Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence

Regional Office-Region 3	**Counties**
Capital District DDRO 500 Balltown Rd. Schenectady, NY 12304	Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Hudson Valley DDRO 9 Wilbur Rd. Thiells, NY 10984	Orange, Rockland, Sullivan, Westchester
Taconic DDRO 38 Firemens Way Poughkeepsie, NY 12603	Columbia, Dutchess, Greene, Putnam, Ulster
Regional Office-Region 4	**Counties**
Bernard Fineson DDRO PO Box 280507 Queens Village, NY 11428-0507	Queens
Metro NY DDRO/Bronx 2400 Halsey St. Bronx, NY 10461	Bronx
Brooklyn DDRO 888 Fountain Ave. Bldg. 1, 2nd Floor Brooklyn, NY 11239	Kings
Metro NY DDRO/Manhattan 25 Beaver St., 4th Floor New York, NY 10004	New York
Staten Island DDRO 1150 Forest Hill Rd. Bldg. 12, Suite A Staten Island, NY 10314-6316	Richmond
Regional Office-Region 5	**Counties**
Long Island DDRO 415-A Oser Ave. Hauppauge, NY 11788	Nassau, Suffolk

3. **Meeting Network Requirements in the Case of Insufficient County Providers**
   If the providers in the county are insufficient to meet network requirements, the SIP-PL must first contract with providers in neighboring counties to meet network requirements. If this is still insufficient, the SIPs-PL must then contract with providers within the DDRO region. Consistent with current NYSDOH approval processes, if the providers in the DDRO region are insufficient to meet the minimum network requirement for the service, or the demand in the service area, the SIP-PL must contract with providers in the next contiguous service area. For example, if a SIP-PL service area includes Rensselaer County, and the Capital District DDRO has an insufficient number of OTPs to meet the demand of the enrollees, then the SIP-PL must contract with providers from the Hudson Valley Region, Sunmount Region, or any combination of regions, to build a sufficient network.

4. **Reimbursement of Non-Participating Providers in the Case of Inadequate Network**
   SIPs-PL whose networks are inadequate, whether due to an insufficient number of contracts or an insufficient number of available appointments, will be required, upon enrollee request, to permit enrollees eligible for services to receive services at a non-participating provider and reimburse those providers at no less than the Medicaid Fee-For-Service rate. SIPs-PL are encouraged to utilize SCAs when necessary.

Attachment F: SIPs-PL Benefit Package/Covered Services

MEDICAL/ HEALTH SERVICES

Inpatient Hospital Services	Yes
Inpatient Stay Pending Alternate Level of Medical Care	Yes
Physician Services	Yes
Nurse Practitioner Services	Yes
Midwifery Services	Yes
Preventive Health Services	Yes
Second Medical/Surgical Opinion	Yes
Laboratory Services	Yes
Radiology Services	Yes
Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Yes
Smoking Cessation Products	Yes
Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))	Yes
EPSDT Services/Child Teen	Yes
Health Program (C/THP)	Yes
Emergency Services	Yes
Post-Stabilization Care Services	Yes
Foot Care Services	Yes
Eye Care and Low Vision Services	Yes
Dental and Orthodontic Services	Yes
Family Planning and Reproductive Health Services	Yes
Renal Dialysis	Yes
Experimental and/or Investigational Treatment	Yes
Observation Services	Yes
Medical Social Services	Yes
Tuberculosis Directly Observed Therapy	Yes
Therapy Services (OT/PT/Speech, Clinic, and Independent Practitioner)	Yes

LONG/SHORT TERM SUPPORT

Home Health Services	Yes
Private Duty Nursing Services	Yes
Hospice	Yes
Personal Care Services	Yes
Personal Emergency Response System (PERS)	Yes
Consumer Directed Personal Assistance Services	Yes
Home Delivered Meals	Yes, if not CFCO eligible
Live-In-Caregiver	Yes

TRANSPORTATION

Non-Emergency Transportation	FFS
Emergency Transportation	FFS

DME/ PRODUCTS/ SUPPLIES

Durable Medical Equipment (DME)	Yes
Audiology, Hearing Aids Services & Products	Yes
Prosthetic/Orthotic Services/Orthopedic Footwear	Yes

BEHAVIORAL HEALTH/SUD

Court-Ordered Services	Yes
LDSS Mandated SUD Services	Yes
Mental Health Services	Yes
SUD Inpatient Detoxification Services	Yes
SUD Inpatient Rehabilitation and Treatment Services	Yes
SUD Residential Addiction Treatment Services	Yes
SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Yes
SUD Medically	Yes
Supervised Outpatient withdrawal	Yes
Buprenorphine Prescribers	Yes
Crisis Intervention Services	Yes

LONG TERM RESIDENTIAL PLACEMENT

Residential Health Care Facility (Nursing Home) Services (RHCF)	Yes
Developmental Centers/ Small Residential Units	Excluded, disenrolled after 90 days of placement

CARE MANAGEMENT/SERVICE COORDINATION

Adult Health Home	No
Children's Health Home	No
CCO/HH Basic HCBS Plan Support, Replaces PCSS	Yes

DAY HEALTH PROGRAMS

Adult Day Health Care	Yes
AIDS Adult Day Health Care	Yes
OPWDD Day Treatment	Yes

OPWDD WAIVER SERVICES

OPWDD Fiscal Intermediary	Yes
Support Brokerage	Yes
Day Habilitation	Yes
Residential Habilitation	Yes-phased in approach
Pathway to Employment, Prevocational Services and Supported Employment	Yes
Family Education and Training	Yes
Individual Directed Goods and Services	Yes
Intensive Behavioral Services	Yes
Respite	Yes
Community Habilitation (CFCO eff. 1/1/19)	Yes, if not CFCO eligible
Adaptive Devices/Assistive Technology (CFCO eff. 1/1/19)	Yes, if not CFCO eligible
Environmental Modifications (CFCO eff. 1/1/19)	Covered under CFCO
Vehicle Modifications (CFCO eff. 1/1/19)	Covered under CFCO
Community Transition Services (CFCO eff. 1/1/19)	Yes, if not CFCO eligible
Live-in Caregiver	Yes

CFCO (effective 1/1/2019)

Community Habilitation	Yes
Adaptive Devices/ Assistive Technology	Yes
Environmental Modifications	Yes
Vehicle Modifications	Yes
Community Transitional Services	Yes
Non-Medical Transportation	FFS
Home Delivered/Congregate Meals	Yes
Personal Care	Yes, if CFCO eligible
Home Health Care Aide	Yes, if CFCO eligible
Consumer Directed Personal Assistance Services (CDPAS)	Yes, if CFCO eligible
Personal Emergency Response Systems (PERS)	Yes, if CFCO eligible
Moving Assistance	Yes, if CFCO eligible
Durable Medical Equipment/Medical Supplies	Yes, if CFCO eligible

CHILDREN'S HCBS WAIVER SERVICES effective 1/1/19 (Not CFCO)

Respite (Planned and Crisis)	See OPWDD Waiver service coverage
Prevocational Services	See OPWDD Waiver service coverage
Supported Employment	See OPWDD Waiver service coverage

Community and Self Advocacy Training and Support	See OPWDD Waiver service coverage
Palliative Care (Expressive Therapy, Pain and Symptom Management, Bereavement Services, and Massage Therapy)	Yes
Health Home Care Management	See CM service coverage
Non-Medical Transportation	FFS
Community Habilitation (CFCO effective 1/1/19)	See OPWDD Waiver service coverage
Day Habilitation	See OPWDD Waiver service coverage
Adaptive and Assistive Equipment (CFCO effective 1/1/19)	See OPWDD Waiver service coverage
Accessibility Modifications (CFCO effective 1/1/19)	See OPWDD Waiver service coverage
Caregiver/Family Supports and Services	Yes

STATE PLAN and DEMONSTRATION BENEFITS - UNDER 21 IN CHILDREN'S SYSTEM TRANSFORMATION **

Assertive Community Treatment (ACT)	Yes
Children's Crisis Intervention	See OPWDD Waiver service coverage
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	Yes
Continuing Day treatment (minimum age 18 for medical necessity for this adult oriented service)	See OPWDD Day Treatment service coverage
Community Psychiatric Support and Treatment (CPST)	Yes
Crisis Intervention Demonstration Service	Yes
Family Peer Support Services	Yes
Youth Peer Support and Training (YPST)	Yes
Psychosocial Rehabilitation Supports (PSR)	Yes
Licensed Behavioral Health Practitioner (LBHP) Service	Yes

Attachment G: OPWDD HCBS Service Definitions

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Habilitation	Individuals with I/DD meeting HCBS eligibility criteria	**Residential** Individually tailored supports that assist with the acquisition, retention or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living (hands-on), community inclusion and relationship building, training and support for independence in travel, transportation, adult educational supports, social skills, leisure skills, self-advocacy and informed choice skills, and appropriate behavior development that assists the participant to reside in the most integrated setting appropriate to his/her needs. **Day** Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, travel and adult education that regularly takes place in a non-residential setting, separate from the person's private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice. Day habilitation services may also be used to provide supportive retirement activities, including: altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior-related activities in their communities. **Community** Services occurring largely in community (non-certified) settings to facilitate and promote independence and community integration. Community habilitation is defined as a face-to-face service and therefore, in order for a service to be billed, the staff must be with the individual. Only those services not reimbursable under the CFCO State Medicaid plan will be reimbursable under the HCBS Waiver.

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Habilitation (continued)	Individuals with I/DD meeting HCBS eligibility criteria	**Prevocational (Site-Based and Community)** Services that provide learning and work experiences, including volunteering, where participants can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time based upon a person-centered planning process. **Supported Employment** Ongoing supports to participants who, because of their disabilities, need continuous support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the state minimum wage. The outcome of this service is paid employment at or above the state minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals; as such, career planning is also an allowable service activity. **Pathway to Employment** A person-centered, comprehensive career planning and support service that provides assistance for participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service that engages a participant in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above the state minimum wage. Within 12 months, the outcome of this service is documentation of the participant's stated career objective; a detailed career plan used to guide individual employment supports; and preparation for supported employment services that assist a participant in obtaining, maintaining or advancing in competitive employment or self-employment.

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Respite	Individuals with I/DD meeting HCBS eligibility criteria	Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences.
Assistive Technology – Adaptive Devices (CFCO)	Individuals with I/DD meeting HCBS eligibility criteria	An item, piece of equipment or product system; whether acquired commercially, modified or customized; that is used to increase, maintain or improve functional capabilities of participants. These services directly assist a participant in the selection, acquisition or use of an assistive technology device. The devices and services must be documented in the participant's Life Plan as being essential to the person's habilitation, ability to function or safety, and essential to avoid or delay institutionalization. Only those services not reimbursable under a Medicaid State Plan option will be reimbursable under the 1115 Waiver.
Environmental Modifications	Individuals with I/DD meeting HCBS eligibility criteria	Physical adaptations to the participant's home, required by the participant's Life Plan, that are necessary to ensure the health, welfare and safety of the participant, or that enable the participant to function with greater independence in the home, and without which the person would require institutionalization and/or more restrictive and expensive living arrangement. Only those services not reimbursable under a Medicaid State Plan option will be reimbursable under the 1115 Waiver.
Family Education and Training	Individuals with I/DD meeting HCBS eligibility criteria	Training given to families of participants enrolled in the HCBS Waiver intended to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of an I/DD on the person and his or her family, including behavioral management practices, and teach the family about service alternatives. The purpose is to support the family unit in understanding and coping with the I/DD and create a supportive environment at home to decrease premature residential placement outside the home.

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Services to Support Self Direction	Individuals with I/DD meeting HCBS eligibility criteria	Any individual eligible for HCBS Waiver services may self-direct some or all of his/her services. The person self-directing receives an individualized portable budget that is directed by the individual pursuant to an approved Life Plan. **Fiscal Intermediary** If an individual chooses to self-hire their own staff, the employer of record must be either the fiscal intermediary or, once the "common law employer" status is implemented, the individual or family may act in this capacity. In addition to using a fiscal intermediary to pay staff that the person "self-hires," an individual must choose a fiscal intermediary agency if the following services are included in their budget in order to provide for appropriate billing and claiming: individual directed goods and services, live-in caregiver, support brokerage or community transition services. The fiscal intermediary supports the individual self-directing with billing and payment of approved goods and services, fiscal accounting and reporting, ensuring Medicaid and corporate compliance, and general administrative supports. **Support Brokerage** Assist Waiver participants (or the participant's family or representative as appropriate) to self-direct and manage some or all of their Waiver services. Support brokerage does not duplicate or replace the Care Management services and differs from Care Management in terms of intensity, frequency and scope. The support broker assists the participant in the day-to-day management of services and provides support and training to participants and their families regarding the ongoing decisions and tasks associated with participant direction.

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Services to Support Self Direction (continued)	Individuals with I/DD meeting HCBS eligibility criteria	**Individual Directs Goods and Services** Services, equipment or supplies not otherwise provided through this Waiver or through the Medicaid State Plan that addresses an identified need in an individual's Life Plan, which includes improving and maintaining the individual's opportunities for full membership in the community. Individuals who choose to self-direct their services with budget authority may receive individual goods and services as a Waiver service. Individuals may manage their individual goods and services budget, as described in their Life Plan, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the criteria as described in the 1915(c) OPWDD Comprehensive HCBS Waiver.
Community Transition Services	Individuals with I/DD meeting HCBS eligibility criteria	Non-recurring set-up expenses for individuals who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in the community where the person is directly responsible for their own living expenses. Allowable expenses are those reasonable and necessary to enable a person to establish a basic household. Items purchased are the property of the individual receiving the service. The service must be identified in the Life Plan. The service is administered by a fiscal intermediary agency for billing purposes, even if this is the only self-directed service that the person accesses.
Live-in Caregiver	Individuals with I/DD meeting HCBS eligibility criteria	An unrelated care provider who resides in the same household as the participant and provides supports to address the participant's physical, social or emotional needs in order for the participant to live safely and successfully in their own home.

OPWDD HCBS Waiver Service Definitions		
Benefit	**Eligibility Criteria**	**Description of Amount, Duration and Scope of Services**
Intensive Behavioral Services (continued)	Individuals with I/DD meeting HCBS eligibility criteria	Available under the following circumstances: For individuals who reside in a non-certified residential location, their own home or family home, or a family care home; and The individual, or a party acting on behalf of the individual, certifies through written documentation that the individual is at risk of imminent placement in a more restrictive living environment due to challenging behavioral episodes. Intensive behavioral services are short-term, outcome-oriented and of higher intensity than other behavioral interventions and are focused on developing effective behavioral management strategies to ensure health and safety and/or improve quality of life.
Vehicle Modifications	Individuals with I/DD meeting HCBS eligibility criteria	Physical adaptations to the participant's vehicle, required by the participant's Life Plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence. These physical adaptations include: portable electric/hydraulic and manual lifts, ramps and ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

Attachment H: Placeholder

Attachment I: Demonstration Services Only – NYSTART (Crisis Prevention and Response)

NYSTART is a community-based program delivered by OPWDD-approved providers that provides crisis prevention and response services to individuals with intellectual and/or developmental disabilities who present with complex behavioral and mental health needs, and to their families and others in the community who provide support. NYSTART is not a separate system and does not replace existing services.

The NYSTART program offers training, consultation, therapeutic services and technical assistance to enhance the ability of the community to support eligible individuals and focuses on establishing integrated services with providers. Providing supports that help individuals to remain in their home or community placement is NYSTART's first priority.

As each of the NYSTART teams are established and become fully operational, the services provided will include:

1. Community partnerships and systems linkages;
2. Systemic and clinical consultation and training;
3. Community training and education;
4. Clinical Education Team training meetings;
5. Cross Systems Crisis Prevention and Intervention Planning;
6. Mobile crisis support and response for individuals enrolled in NYSTART services;
7. Outreach and follow-up; and
8. Comprehensive Service Evaluations

The NYSTART team will clinically assess individuals enrolled in NYSTART services to determine the need for the provision of:

1. Therapeutic in-home support services for NYSTART-enrolled individuals age 6 and over;
2. Therapeutic emergency or planned Resource Center services for NYSTART- enrolled individuals age 21 and over.

NYSTART services are available to individuals age 6 and over with intellectual and/or developmental disabilities who present with complex behavioral and mental health needs. An OPWDD eligibility determination is required in order to receive the full array of NYSTART services.

The NYSTART initiative is a behavioral health crisis prevention and response model that brings short term support to individuals who are at risk. There is a very focused educational and training program for NYSTART team members that ensures strong skills in serving individuals with I/DD with behavioral health challenges. NYSTART services are currently covered through a variety of funding streams and will continue to be developed within the 1115 Waiver. OPWDD is requiring a linkage agreement between CCO/HHs and the NYSTART teams to ensure that there is partnership and coordination for the individuals receiving services.

Attachment J: The Life Plan

CCO/HH Life Plan and Basic HCBS Plan Support Life Plan	
CCO/HH Life Plan	**Basic HCBS Plan Support Life Plan**
The 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.
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 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 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 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 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 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 K: Chart of Populations, Enrollment Strategies, and Benefits

Phase 1: Voluntary Early Adopter/MMC under 1115 Authority			
Target Date – January 1, 2019 for MMC with submissions to NYSDOH 1/1/18			
Population	**Mandated Enrollment**	**Eligible**	**Excluded/Not Participating**
Population eligible for enrollment	N/A	• I/DD–Medicaid non-dual • I/DD member • Other eligible enrollees may enroll if they request the Plan, but may be subject to transition with implementation of SIP-PL Includes 25,000 I/DD who are enrolled in MMC today	• Third Party Comprehensive (TPHI) • Other Factors that exclude population from enrollment in MMC Plan such as individuals eligible for Medicaid through meeting their spenddown • Individuals in Developmental Centers/Small Residential Units (DC/SRU)
Benefits			
Benefit Type	**Services Included**	**Recipients**	**Plan Payment – Individual Access**
Comprehensive Care Management	• CCO/HH • Basic HCBS Plan Support Services	Eligible • I/DD–Medicaid-non-dual • I/DD member eligible for HH Ineligible • I/DD member not eligible for HH	CCO/HH • FFS and capitated members ○ Paid outside capitation • Not at risk • Not managed by Plan for members

Phase 1: Voluntary Early Adopter/MMC under 1115 Authority (continued)			
Benefit Type	**Services Included**	**Recipients**	**Plan Payment – Individual Access**
MMC Benefit Package	• Health Care • Hospitalization • Article 28/32 Clinic	Eligible • I/DD–Medicaid-non-dual • I/DD member	• In capitation – at risk
CFCO Benefit Package	• ADL/I-ADLs (Personal Care and CDPAS) • Community Habilitation • E-Mods • Assistive Technology • Community Transitional Services • Vehicle Modifications • Social Transportation • Moving Assistance	Eligible • Any member meeting LOC	• In capitation – at risk
OPWDD HCBS benefits	• 1915c HCBS Comprehensive Waiver	• Participants in 1915c HCBS Comprehensive Waiver	• Paid Fee-For-Service

Phase 2: Adding SIPs-PL – Voluntary Enrollment under concurrent 1915c/1115 Waiver Authority

Note: 25,000 I/DD members who are enrolled in MMC today can choose to remain in their MCP or opt into a SIP-PL.

Target Date – August 1, 2019

Population	Mandated Enrollment	Eligible[5]	Excluded/Not Participating
Population eligible for enrollment	N/A	• I/DD–Medicaid non-dual • I/DD–Medicaid dual	• TPHI • Other Factors that exclude population from enrollment in MMC Plan such as individuals eligible for Medicaid through meeting their spenddown • Individuals in DC/SRUs

Benefits

Benefit Type	Services Included	Plan Payment – Individual Access
Comprehensive Care Management	• CCO/HH • SIP-PL Care Management • HH for non-I/DD family members	• In capitation – at risk (Plan pays HH rate for 24 months)

[5]Family members of eligible I/DD members can also opt to enroll in a SIP-PL and receive the MMC benefit package as outlined in the 1115 special terms and conditions.

Phase 2: Adding SIPs-PL – Voluntary Enrollment under concurrent 1915c/1115 Waiver Authority (continued)		
Benefit Type	**Services Included**	**Plan Payment – Individual Access**
MMC Benefit Package	• Health Care • Hospitalization • Article 16/28/32	• In capitation – at risk • Wrap-around benefit for duals
CFCO Benefit Package	• ADL/I-ADLs (Personal Care and CDPAS) • Community Habilitation • E-Mods • Assistive Technology • Community Transitional Services • Vehicle Modifications • Social Transportation • Moving Assistance	• In capitation – at risk
OPWDD HCBS Residential Benefit	• 1915c HCBS Comprehensive Waiver Services • Residential and non-residential HCBS benefits • Residential Habilitation • Day Treatment • Community Based - ICFs	• Managed by SIP-PL under contract – not at risk (non-risk subject to 42 CFR 447.361 UPL) • Eligible for Levels 0-2 VBP

Phase 3: Allowing MMCs to become SIPs-M – Mandatory Enrollment under concurrent 1915c/1115 Waiver Authority			
Target Date – 2021 (Downstate) and 2022 (Upstate)			
Population	**Mandated Enrollment**	**Eligible[6]**	**Excluded/Not Participating**
Population eligible for enrollment	Yes, subject to choice of Plans being available	• I/DD–Medicaid non-dual • I/DD–Medicaid dual • I/DD–TPHI except for Medicare – subject to future 1115 Amendment	• Other Factors that exclude population from enrollment in MMC Plan including spenddown • Individuals in DC/SRUs
Benefits			
Benefit Type	**Services Included**	**Plan Payment – Individual Access**	
Comprehensive Care Management	• CCO/HH • SIP-PL Care Management • HH for non-I/DD family members	• In capitation – at risk (Plan pays HH rate for 24 months)	
MMC Benefit Package	• Health Care • Hospitalization • Article 16/28/32	• In capitation – at risk • Wrap-around benefit for duals	

[6]Family members of eligible I/DD members can also opt to enroll in a SIP-PL and receive the MMC benefit package as outlined in the 1115 special terms and conditions

Phase 3: Allowing MMCs to become SIPs-M – Mandatory Enrollment under concurrent 1915c/1115 Waiver Authority (continued)		
Benefit Type	**Services Included**	**Plan Payment – Individual Access**
CFCO Benefit Package	• ADL/I-ADLs (Personal Care and CDPAS) • Community Habilitation • E-Mods • Assistive Technology • Community Transitional Services • Vehicle Modifications • Social Transportation • Moving Assistance	• In capitation – at risk • Continuity provision TBD
OPWDD HCBS Residential Benefit	• 1915c HCBS Comprehensive Waiver Services • Residential and non-residential HCBS benefits • Residential Habilitation • Day Treatment • Community Based - ICFs	• Managed by SIP-PL under contract – not at risk (non-risk subject to 42 CFR 447.361 UPL) for no longer than 24 months from the beginning of mandatory enrollment (2023-2024) • Eligible for Levels 0-2 VBP for 2 years