

Response to Public Comment on Draft Transition Plan

Introduction

On December 5, 2017, the New York State Department of Health (DOH), in collaboration with the New York State Office for People With Developmental Disabilities (OPWDD), announced that a draft of the 1115 Waiver Transition Plan for people with intellectual and developmental disabilities (I/DD) was available for public comment. The State requested comments from the public from December 5, 2017 through January 5, 2018.

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

The purpose of this document is to provide responses to questions raised during the public comment period.

Major Changes to the Draft Transition Plan Based on Public Comment

Many clarifying changes were made to the Final Draft Transition Plan, based on stakeholder input, including:

- The renaming of the Care Management opt-out option to “Basic HCBS Plan Support”;
- An extended timeframe for completion of the initial Life Plan to align with each individual’s person-centered review schedule;
- Modification to the Health Home Checklist to include a signature line for the individual, family member or guardian;
- Clarification on the impact on children enrolled in OPWDD Care At Home (CAH) Waiver; and
- Additional detail surrounding Phase II & III implementation plans.

Other changes made to the Draft Transition Plan are described below in the response to questions and comments.

The updated Draft Transition Plan is available for your reference at:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/draft_idd_1115_waiver.htm.

Key Components of Transition

- 1. Based on OPWDD’s long history of championing the rights of people with disabilities, respondents expressed concern about the future role of OPWDD, especially when going into a managed care environment, and wanted confirmation that OPWDD will remain the leader in protecting the needs of people with disabilities.**

Since its origin in 1978, OPWDD has been and will continue to be committed to the care and protections of individuals with I/DD. OPWDD is the Cabinet-level agency that has been designated to lead the development, implementation, and oversight of Specialized Managed Care Plans for the I/DD population.

- 2. A respondent suggested that “Home and Community Based Service (HCBS) Care Management” be renamed. The concern was raised that the current terminology suggests individuals will receive a higher-level of involvement with a Care Manager under this model than is actually provided.**

The State agrees and will amend the Transition Plan and future communication to reflect the name, “Basic HCBS Plan Support.”

- 3. Commenters agreed that the differences between a Care Coordination Organization/Health Home (CCO/HH) and a Managed Care Plan must be clearly defined to ensure that individuals and families do not choose to opt-out of comprehensive Care Management with the belief that those enrolled in Basic HCBS Plan Support will not be required to enroll in a Managed Care Plan in the future.**

CCO/HHs will coordinate a variety of health and behavioral health care, wellness and Developmental Disability (DD) services through a holistic and integrated approach to meet an individual’s full range of needs. The CCO/HH will employ the Health Home Care Management model, which is an improved and expanded model of Care Management, to provide comprehensive Care Management for individuals with I/DD. The CCO/HH is not a Managed Care Plan and will **not** authorize Medicaid services or pay for services an individual receives other than Care Management. CCO/HHs will operate on a fee-for-service basis. Enrollment in CCO/HH Care Management services will replace Medicaid Service Coordination (MSC) and Plan of Care Support Services (PCSS). The implementation of CCO/HHs will not affect the other developmental disability, health, behavioral health, or other Medicaid-funded supports an individual receives.

Individuals who choose not to receive the comprehensive person-centered care planning services that the CCO/HH model provides will still receive limited care planning services called Basic HCBS Plan Support. This service primarily focuses on planning related to only HCBS services and not the other services important to an individual’s comprehensive needs (e.g., health, behavioral health, and community and social supports that are needed to maximize an individual’s health and social well-being). Individuals that decline comprehensive CCO/HH Care Management and do not want regular contact with a Care Manager, will receive the limited care planning option described in Attachment B of the Transition Plan. Attachment B lays out the key program differences between comprehensive CCO/HH Care Management and Basic HCBS Plan Support.

An individual's enrollment in CCO/HH or Basic HCBS Plan Support will not have any effect on their future enrollment in a Specialized Managed Care Plan during both the voluntary enrollment phase of managed care and ultimately during the mandatory phase.

4. Respondents asked OPWDD to clarify what the technical difference was between the Draft Transition Plan and the submitted 1115 Waiver.

The submitted 1115 Waiver is New York State's amendment to its current 1115 Medicaid Redesign Team (MRT) Waiver. A State offers Medicaid services under either the authority of a Medicaid State Plan or a State-specific Waiver of sections of the Social Security Act. Certain provisions of Medicaid law may be "waived" to give States additional flexibility to design and improve their Medicaid programs. An 1115 Waiver is the most flexible type of Waiver available under Medicaid. The Application begins a Federal-State negotiation that will result in the Federal government issuing new Terms and Conditions for the 1115 Waiver in NYS. The Terms and Conditions describe the requirements for the State's operation of Medicaid.

The Draft Transition Plan is a blueprint for how services for individuals with I/DD will transition from the current OPWDD Comprehensive 1915(c) Waiver to New York State's 1115 Waiver. The Draft Transition Plan also outlines timelines and steps for launching CCO/HH services under the proposed State Plan Amendment (SPA) (i.e., the steps to begin implementation of the approved 1115 Waiver and State Plan for CCO/HH services). After incorporating public comments received and drafting any necessary changes to the Plan, the revised Draft Transition Plan will then be submitted to CMS for their review and approval.

5. Commenters also requested information on the differences between the 1915(c) Waiver and the 1115 Waiver.

Home and Community Based Services (HCBS) 1915(c) Waivers authorize States to provide HCBS to help individuals receive services they need to remain in the community (i.e., as an alternative to institutional care, such as a nursing home or an ICF). Under HCBS Waivers, States can provide different sets of services to specific populations. States can impose caps on HCBS Waiver enrollment and average costs per person to ensure that they do not exceed the comparable cost of institutional services.

An 1115 Waiver allows the CMS to waive certain provisions of the Social Security Act and provides States the ability to use Federally-matched Medicaid funds in different ways to demonstrate better outcomes for individuals by using more flexible service delivery models than a 1915(c) Waiver authority allows. For example, the OPWDD 1115 Application proposes to demonstrate that NYSTART (Systemic, Therapeutic, Assessment, Resources and Treatment) helps to avoid costlier institutional placements and therefore create Medicaid savings. Including NYSTART as a demonstration under the 1115 Waiver means Federal funds can support the service.

For individuals enrolled in the 1915(c) Waiver, the transition to the 1115 Waiver will not affect the services they receive, with one exception. PCSS will be the only current 1915(c) HCBS Waiver service that will not be available under the 1115 Waiver. However, in place of PCSS, PCSS enrollees will have the choice of receiving either CCO/HH Care Management or Basic HCBS Plan Support.

- 6. Respondents noted that the Draft Transition Plan does not clearly distinguish the subset of children in the CAH Waiver who will not transition to CCO/HHs and requested this distinction be made. Additionally, commenters identified a lack of guidance available on the expectations regarding children and requested clarification on how to determine the appropriate Health Home options available to children with I/DD.**

The Transition Plan will be amended to note that children enrolled in the OPWDD CAH Waiver are not included in the transition to CCO/HHs. For the time being, OPWDD will continue to operate the OPWDD CAH Waiver under the 1915(c) authority and children enrolled in this Waiver will receive CAH Waiver case management. Children enrolled in the OPWDD CAH Waiver are both medically fragile and have a developmental disability. The State is continuing work to implement the proposed Children's Medicaid System Transformation. The Children's Medicaid System Transformation involves another proposed amendment to the 1115 Waiver to integrate HCBS services across the six 1915(c) waivers, including the OPWDD CAH Waiver, that exclusively serve children. When the Children's Medicaid System Transformation is implemented, children receiving HCBS under the 1115 Waiver will receive Health Home Care Management by designated Health Homes that are authorized to serve children under 21 (i.e., Health Homes Serving Children (HHSC)). All children enrolled in the OPWDD 1915(c) Comprehensive Waiver who are transitioning to the 1115 Waiver, have a choice of receiving CCO/HH Care Management or basic plan support. In addition, children who have a developmental disability that is authorized under a proposed SPA and who are not eligible for OPWDD HCBS services (either under the 1115 waiver or the 1915(c) waiver), may receive Health Home Care Management from a designated Health Home serving children.

- 7. Commenters questioned why the term "Care Manager" is used rather than "Care Coordinator." Some commenters stated that "Care Manager", is understood within a medical context and does not represent a person- and family-centered approach to addressing the holistic needs of the entire person.**

The term "Care Manager" is a term associated with Health Homes; it is defined in the Federal guidance for Health Home services. Health Home Care Managers are required to provide the CCO/HH core services, two of which are comprehensive Care Management and Care Coordination and health promotion. Per federal regulations, OPWDD is requiring that Care Managers use person-centered practices and complete planning and service recommendations in line with the holistic needs of the individual and as required by the CCO/HH Care Management Model.

General Questions/Comments on Transition Plan

- 8. Many commenters noted that the Public Comment period to review the Draft Transition Plan was too brief. Additionally, given the document's importance, Commenters requested that it be written in a way individuals and families could more easily understand; and a hard copy should have been made available for those who do not have access to a computer.**

OPWDD's Public Notice of the Draft Transition Plan satisfied all Federal and State regulatory requirements. OPWDD distributed notices to all Stakeholder e-mail distribution lists and published the Draft Transition Plan materials on both the agency and the DOH's website. OPWDD also held two web-based information sessions at the start of the comment period, and published materials and responded to questions from these sessions on the OPWDD website, where they are currently maintained. https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations In addition, OPWDD will forward a hard copy of the Transition Plan to all Developmental Disabilities Regional Offices (DDRO) for on-site review.

- 9. Many respondents recommended that a glossary of terms accompany the Transition Plan because not all stakeholders are familiar with the terminology frequently used.**

A CCO/HH Glossary of Terms was published in Appendix A of the CCO/HH Application to Serve Individuals with I/DD and is available at: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd

- 10. A group of respondents noted that page 8 states the transition to the 1115 Waiver "will have no impact on individuals, families and the authorization of HCBS Services." These commenters recommend revising the sentence to indicate that the transition is "*intended*" to have no impact.**

OPWDD considered this feedback, and will revise the sentence to say, "the transition is designed to have no impact." As described in the Transition Plan, the current HCBS Waiver rates, provider agency requirements and administrative processes for authorization and access to HCBS Waiver services will not change because of the transition, except as noted for PCSS. A primary goal of the Transition Plan is to ensure continuity of care – that individuals continue to receive the services they do today, but in a more comprehensive manner to ensure their needs continue to be met.

- 11. Multiple respondents expressed concern over the ambitious timelines associated with each phase of the transition. They expressed fear that individuals will not make a truly informed decision which could lead to a disruption of services. Some recommended that the implementation deadline be extended. Some respondents asked that the Transition Plan provide more information on how the transition to Health Home Care Management and eventually managed care will directly impact individuals.**

To ensure a smooth transition, the schedule for transforming the I/DD service system will be implemented in phases, beginning with the implementation of CCO/HHs. While the initial phase of the schedule is ambitious, it will not be fully implemented until all CCO/HHs pass readiness review assessments by the State. OPWDD is committed to protecting individual choice during this transition and is dedicated to comprehensive outreach, training and information sharing as each transition phase is implemented. The transition to the 1115 Waiver will occur through a series of carefully organized and communicated steps. Individuals and families will be well informed of their options and rights throughout the transition to CCO/HHs. To ensure that this change has no immediate impact on individuals, for up to twelve (12) months following the July 1, 2018 implementation date, all plans of care known as Individualized Service Plans (ISPs) will remain in place and services will be considered authorized under the 1115 authority. Any change in an individual's OPWDD services will remain subject to existing fair hearing rights following the transition to the 1115 Waiver.

The transition into managed care will proceed in a planned and thoughtful way, where information is continually gathered to assess how individuals are faring. It should be noted that Phase II into managed care is completely voluntary until 2021. At that time, downstate mandatory enrollment will progress in regions where the State has confirmed a choice of Plans. OPWDD is working towards making this process a seamless and well-informed transition.

12. Respondents asked how New York is looking at the experience of national models when developing its I/DD Health Home services and Managed Care design.

There are elements of CCO/HH services that are modeled after the experience of other States. For example, New York is using a similar Health Home eligibility standard for individuals with I/DD used by the State of Maine. Many elements are already in place under the Fully Integrated Duals Advantage for I/DD (FIDA-IDDA), a national demonstration, that has operated in the downstate area for two years. The FIDA-IDDA is a comprehensive Medicare - Medicaid Managed Care Plan that already uses a Care Management model that shares many of the person-centered planning requirements that are incorporated into the CCO/HH design; these elements will be integrated into the managed care policy guidance document that will be published for public comment later in 2018. This document will outline the unique operational elements for Specialized Managed Care Plans serving individuals with I/DD.

13. Many respondents asked the State to provide more details regarding the Community First Choice Option (CFCO) State Plan.

Information on CFCO can be found on the DOH website here:
https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm

- 14. Several respondents questioned the NYSTART program, asking if NYSTART will be a new service separate and apart from HCBS Waiver and State Plan services and if there was evidence the model included clinicians that have expertise in I/DD?**

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.

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

General

- 15. Respondents expressed concern about meeting conflict-free case management standards and asked the State to clarify how the CCO/HH model meets those standards.**

The mission of CCO/HHs is exclusively focused on the provision of Care Management under either the CCO/HH or Basic HCBS Plan Support models. The CCO/HH does not deliver other HCBS Waiver services. This separation of the Care Management functions and service provision meets the higher standards for conflict of interest.

- 16. Commenters asked if the Health Home SPA has been approved by CMS?**

The DRAFT SPA to expand Health Home eligibility criteria to include I/DD conditions was shared with CMS in August 2017. CMS responded with questions and OPWDD and DOH are currently preparing responses that will be included with the final SPA submission. We expect approval of this Amendment no later than March 31, 2018.

- 17. OPWDD was asked to confirm whether individuals will have the right to invoke fair hearing rights related to the July 1, 2018 end-date of MSC and PCSS.**

Individuals do not have the right to a fair hearing related to the sunset of these programs. The State is ending the provision of MSC and PCSS, and providing all recipients with a choice of services to replace these two options. All individuals currently receiving MSC services or PCSS will have the choice to enroll in a CCO/HH to receive comprehensive CCO/HH Care Management or Basic HCBS Plan Support (see Question 3, Basic HCBS Plan Support is a lesser service for

individuals who do not elect to receive comprehensive Care Management). Hearing rights for all other services remain the same.

18. Respondents urged the State to announce the approved CCO/HHs as soon as possible to ensure the significant tasks are completed by June 30, 2018.

OPWDD and DOH agree with this recommendation; initially designated CCO/HHs will be announced shortly and before February 28, 2018.

19. The State was asked to clarify if it has officially told all MSC agencies that have not yet affiliated that they must by a certain date.

Throughout this transition, OPWDD has been working with the DDRO Directors to communicate and develop succession plans with MSC agencies that have not yet affiliated or who have chosen not to affiliate with an emerging CCO/HH within their region.

20. Respondents pointed out that many I/DD agencies do not have existing relationships with specialized medical care providers and suggested that there be a period for CCO/HHs to identify and engage with appropriate medical staff.

DOH and OPWDD agree. CCO/HHs and the public were provided with the list of primary Medicaid providers that now serve the OPWDD population. This report was compiled to assist with the development of needed partnerships. This report is available at the following link as Appendix E to the CCO/HH Application:
https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/part_1_attachment_e.pdf.

During the readiness review process and on an ongoing basis thereafter, CCO/HHs will be expected to develop and maintain a network of partnerships with cross-system service providers and have agreements in place that allow access to comprehensive, timely and high-quality services. CCO/HHs are expected to continue building these networks and the State anticipates additional follow-up will be required to ensure network adequacy beyond the implementation and readiness period. The State will provide educational opportunities for providers to support the provision of comprehensive, timely and high-quality services according to an individual's Life Plan.

21. Commenters asked how the relationship between CCO/HHs and the various partners will be documented and when will the State review these documents?

Initially designated CCO/HHs have received a list of required agreements and the timeframe for readiness reviews. Among these agreements is one that delineates the relationship between the CCO/HH and the network partners.

22. The State was asked to identify what the “Valued Outcomes of OPWDD” are, as identified on page 17.

As outlined on page 10 of the CCO/HH Application to Serve individuals with I/DD, OPWDD’s Valued Outcomes include:

- a. Individuals live and receive services in the most integrated settings,
- b. Have meaningful and productive community participation, including paid employment; and accommodating people’s needs as they change,
- c. Develop meaningful relationships with friends, family, and others in their lives, including the option of participating in the self-advocacy association, peer support and mentoring program, and
- d. Experience personal health, safety and growth.

This is available at the following link:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/index.htm.

23. Cultural competence and language accessibility are priorities of many diverse communities across New York State. Commenters expressed concern that individuals and families may be hesitant to participate in a large CCO/HH that may not understand or be responsive to their unique cultural attributes.

Cultural competency is a requirement of the CCO/HH Care Management Model. In addition to the person-centered principles outlined in the Transition Plan, OPWDD has included a requirement that Care Managers be trained on the fundamentals of cultural competence so that they can:

- Recognize individuals’ and families’ cultural needs/actors that influence choices and engagement in services
- Provide culturally appropriate and person and family-centered services
- Communicate with individuals and families in a culturally competent manner
- Promote inclusion

In addition, the CCO/HH is working with existing MSC agencies and MSC service coordinators to ensure the continuity of best practices as they relate to cultural competence.

24. Stakeholders expressed concern that the transition to CCO/HHs may lead to a loss of needed support from MSC Service Coordinators; some have observed and feel that this transition has resulted in the loss of MSC Service Coordinators, the creation of waitlists, and a lack of information about future benefits.

The intent, design and implementation of the CCO/HH Model is to empower and better resource the coordination function. The Transition Plan includes ensuring that the expertise of MSCs is transitioned to the role of CCO/HH Care Manager. OPWDD and DOH recognize that system change is difficult for staff. We believe that current MSC Service Coordinators will have greater opportunities for growth and employment options as CCO/HHs are launched. The initial designations of CCO/HHs will be

announced shortly. Once this occurs, CCO/HHs will announce the salary and benefit packages for Care Managers.

- 25. The Transition Plan does not address individuals with co-occurring conditions and commenters requested clarification on how these crossover populations will be served. For example, will individuals eligible for the OPWDD Waiver be allowed to enrollee in a Health Home not operated by OPWDD?**

The CCO/HHs must provide better access to services in other systems, such as behavioral health. Individuals who meet the requirements for enrollment into another CCO/HH may enroll in that CCO/HH. However, if individuals want to receive OPWDD HCBS services they must enroll in their choice of either the CCO/HH or in Basic HCBS Plan Support.

- 26. A commenter suggested that upon designation as a CCO/HH, the State establish regular, bi-weekly meetings to address transition and implementation issues and to clarify the role of the CCO/HH during the transition period.**

OPWDD agrees and is working to establish routinely scheduled meetings with CCO/HHs during the transition period.

Stakeholder Outreach

- 27. Overall, commenters agreed that a more robust and transparent process of stakeholder outreach and engagement is necessary to ensure that the stakeholder community is well informed and represented. Respondents recommended that communication materials, including PowerPoints, FAQs and other documents, be available in all primary languages of individuals being served and/or their designated representative.**

A major priority of OPWDD over the past few months has been outreach and education across the State and in many different venues to reach the diversity of audiences that may be affected by this system change. We have organized numerous regional Forums and are planning future additional Forums as well. OPWDD has also held and will continue to hold several web-based and in-person informational sessions for individuals, families, MSC Service Coordinators and providers. Materials from these sessions have been posted to OPWDD website at https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations.

To facilitate communication and overcome language barriers, OPWDD has translated the Transition Plan into Spanish and Chinese languages. Other language translations are also available upon request. In addition, once this response to public comment is finalized and the Transition Plan is updated, these documents will also be translated.

- 28. Commenters remarked that the Transition Plan assumes all people served have a MSC Service Coordinator or receive PCSS and asked how OPWDD will ensure that everyone, including those who do not receive MSC or PCSS, obtains information and notifications about this transition.**

OPWDD has been conducting informational sessions with the current MSC workforce and other interested parties and will be working with the CCO/HHs as they receive initial designation. Through consistent communication practices that will be outlined for the MSCs who work with individuals today, we expect comprehensive communication and related notice and choice documentation to be completed. Reaching people served by MSC agencies or those who receive PCSS has been the agency's priority. Eligible individuals who do not currently have MSC or PCSS will receive information as they request services through the DDROs.

- 29. There was a strong consensus among respondents that more stakeholder involvement, particularly from individuals and families, is needed and requested that more orientation sessions be offered. Additionally, commenters advised that education and training to individuals and families not be the sole responsibility of the CCO/HH and suggested that Parent Centers/Organizations be utilized more.**

OPWDD recognizes that stakeholder involvement is critical to a smooth and seamless transition into a Care Coordination service delivery model. Towards this end, various outreach efforts have been conducted including regionally-based information sessions open to all individuals and their families, as well as stakeholder organizations. We recognize the need to do more of this and plan to roll-out additional education and awareness sessions for individuals and families over the coming weeks and months. This information will be announced through direct emails and on our website.

- 30. Many stakeholders recommended that the formal advisory bodies supporting OPWDD decision making include self-advocates, parents, siblings, guardians, and other relatives and requested more information on how people can join these councils.**

The formal advisory bodies referenced in the stakeholder comments are made up of parents/guardians, self-advocates, and providers. Many of these advisory bodies are legislatively mandated and members are appointed to serve on these committees. These bodies are typically fully appointed, but individuals who are interested in serving on an advisory body should a vacancy arise, can contact the OPWDD Commissioner's Office and request a Volunteer Interest Form for completion.

- 31. Commenters supported the requirement for the CCO/HHs to establish an Advisory Committee but asked for clarity on the expectations for the committee, expressing concern that the Advisory Body has no authority over the actions or decisions made at the CCO/HH and recommended that family members and self-advocates play a more substantive role in the governance of the CCO/HH.**

The role of the CCO/HH advisory body is to review CCO/HH processes and outcomes and advise the CCO/HH leadership regarding the policies and operations of CCO/HHs and bring emerging concerns to leadership's attention. During the CCO/HH Application readiness review process, OPWDD will be examining the CCO/HHs governance and leadership structure to ensure the established advisory body is robust and includes individuals and their family members.

- 32. Commenters requested clarification on how OPWDD is “actively seeking input on regulatory streamlining of operations and oversight to enhance access to, and operations of, services”, as noted on page 15 of the Transition Plan.**

Regulatory streamlining continues to be a focus for OPWDD; the advance public notice process is in place to receive and consider stakeholder input. With the transition to the 1115 Waiver, Managed Care and ultimately a Value Based Payment (VBP) environment, the State's goal is to focus on the measurement of individual outcomes for people. Additionally, OPWDD convenes a monthly meeting with external stakeholders to review and discuss regulatory projects and agency memoranda.

- 33. Respondents asked when the informational letter will be made available and recommended the meetings between the Care Manager and the individual/family be face-to-face.**

OPWDD has stated that meetings between the Care Manager and individual/family should be face-to-face, although flexibility will be necessary based on individual circumstances. OPWDD is developing an informational letter and brochure that clearly delineates the differences between CCO/HH Care Management and Basic HCBS Plan Support. It is expected to be available in March 2018.

Workforce

- 34. Commenters fear the stress associated with mandating a change in employer will negatively impact an already limited workforce and asked for clarification on the rationale for the one-year subcontracting time limit.**

OPWDD has been working with stakeholders and MSC agencies and staff and providing information in forums, both statewide and regionally, through MSC Quarterly Webinars and bi-weekly information sessions to reduce the stress of the transition. OPWDD is working in partnership with the new entities to empower the role of coordination. It is envisioned that these changes will ultimately strengthen the workforce.

- 35. Many submitted comments addressed the absence of information on the level of compensation for Care Managers based on their increased roles and responsibilities.**

Compensation is set by the CCO/HHs and is not under the control of OPWDD. Once CCO/HHs have been initially designated in February, compensation packages will be announced. The rates developed by the State, and now under CMS review, assume a higher compensation for staff who serve as Care Managers.

- 36. Other commenters recommended the Care Manager qualifications be broadened to expand the pool of potential candidates.**

OPWDD has defined qualifications quite broadly by allowing the current workforce to transition to Care Manager roles based on their experience and training in the MSC role. Registered Nurses (RNs) are specifically identified as qualified based on their license and their relevant experience since RNs possess a license and not a Bachelor's degree. Other licensed professionals, special educators or social workers would be qualified based on the Bachelor's level depending on their relevant experience. These qualifications are necessary to support the requirements of enhanced Care Management offered by CCO/HHs.

Training

- 37. Several respondents identified the potential risks for training variability among Care Managers if left solely to the CCO/HHs and requested more involvement from OPWDD, including training standardizations and information on the benefits and possible risks of enrolling in a CCO/HH.**

Skills, learning objectives and training development resources are all being provided to the CCO/HHs for Care Manager training to ensure consistent quality standards. A Training Guide was developed and provided to all CCO/HHs. OPWDD will continue to provide some curricula and trainings for Care Managers. Staff developers from multiple CCO/HHs are collaborating on training development. OPWDD will be working with all CCO/HHs to support consistency and quality as they develop staff.

- 38. Commenters recommended Care Managers participate in a training focused on individual and family awareness to ensure they learn about the perspectives and experiences of individuals and families.**

In the required skills and learning objectives for Care Managers, there is extensive emphasis placed upon the understanding and demonstration of person-centered planning, support for self-advocacy of the individual, as well as communication skills required to effectively coordinate and support services.

- 39. Respondents reiterated the importance of Care Managers being trained to answer questions about the program and the consent elements to ensure that individuals are truly informed of what the program will look like when fully implemented.**

The MSC Service Coordinator, who will transition to the role of a CCO/HH Care Manager, will assist individuals and families with information and the signing of consent forms in preparation for the enrollment in CCO/HH services effective July 1, 2018. These discussions are anticipated to occur between April 1, 2018 and June 30, 2018 and there should be an in-person meeting scheduled with the individual and their family/advocate. CCO/HH Care Managers will explain the transition in general terms during these meetings.

- 40. A commenter asked how Care Managers will be trained to assume the responsibilities of Early Intervention (EI) Service Coordination?**

Most children who are enrolled in EI receive services exclusively through EI and receive EI case management. Further guidance will be forthcoming regarding the provision of Care Management for children who receive both EI and OPWDD HCBS Services.

Programmatic Issues

- 41. Many respondents asked for more detail on how Self-Direction will be affected by this transition.**

It is an important priority of OPWDD that the Self-Direction option continue to grow as the I/DD system transitions to CCO/HHs. Today, individuals who self-direct their services have an ISP that is managed by the MSC Service Coordinator. The individual then receives assistance from a support broker with the day-to-day management of self-directed services. Based on the needs of the individual, a support broker may assist with budget management, staff scheduling or completing necessary paper work. Within CCO/HH services, a similar division of duties is planned with the CCO/HH Care Manager assisting with the development and management of the individual's Life Plan and other core services, such as Health Promotion and Transition Services.

- 42. Several respondents asked OPWDD to elaborate on how the transition to CCO/HH Care Management will be accomplished for Intermediate Care Facility (ICF) residents and how it may impact the timeline/requirements for ICF conversions.**

Individuals living in ICFs will not transition to CCO/HH services. ICF residents will continue to receive case management as part of their ICF services. For ICFs that convert to Individualized Residential Alternatives (IRAs), individuals will have a choice of CCO/HH service provider.

Health Home Core Services

- 43. Many commenters expressed concern that the Health Home Core Services focus too heavily on health outcomes and asked how these services address the goals of helping people with I/DD live richer lives?**

The CCO/HH model that is being developed is an expansion of the current Health Home Care Management model, as specified under Federal law. CCO/HHs have been designed to meet the person-centered needs and valued outcomes of individuals with I/DD. The Life Plan will play a critical role in enhancing person-centered supports for an individual's goal attainment. The Life Plan integrates all preventive and wellness services, medical and behavioral health care, community and social supports, personal safeguards, and habilitation. The CCO/HH will assist individuals and families with accessing services that support well-rounded and fulfilling lives. CCO/HHs will address the broad health and behavioral health needs of individuals and offer supports and services promoting healthy lifestyles and increase community integration. Additionally, the CCO/HH model and core services was designed to prevent hospitalizations, reduce emergency department use, and improve transitions between settings.

- 44. Others asked how the Care Manager function of accessing and monitoring HCBS Waiver services relates to the Health Home Core Services.**

The CCO/HH Care Manager will assist the individual with accessing needed HCBS services by working with the DDRO – just as the MSC Service Coordinator does today. This function is part of the Care Manager's responsibility to deliver Comprehensive Care Management, one of the CCO/HH core service requirements. CCO/HH Care Managers will be responsible for developing a comprehensive Life Plan that includes all medical, behavioral health (mental health and substance use) and community and social support services, including HCBS authorized under the 1115 Waiver.

- 45. Commenters questioned why the interaction between the CCO/HH and public and 853 schools is not addressed under the "Comprehensive Transitional Care" service description.**

The CCO/HH policy and procedures will identify the CCO/HHs responsibilities to address school transitions, as recommended.

- 46. Other respondents asked how a Care Manager will successfully provide "Referral to Community and Social Support Services", when covering such a large geographic region.**

A CCO/HH must deliver services throughout its geographic catchment area and will do so by employing Care Managers who live in and work in communities throughout the entire region. The formation of CCO/HHs and the required partnerships with today's MSC agencies assure that this region-wide coverage is provided. In addition,

the CCO/HH must establish a network of partnerships with various service providers to meet CCO/HH requirements and support effective sharing of information and referrals. The CCO/HH Care Manager will be responsible for facilitating connections with those service providers to address the individual's need for services.

- 47. Another commenter expressed concerns about the focus on adherence to protocol and compliance which may negatively impact a person's health and wellness and asked if individuals will lose their services if they don't adhere to treatment regimens.**

The CCO/HH service is geared at assisting people to meet their comprehensive personal outcomes, including outcomes around health and wellness. An individual's services are not in jeopardy based on an inability to adhere to treatment regimens.

- 48. Respondents asked the State to identify how CCO/HHS will provide Care Management for individuals who need specialized medical services?**

The CCO/HH Care Manager will play a vital role in coordinating the individual's Life Plan that includes all services, including specialized medical services. The extent that a Care Manager assists individuals in accessing specialized medical services is dependent on an individual's service need and desire for support from the Care Manager. The CCO/HH will be required to establish network agreements with specialized medical, behavioral health and other service providers that deliver services to the I/DD population. This network partnership is required to support care planning and referral to services.

The CCO/HH model of Care Management is well aligned with the needs of individuals with I/DD who often have a need for cross-system services. Recently completed survey results from New York State National Core Indicators (NCI) surveys demonstrate high levels of co-morbidity of anxiety disorders (23%), mood disorders (32%), or mental illness or psychiatric diagnoses (9%). Nationally, the National Association on Dual Diagnosis indicates that 30-35% of individuals with I/DD have a comorbid mental health condition. A number of medical conditions are also common to individuals with I/DD, such as epilepsy, obesity, and chronic pain. For example, the US Centers for Disease Control and Prevention identified that children with autism have much higher than expected rates of all medical conditions studied, including: eczema, allergies, asthma, ear and respiratory infections, gastrointestinal problems, severe headaches, migraines, and seizures (Kohane et al., 2012).

Eligibility/ Enrollment

- 49. Commenters asked what the CCO/HH's role will be in relation to an individual's OPWDD eligibility, Level of Care (LOC) determination and enrollment process.**

CCO/HHs will be responsible to take an active role in an individual's pursuit of eligibility, whether Medicaid or OPWDD. Guidance and facilitation with obtaining eligibility, and referral to community and social supports, are key elements to the

CCO/HH responsibilities. For individuals, the CCO/HH must ensure the Level of Care is renewed annually, or as situations dictate.

- 50. Commenters requested that the temporary extension for the annual LOC redetermination be extended to include March and April to accommodate the numerous transition activities.**

The State recognizes the workload associated with supporting individual and family education and choice during this time. Rather than relaxing the timeframe for annual LOC redeterminations, which is an essential requirement for CCO/HH eligibility, the State will consider other alternatives to relieve workload activities for MSC Service Coordinators MSCs. Following initial designation of the CCO/HH, the State will work with CCO/HHs and MSC agencies to identify areas where this can be achieved.

- 51. Respondents asked how OPWDD is working with the CCO/HH to streamline the eligibility processes under the 1115 Waiver and asked if this process would be finalized prior to July 1, 2018?**

The same eligibility/enrollment processes will be used until the 1115 process is developed. There will be no impact on the delivery of services with this transition. This process will seamlessly transition on the July 1, 2018 start date of the 1115 Waiver Amendment.

- 52. Commenters questioned the future role of Family Support contracts as they also assist families with Medicaid eligibility.**

Family Support Contracts will not be affected by CCO/HH development.

- 53. A respondent asked if individuals in Congregate Care Level Two settings would be eligible for HCBS Waiver services.**

The requirement that people live in certain settings to receive OPWDD targeted HCBS services will not change under the 1115 Waiver. As is currently required, individuals who receive OPWDD HCBS services must live in their own home or family home, or in a certified residence under the auspice of OPWDD. Level Two Congregate Care Settings are not included among the qualified residential settings for HCBS enrollment.

- 54. Commenters questioned how the risk of coercion would be eliminated in the CCO/HH enrollment process.**

The role of the Care Manager in assisting individuals as they transition to the CCO/HH must, above all, follow the person-centered planning standards and process. Care Managers will be required to maintain ethical and person-centered methods as they educate individuals and families. Their role is not to promote services of any kind, but to coordinate the services needed and sought by the individual within the interdisciplinary team that supports the individual. Ethics is one of the required

training areas for Care Managers. During the transition to CCO/HHs, all individuals will be able to choose a CCO/HH in their region and will then be provided a choice to receive CCO/HH Care Management or Basic HCBS Plan Support.

The State is developing consent forms and information for individuals regarding CCO/HHs and enrollment consent forms. The forms will be used to effectuate enrollment and the sharing of information among service providers and the team engaged in implementing the individual's Life Plan.

55. Commenters asked if an individual does not select a Care Management option, would they automatically be enrolled in Basic HCBS Plan Support?

There is no automatic enrollment of individuals into CCO/HH or Basic HCBS Plan Support. OPWDD is developing regulations which will address a supported enrollment process where needed.

56. Commenters recommended the public provide input on the consent forms, enrollment forms and other information that will be shared with families and requested a timeframe for when these documents would be made available.

The consent forms are not subject to public input or review, as they are documents that are developed by DOH attorneys with responsibility for ensuring that the notices meet applicable legal standards under the Medicaid program and Federal and State laws governing the confidentiality of protected health information. OPWDD and DOH are working collaboratively to update existing health home consent forms for use with CCO/HHs. The State is working with its stakeholders on the development of informational materials that will be shared with individuals and families regarding the consent and enrollment process. The informational materials include a resource "toolkit" for MSC Service Coordinators that will be available in March 2018. The toolkit will prepare MSC Service Coordinators and other staff to engage families and individuals on what the July 1, 2018 transition means to them and what they need to know to make informed decisions.

57. Commenters agreed that HCBS provider referrals should be the responsibility of the CCO/HH and not the DDRO, as the CCO/HH works with the individual and family to develop and implement the person-centered Life Plan.

The CCO/HH will be responsible for assisting individuals with referrals. However, the DDRO will remain responsible for the authorization of HCBS services until the advent of managed care.

58. Respondents asked how OPWDD expects to work with the Local Government Units (LGUs) to identify individuals with I/DD newly in need of services and how the CCO/HH will help?

The LGUs are an important link in the CCO/HH enrollment chain, as they determine Medicaid eligibility and are an important resource for families seeking services.

DDROs will continue to act as the liaison with needed LGUs to establish eligibility for OPWDD services.

CCO/HHs are expected to assist individuals who are “new to services” in any coverage or service related inquiry, in keeping with the role of today’s MSC agencies. The CCO/HH can support potentially eligible individuals with referral to community agencies, assisting in obtaining eligibility documentation or helping an individual apply for Medicaid. There is a “transition payment” that funds the costs of such services, once the individual selects and enrolls in a CCO/HH.

59. Respondents asked how CCO/HH enrollment will be handled in CHOICES on day one of this initiative.

The OPWDD system, CHOICES, is being enhanced to support the CCO/HHs enrollment of individuals who consent to receive CCO/HH Care Management and Basic HCBS Plan Support services. CCO/HHs and Care Managers will securely access the system and record the individual’s enrollment choice using a CCO/HH enrollment form. OPWDD will provide training on user access to CHOICES and the use of this form this spring.

Life Plan

60. Many commenters noted that the Transition Plan should clearly indicate that the Life Plan is flexible to recognize the wide array of services an individual may receive, including out-of-state provisions for specialty medical services, and that Life Plan development will include the individual’s circle of support.

OPWDD concurs that an individual’s comprehensive service needs should be identified in the Life Plan and that the individual and his/her family/guardian are central to the person-centered planning process. We believe the Transition Plan is clear on these points.

61. Comments were received regarding the use of the term “family-driven” as related to the development of the Life Plan. Some commenters stated that under Federal person-centered planning regulations, the only “driver” of a person-centered care plan is the individual.

Person-centered practices are a requirement for the CCO/HH and the individual who is receiving services is directing the planning process as much as possible. The State will review the plan and identify where clarification is needed, although it should be noted that other stakeholders commended use of the term “family-driven” in recognition that families often play a critical role in assisting the individual with the planning process.

Billing/Payment

- 62. Commenters asked the State to confirm that the most current rate methodologies in place at the time of the transition will remain in effect under the 1115 Waiver until there are publicly proposed amendments or the methodologies sunset with the implementation of managed care.**

The reimbursement methodologies under the 1915(c) Waiver will remain as is under the 1115 Waiver authority. DOH will continue to be responsible for HCBS reimbursement rates/fee schedules. Any future changes to provider reimbursement rates will be subject to appropriate public notice.

- 63. Several questions were raised regarding the payment tiers and asked when will individuals be assigned a tier, what is the frequency for which an individual's tier will be reevaluated and updated, and is there a mechanism available to challenge or appeal an enrollee's tier assignment?**

The payment tiers will be established by OPWDD based on the most recent enrollment and Developmental Disability Profile 2 (DDP2) data in the Tracking and Billing System (TABS). A roster will be developed monthly and CCO/HHs will first be informed of this in July 2018 to support the first CCO/HH claims to Medicaid.

- 64. Respondents asked how the unreimbursed costs incurred by individuals and/or their families for services from specialized providers that are not covered by the fee-for-service (FFS) system will be covered in the 1115 Waiver.**

While there is no expansion of service payments envisioned, we will work with individuals and families to maximize choice and flexibility under the 1115 Waiver.

- 65. Commenters asked when Care Managers would be expected to implement the Coordinated Assessment System (CAS) Tool and expressed hesitation regarding its use as the basis for acuity scores to determine tier levels and reimbursement rates.**

OPWDD has been working over the last several years to implement and collect strengths and needs-based information about individuals who receive services in the OPWDD system. The CAS is the new tool to complete these assessments. Scoring and tiering using the CAS continues to be a project under development. The CCO/HHs will ultimately be taking on the reassessment responsibility using the CAS and training will be undertaken to implement that new role.

Quality

66. Commenters questioned whether OPWDD or DOH will take the lead in the quality oversight of CCO/HHs?

OPWDD was created as an independent Cabinet level entity to develop and ensure high quality services for people with I/DD with a habilitative focus. OPWDD will continue to develop and set policy related to services provided to people with I/DD. DOH, as the lead Medicaid Agency, is responsible for oversight and monitoring of all Medicaid programs and will do so in collaboration with OPWDD. DOH and OPWDD will continue to work side-by-side and work collaboratively to designate and re-designate CCO/HHs and monitor and conduct site visits to confirm CCO/HHs' adherence to State and Federal legal, statutory and regulatory requirements. OPWDD and DOH have a long history of collaboration.

67. Respondents asked how the inclusion of OPWDD services under the 1115 Waiver will impact the existing differences between DOH and OPWDD regarding the information that is available to the public related to the inspection of facilities.

Current oversight requirements and quality standards for both OPWDD and DOH programs will remain in place with the transition to the 1115 authority. As described in page 14 of the Draft Transition Plan, for services under the jurisdiction of OPWDD, the current oversight, incident reporting requirements and quality standards for State and voluntary-operated State Plan and HCBS services will not change with the transition to the 1115 Waiver. Further, DOH responsibility and reporting related to nursing facility reviews will continue.

68. Respondents asked what the regulatory authority for incident reporting and monitoring is under the 1115 Waiver and to identify the responsibility of the CCO/HH for reporting and investigating incidents.

OPWDD and DOH are working to finalize CCO/HH standards and requirements related to incident reporting and monitoring. CCO/HHs must develop incident management and reporting policies and procedures using current OPWDD incident reporting requirements as guidance. For additional information and current OPWDD reporting guidance:

https://opwdd.ny.gov/opwdd_resources/incident_management/the_part_624_handbook.

69. Commenters questioned how services will continue to be provided if a CCO/HH's operating authority is revoked?

If an operating CCO/HH is not re-designated upon review, a plan to transition individuals to an alternative CCO/HH would be developed to ensure continuity of care for individuals served.

70. Commenters recommended that CCO/HHs be involved in developing the performance metrics.

OPWDD agrees that stakeholder input is essential to the short and long-term quality strategy of our agency. We continue to use the Developmental Disabilities Advisory Council and the Joint Advisory Council and other stakeholder groups to share developments around CCO/HH performance metrics, as well as long-term measures tied to a future value-based quality strategy.

71. Respondents asked how information regarding enrollee/representative satisfaction will be used in oversight activities, if oversight information will result in site visits, and if Quality Management Plans will be available to the public?

OPWDD will require the CCO/HHs to administer a short 5-7 item survey to individuals and their circle of supports as part of the care planning process. OPWDD's Division of Quality Improvement (DQI) also collects data on satisfaction through its oversight activities. DQI's Person Centered Review is conducted for a statewide random sample, all Willowbrook individuals and a sample of individuals selected by the Department of Health for Individualized Service Plan Reviews.

It is expected that the CCO/HH will have the capability to assess the quality of services and act to improve outcomes for individuals and families who receive CCO/HH services. CCO/HHs must provide timely, comprehensive, high quality Health Home services under the Health Home care management standards and requirements using the person-centered approach to care. To meet these requirements, CCO/HHs must maintain an environment that fosters continuous quality improvement strategies. This is achieved through implementation of a Quality Management Program (QMP), a system to monitor and objectively evaluate Health Home quality, efficiency, and effectiveness.

The State's administration of the Health Home program includes developing and monitoring quality and health outcomes measures, which have been modified to include measures that are specific to assessing quality outcomes of the I/DD population.

The CCO/HH will have a QMP Chair and Coordinator who will manage the QMP Committee that must include representation from other entities that serve the Health Home population. CCO/HHs must obtain feedback from members and family members and apply their input into QMP processes.

The existing Health Home policies are being evaluated to determine how they will be modified to reflect the initiation of CCO/HH services. Additional information regarding existing policies are available at the following site:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/index.htm

Basic HCBS Plan Support (formally referred to as “HCBS Care Management”)

72. Respondent asked how individuals will be enrolled in Basic HCBS Plan Support.

For an individual who chooses not to receive comprehensive Care Management through the CCO/HH, the CCO/HH Care Manager will be responsible for enrolling the individual in Basic HCBS Plan Support. Attachment B in the Draft Transition Plan outlines the standards and requirements for Basic HCBS Plan Support.

73. Many respondents requested that the State clearly define and explain Basic HCBS Plan Support and asked how the State will ensure that individuals who opt to receive this service will not be discriminated against.

During the CCO/HH enrollment process, an individual and his/her family/guardian will receive information and make an informed decision about which Care Management service, both offered by the CCO/HH, is most appropriate for him/her; this decision will be respected by the CCO/HH and Care Manager. The education and outreach process will also require the Care Manager to clearly explain that the decision to receive Basic HCBS Plan Support does not preclude an individual from mandatory managed care enrollment in the future. Individuals choosing not to receive comprehensive CCO/HH Care Management will receive Basic HCBS Plan Support from a Care Manager employed by the CCO/HH.

74. Commenters asked if the IRA is expected to coordinate medical appointments through the CCO/HH for individuals who receive Basic HCBS Plan Support?

The IRA will continue to have responsibility for day-to-day oversight of Residential Habilitation services for people they serve, including those services identified in NYCRR 635-10.4(b)(1)(c)4:

“... coordination of individuals’ health care services, including, but not limited to, arranging for needed medical appointments and diagnostic testing, interfacing on behalf of individuals with community-based healthcare providers, and ensuring that treatments are carried out in accordance with physicians’ orders. The CCO/HH payment tier reflects the fact that residential staff continue to have these responsibilities.”

For people receiving IRA Residential Habilitation, the CCO/HH Care Manager will collaborate with the individual and family/representatives to establish and maintain the individual’s comprehensive Life Plan. The CCO/HH will assist the Residential staff and support the individual’s access to needed services and coordination among providers to ensure coordination of care among providers.

Timelines

- 75. Many commenters asked if the 1115 Waiver could become effective prior to the CCO/HHs launching? If so, what is the State's plan to provide service coordination and how will it be paid for?**

The State's goal is for the 1115 Waiver and the Health Home State Plan Amendment, which will authorize CCO/HHs, to be approved as concurrently as possible by CMS for implementation on July 1, 2018.

- 76. Questions arose related to the impact on implementation if a CCO/HH in a given region is not deemed ready to deliver services by July 1, 2018.**

The timeframe for the initial designation of CCO/HH is February 28, 2018. Readiness and preparatory activities will begin following initial approval. At this juncture, OPWDD anticipates that there will be a choice of at least two (2) CCO/HHs in every region. A readiness review will be conducted prior to the July 1, 2018 to assure that all CCO/HHs are prepared for operation.

- 77. The Federal government will provide a higher percentage of Federal Financial Participation for the initial eight quarters of Health Home Services. Respondents asked how the additional Federal Financial Participation would be affected if the roll out of CCO/HH services do not occur simultaneously in all regions of the State?**

The State is currently anticipating CCO/HHs will be implemented Statewide on July 1, 2018. Deviation from a Statewide rollout may result in lower Federal participation. However, the State is working with CMS to provide as much flexibility as possible to ensure that readiness activities and the roll-out schedule of CCO/HH services maximizes the higher percentage of Federal participation. The State will keep stakeholders apprised of those discussions.

- 78. A commenter questioned the feasibility of completing the Health Home Services Checklist within a three-month time span.**

The State agrees and will amend the timeframe for completing the checklist. The checklist, which identifies the new expanded services available under the CCO/HH model may be completed between April 1, 2018 and July 31, 2018. OPWDD and DOH will conduct trainings for MSCs on the CCO/HH Services Checklist in the upcoming months.

This process is essential to the successful delivery of CCO/HH core services and will confirm continuity of care and identify additional areas for needed services. The checklist must be completed in partnership with the CCO/HH and the individual and his/her designated representative, in either a face-to-face meeting or telephone conversation. Based on stakeholder feedback, the checklist has been modified to include a signature of the individual, family member or representative.

79. Commenters stated that timelines associated with developing the Life Plan are not feasible to complete and suggested that the timing be aligned with individual's ISP renewal.

The State agrees and the Transition Plan timeframe for completion of the initial Life Plan is extended up to twelve (12) months from the start of CCO/HH services, subject to the provisions described below. For most people, the Life Plan will be implemented using the individual's regularly occurring cycle of ISP meetings. Using the existing schedule will reduce the immediate workload and allow for a smoother transition. The draft Transition Plan had initially allowed a six-month window.

Today, the ISP is reviewed at least twice annually with the "annual review meeting" occurring at a face-to-face meeting with the individual and family, major service providers, and others that the individual selects. With the allowed extension, the development of an initial Life Plan will, in most cases, follow the individual's established schedule for annual care planning meetings. The schedule for completing the initial Life Plan for individuals who transition to CCO/HH services from MSC or PCSS is as follows:

- For individuals in Tier 4, the highest payment Tier, the Life Plan must be completed at the next review meeting, but no later than December 30, 2018 (six (6) months following the July 1, 2018 start of CCO/HH services).
- For Individuals in Tier 1, 2 or 3, the Life Plan must be completed at the next "annual" review meeting, but no later than June 30, 2019 (twelve (12) months following the July 1, 2018 start of CCO/HH services).

For all CCO/HH enrollees, the initial Life Plan development must occur earlier than the above schedule if there is a significant change in the needs of the individual or if requested by the individual or family. For individuals who enroll into CCO/HH services after July 1, 2018 and have not received MSC or PCSS, the initial Life Plan must be completed within 60-days of CCO/HH enrollment.

Prior to the completion of the initial Life Plan, the checklist and enrollment documents serve as the "addendum" to the ISP identifying the new entity for Care Coordination.

80. Additionally, commenters expressed concerns that the workforce transition from MSC Service Coordinator to Care Manager is too brief, noting that the training schedule is very compressed. These respondents felt that because the outreach and education to families relies heavily upon the Care Manager that these timelines should be reevaluated to eliminate some stress.

The transition period for MSC Service Coordinator to Care Managers is beginning currently with MSC informational sessions conducted by OPWDD. Those sessions will continue through July. As CCO/HHs begin their readiness, there will also be training that is required for MSCs before July 1, 2018 on areas that are needed for day one operations. Other training will be part of the on-going need for professional development. The February 14, 2018 MSC Webinar will provide an overview of this training. See the following link:

https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/msc_webinars

MSC Service Coordinators already have much of the required foundation for person-centered support coordination. CCO/HHs will have one (1) year to provide any additional training that is needed for MSCs as they transition into the Care Manager role. OPWDD and CCO/HHs are also taking an active role in educating individuals, families, and other stakeholders.

Phase II & III - Voluntary and Mandatory Managed Care Enrollment

General

- 81. A commenter asked that the Transition Plan be expanded to further describe what specific medical services would be available under the Specialized Managed Care Plans.**

The medical and health care services included in the Specialized Managed Care Plans for I/DD will be comprehensive and include most services that are currently included in the Medicaid State Plan. The benefit package will align with services available from mainstream Medicaid Mainstream Managed Care Plans, which currently include:

- **Hospital Care**
 - inpatient care
 - outpatient care
 - lab, x-ray, other tests
- **Emergency Care**
- **Primary and Specialty Care**
 - Includes the services of other practitioners, including occupational, physical and speech therapist
 - audiologists
 - midwives
 - cardiac rehabilitation
 - Podiatrists if you are diabetic
- **Residential Health Care Facility Care (Nursing Home)** which includes short term, or rehab, stays and long-term care
- **Behavioral Health Care Services** which includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services.
- **Other Covered Services**
 - Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics/eye care/ pharmacy
- **Dental Care** - services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care

The above benefits are based on an individual having “Medicaid Only.” There are differences in the services that are provided by a Managed Care Plan if the individual has other Health Care Coverage (see questions 86 and 87).

82. Respondents asked the State to provide more detail on how Specialized Managed Care Plans would provide medical services to individuals with I/DD and expressed concern about the availability of Medicaid doctors, especially specialists.

NYS experience in the implementation of Medicaid Managed Care has shown that provider availability, including specialists, is greatly increased over fee-for-service (FFS) availability. OPWDD is confident this will be the case in the Specialized Managed Care Plans. Potential Specialized Plan 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.

A Qualification Document is the application that an entity will submit to NYS to become a Specialized Managed Care Plan. As with the approval of any new Managed Care Plan, the Qualification Document will request detailed information regarding the applicant's proposal for service provision. The Specialized Managed Care Plan applicant must also submit a provider network that identifies all the providers that have agreed to work with the plan. The State will review the provider network to ensure there is adequate choice of provider and regional coverage. In addition, because the Managed Care Plan authorizes and pays for services directly, there are administrative efficiencies that result in more responsive service access.

When individuals and families are selecting a Managed Care Plan, they will have assistance from Medicaid Choice (the independent Medicaid enrollment broker). Medicaid Choice can answer questions about the providers associated with each plan.

83. Commenters asked how Direct Support Professional (DSP) staffing shortages will be addressed in managed care.

The State's review of Managed Care Plan applications will include the availability of all service providers, including Habilitation and Personal Care providers to deliver services for CCO/HH enrollees. Managed care can influence labor force dynamics by offering financial rewards to providers for effectively and efficiently organizing and retaining staff to deliver valued services. The use of VBP strategies in managed care can reward plan performance in ways that are important to individuals and families. Although the VBP strategy is under development, access to services and available staffing is likely to be an outcome that will be included in this strategy. Plans and providers will decide how to implement program changes to achieve the valued outcome; it might be through wages or other Human Resource benefits that will expand available staffing. Ultimately, when savings are generated through managed care, it is anticipated that these savings can and will be reinvested and used for DSP salary enhancements.

- 84. Respondents noted that the clinically defined managed care approach does not align well with the support delivery process for people with I/DD because they feel that managed care is rationed care.**

The purpose of developing a Specialized Managed Plan is to ensure that plan leadership and staff understand the needs and tradition of person-centered planning associated with the I/DD community. Managed care provides additional opportunities to improve enrollee access to high quality care services. The Specialized Managed Plan will be expected to assure the right level of services and supports is offered at the right time, and alter the package of services and supports an individual receives based on his/her changing needs. These Specialized Managed Plans will direct any potential savings to expansion of long-term care and Habilitation services. How resources are redirected toward service expansion will be evaluated based on required cost reporting.

- 85. Commenters noted that the Transition Plan failed to clearly define or identify excluded and exempt individuals. Clarification was requested.**

Within managed care, an individual is “excluded” if they cannot enroll into a Managed Care Plan, even if they would like to enroll. Examples include: individuals residing in a NYS operated psychiatric center.

Exempt status allows individuals to enroll in managed care if they wish, however they will not be mandated to enroll into a Plan. An example of exempt status includes Native Americans.

OPWDD is working closely with DOH to align systems and policies that will ensure compliance with the exclusions and exemptions policies in place at the time of managed care roll-out for the I/DD population.

- 86. Respondents stated that the Transition Plan does not identify the options available to dual Medicare Medicaid participants under the Medicaid Managed Care Plans and questioned whether such individuals would be free to continue to utilize medical services covered by Medicare even though similar services may or may not be available under the Managed Care Plan?**

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

- Receive their Medicare acute health benefits through traditional FFS Medicare, and enroll in the Specialized Managed Care Plan for coverage of those services that are only covered by Medicaid – including HCBS services; or
- Receive their Medicare acute health benefits through a Medicare Advantage product and enroll in the Specialized Managed Care Plan for coverage of those services that are only covered by Medicaid – including HCBS services.

- Alternatively, these individuals may enroll in a Dual Advantage product that offers all Medicare and Medicaid benefits through one plan (e.g., the Fully Integrated Duals Advantage for Individuals with I/DD (FIDA-IDD)).

The Transition Plan will be updated to reflect these options.

87. Clarification was requested regarding individuals with Third Party Health Insurance/TPHI (typically employment-based health insurance) during the implementation of managed care for the I/DD population.

Individuals with comprehensive TPHI are excluded from enrollment in a Managed Care Plan with a benefit package that includes medical services covered by the TPHI. Exclusions currently in place for those individuals with TPHI will continue for the I/DD managed care program. However, the State is developing an option for individuals with TPHI to enroll in the Specialized Managed Care Plan for coverage of Medicaid-only benefits inclusive of HCBS services. OPWDD is working closely with DOH to align systems and policies that will ensure compliance with the exclusions and exemptions policies in place at the time of managed care roll-out for the I/DD population.

88. Commenters questioned the for-profit Managed Care Plan structure expressing concern that a for-profit entity may not incentivize care to individuals and recommended that the Specialized Managed Care Plans be not-for-profits.

The development of Specialized Managed Care Plans is designed to support the development of Plans with leadership provided by not-for-profit organizations with a history of commitment and service delivery to the I/DD community. There are other protections in place to assure that funding is directed to services. Federal rules set limits on the percentage of revenue used for services to the individual, rather than for other items such as administrative expenses or profit.

Further, there are individual protections related to access and choice of plan. Anyone who is eligible to enroll in a Specialized Managed Care Plans and wishes to enroll, regardless of his/her level of need, will be enrolled in the Plan they choose. A Specialized Managed Care Plan will not be able to dis-enroll an individual based on the cost of their services.

89. Respondents recommended that OPWDD and DOH allow individuals to obtain necessary services from out-of-network providers when an in-network provider is not available, based on concerns that an individual's choice may be limited.

There are Federal and State rules that require Managed Care Plans to allow enrollees access to out-of-network providers when their needs cannot be met by a participating provider. OPWDD will be reviewing the current policies to ensure that they are appropriate for I/DD individuals. NYS experience in the implementation of managed care has shown that provider availability, including specialists, is greatly increased over FFS availability.

- 90. Many commenters asked OPWDD to expand on the individuals with I/DD already enrolled in managed care requesting to know their characteristics and what type of services they are receiving.**

Approximately 26,000 individuals with I/DD are currently enrolled in Medicaid Managed Care (24,500 in mainstream, 1,500 in the Health and Recovery Plan/Behavioral Health (HARP)). Of those in mainstream plans, approximately 35% are in NYC and 65% are in the rest of the state. 60% are under age 21, 40% are 21-59, and less than 1% are over age 60. Approximately 54% of mainstream enrollees are also enrolled in OPWDD HCBS waiver. The benefit package is the mainstream managed care benefit package and is available at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf. OPWDD services are currently covered by FFS, except for the FIDA-IDD.

- 91. The State received inquiries regarding the mechanism for Mainstream Managed Care Plans to contract with CCO/HHs and HCBS providers and asked if the State will provide a boiler-plate contract that the Mainstream Managed Care Plans and CCO/HHs can utilize to effectuate the relationship?**

OPWDD, in consultation with DOH, will develop guidelines for CCO/HHs to contract and enter into agreements with Managed Care Plans.

- 92. Commenters stated that the Transition Plan should specify that all medical providers for Managed Care Plans must comply with the Americans with Disabilities Act (ADA) as legally required to.**

The Transition Plan will be amended to state that all medical providers for the Managed Care Plans must comply with the ADA, as required by law.

- 93. Many commenters asked OPWDD to define “Upstate” vs. “Downstate”.**

For ease of understanding, the 1115 Application refers to a planned roll-out of Specialized Managed Care operations beginning in the “Downstate area.” This assumption is since there are already comprehensive managed care options that serve the I/DD population in the Long Island, New York City and lower Hudson Valley area. Specialized Managed Care Plans will need to identify the counties in which they intend to operate in their application. The actual establishment of new Specialized Managed Care Plans will be based on the State’s assessment that Plans are ready to operate counties, so the exact definition of counties in the “Downstate” area has yet to be determined.

Outreach & Education

- 94. Commenters requested clarification on allowable partnerships between a CCO/HH and insurance entity.**

It is anticipated that some CCO/HHs will develop the capacity and transition from the provision of CCO/HH Care Management to become a Specialized Managed Care Plan. During the voluntary enrollment phase, current CCO/HHs will be expected to enter into Administrative Service Agreements with Managed Care Plans to provide Care Management to individuals with I/DD who opt to participate in managed care.

- 95. Commenters reported that there was a lack of information regarding how managed care approaches already taken with other Medicaid populations will be applied to individuals with I/DD long term services and supports.**

The experiences encountered during the recent years' integration of additional populations and specialized benefits will continue to be carefully considered when developing a detailed implementation strategy for enrollment of the I/DD population into managed care. OPWDD is working closely with DOH in this program development to ensure success.

- 96. Many respondents recommended convening a small workgroup of individuals, family members, advocates and CCO/HH representatives to discuss the development of VBP methodologies.**

The OPWDD Acting Commissioner is formulating a small group to discuss this issue and make recommendations.

Managed Care Enrollment

- 97. Commenters questioned how the State will track voluntary enrollment.**

Enrollment will be supported by the current independent Medicaid enrollment broker (Medicaid Choice) and will be tracked through the State's enrollment systems and in the OPWDD TABS system.

- 98. Commenters questioned whether the option of two (2) Managed Care programs in any given region truly reflects the person-centered principles guiding this transition.**

Person-centered principles emphasize the ability for the individual to choose what they believe is best for themselves. Having a choice between Managed Care Plans and the choice of providers and Care Managers within those plans provides this.

- 99. A few commenters requested information regarding the State’s approved auto-assigned algorithm, and if it is publicly available. What are the inputs beyond “geographical accessibility and the plan’s affiliation”? How will the proposed process of “auto-assignment” work?**

The State’s approved auto assignment algorithm may be found in the following document: https://www.health.ny.gov/health_care/managed_care/mco/app4-4.pdf. During the voluntary enrollment period, the algorithm will not be used for assignment of individuals with I/DD to Managed Care Plans. Prior to the initiation of mandatory enrollment in 2022, the State will develop a tailored approach for assigning individuals with I/DD to Managed Care Plans if a choice is not made within the allotted time frames.

- 100. Other commenters acknowledged the Transition Plans lacks inclusion of Individuals Residing in Developmental Centers (DCs) phasing into managed care.**

There are two institutional benefits that are “carved out” of the managed care benefit due to the highly-specialized nature of services, high-cost, and limited capacity. These institutional services are DCs and Specialty Hospitals. Enrollees in these settings are excluded from managed care enrollment. There are currently 223 individuals residing in DCs statewide. DCs are large, campus-based Intermediate Care Facilities (ICF/IIDs) operated by NYS (i.e., DC staff are NYS employees). Specialty Hospitals are operated by not-for-profit agencies and provide specialized comprehensive and nursing care for individuals with I/DD and complex medical and/or neurological conditions. There are currently 54 opportunities statewide. Individuals residing in community-based ICFs will be allowed to voluntarily enroll in a Managed Care Plan during the voluntary phase and will be included in the eligible population during the mandatory phase. Community-based ICFs are OPWDD-certified group homes operated by both OPWDD and by not-for-profit agencies.

- 101. Commenters asked if people can enroll in a Specialized Managed Care Plan if they need support with decision making and guardianship is not established?**

OPWDD is developing regulations which will address a supported enrollment process where needed.

Managed Care Benefits

- 102. Respondents expressed concerns with the contracts between Managed Care Plans and residential providers as the current financial proposal may monetarily reward plans for individuals choosing to live in certified settings over community settings which is a violation of Olmstead.**

There is no inherent bias toward the provision of certified residential placements within managed care.

103. Commenters questioned the circumstances that individuals with I/DD will be allowed to dis-enroll or change Managed Care Plans.

During the voluntary enrollment phase, individuals may contact the State's enrollment broker and request disenrollment at any time. When subject to mandatory enrollment, the model contract includes an explanation of when individuals may be permitted to dis-enroll. Individuals will be able to transfer to another plan, within the monthly enrollment framework, at any time. See the current model contract Appendix H at https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf.

104. Respondents asked if Consumer Directed Personal Assistance Program (CDPAP) and skilled nursing will continue in managed care?

Consumer Directed Personal Assistance Program (CDPAP) and skilled nursing will continue in managed care.

105. The State received comments indicating that social transportation and Medicaid Cab services are not addressed as a service in the Transition Plan.

The benefit package will include State Plan services. Social Transportation, as included in CFCO, has not yet been implemented. Medical Transportation will be implemented within managed care in the same manner as mainstream managed care. Currently, this service is not generally covered by the plans, but through DOH approved regional transportation entities.

106. Commenters asked if individuals enrolled in managed care will continue to be eligible for services provided by Local Department of Social Services (LDSS)?

Non-Medicaid services provided by the LDSS will continue to be available upon implementation of managed care.

Eligibility/Enrollment –

107. Commenters questioned what prevents CCO/HHs from erroneously asserting that a Managed Care Plan is a more adequate service provider for the specialized services required for the I/DD population.

The CCO/HHs will not be making the determinations of network adequacy for mainstream or Specialized Managed Care Plans. Nor will the CCO/HH be empowered to make enrollment decisions for individuals.

108. Respondents asked the State to clarify the role of the DDROs in a managed care environment.

The DDROs will continue to be responsible for establishing an individual's eligibility for OPWDD services and to operate the "Front Door" to assist individuals and families with understanding and accessing OPWDD service system. DDROs will remain an important link for individuals, families and other stakeholders regarding regional service opportunities.

Billing & Payment

109. Commenters requested more detail on the reimbursement rates for providers of existing HCBS services after an individual is enrolled in managed care.

OPWDD, in consultation with DOH, will develop guidelines for contracting with I/DD specialized providers, which will be made available once developed and approved. These guidelines will require Managed Care Plans to contract with providers currently serving individuals receiving OPWDD services, which are in statute and described in the Transition Plan. These safeguards establish lengthy timeframes for the payments to OPWDD providers to be made at rates established by the State. The State will provide boilerplate provider contract guidelines, and will be encouraging the Managed Care Plans, as well as providers, to enter contracts to ensure the availability of OPWDD specialized services.

110. Respondents suggested that managed care rates based on FFS structure will not support the full costs of a Managed Care Plan's functions.

The payments to Managed Care Plans will be developed using data and cost reports across the spectrum of services provided to the I/DD population. Federal regulations require that rates be actuarially sound and must be certified as such.

111. Many commenters asked if there will be adjustments to the reserve requirements or if additional funds will be provided to CCO/HHs that want to become early adopters.

Managed Care Plans are required to meet certain capital requirements and hold a certain amount of funds in reserve to cover the costs of any unexpected service costs for enrollees. OPWDD and DOH are assessing whether reserve requirements may be adjusted for Specialized Managed Care Plans given the duration and cost of certain OPWDD services.

112. Respondents asked OPWDD to provide information on how a capitation rate developed for an individual is accounted for by the Managed Care Plans to ensure that the rate provided for that individual is applied specifically for the benefit of that individual.

The managed care payment is developed based on the historic cost of services provision for groups of people. The Managed Care Plan receives a monthly payment for each individual (called a PMPM or per member per month) payment. It is the Plan's responsibility to use the funds it receives to meet the needs of all individual. The Plan cannot limit an individual's services to cost less than the PMPM, nor is it required to spend the full value of the PMPM on an individual's services if those services are not needed. Within managed care, individuals have extensive protections if they feel that services are not sufficient.

Federal statutes require that Medicaid payments be consistent with efficiency, economy, and quality; avoid payment for unnecessary utilization; and are sufficient to enlist enough providers (§1902(a)(30)(A) of the Social Security Act). In addition, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) added the requirement that capitation payments to risk-based Managed Care Plans be made on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Act). These are all important protections that ensure funds are directed to needed services.

113. Commenters questioned what participation, if any, the service recipient is entitled to in the provider's decision to participate in "advanced level VBP strategies" at an earlier date.

A service recipient has free choice of provider, but does not have the right to determine whether a provider participates in a VBP arrangement or at what level it participates.

114. Questions submitted requested clarification on which entity bears the risk of the cost of services not available within the Specialized Managed Care Plan.

As with current Managed Care policy, if a benefit is included in the Specialized Managed Care Plan's benefit package, the Plan must ensure access to that service. This would include coverage of, and payment for, covered services that the Plan does not have an available provider, as well as emergency services (within the United States or its territories).

115. What happens if an emergency service is needed and it is not included in an individual's Life Plan?

The emergency needs of an individual must always be met, even if the emergency service provided is not included in an individual's Life Plan. Following the provision of the emergency service, the Life Plan may need to be adjusted based on an individual's new needs. For example, if an individual breaks his/her arm and needs emergency room (ER) services, the ER services must be provided. The Life Plan

may later be adjusted, if the individual now needs additional support because of the broken arm.

116. Commenters questioned which entity will be responsible for the resulting charges in the case of a wrongful or erroneous denial of services.

If a Plan makes a wrongful or erroneous denial of services as determined by the DOH, OPWDD or a Fair Hearing, the Plan is responsible for payment.

Managed Care Quality

117. Commenters asked if a baseline and/or benchmarks have been established to measure the rate of success of the early phases of the transition for which the trajectory to full managed care implementation will be based.

This is currently being developed and finalized. As stated in the Draft Transition Plan, additional details will be provided on Phase 2 activities when available.

118. It was noted that the Quality Review of Managed Care section on page 38 fails to include the views and opinions of those individuals with I/DD utilizing the program. A suggestion was made that after the 90 days following the July 1, 2018 effective date and subsequent resubmission of the State's Quality Strategy to CMS, there should be an ongoing public comment period, rather than a 30-day period.

The State's current Quality Strategy does include the views and opinions of managed care enrollees. OPWDD has many ways to engage with stakeholders both formally and informally, and these avenues for communication will remain in place. To proceed with the implementation of the Quality Strategy the public comment period cannot extend indefinitely. However, the Quality process is ongoing and the Quality Strategy is reevaluated and updated annually. As such, there is opportunity to adjust future iterations of the Quality Strategy based on the on-going dialogue of stakeholders with OPWDD and DOH.

119. Commenters also asked OPWDD to describe what safeguards will be put in place to prevent an unscrupulous operator from taking advantage of the program for personal financial gain.

Prior to Managed Care Plan certification and/or Medicaid provider enrollment, DOH conducts program integrity checks. Managed Care Plans and affiliated networks are subject to robust oversight, as are all Medicaid providers. The Office of the Medicaid Inspector General (OMIG), DOH, and OPWDD will have oversight roles in addition to Federal authorities. Managed Care Plans also will conduct internal fiscal oversight and monitoring of the services provided to its beneficiaries by network providers.

120. Commenters requested clarification on the role NYS entities will have and what role Managed Care Plans will have in ensuring financial integrity and compliance?

Quality and fiscal oversight directed at the integrity of Medicaid claims is a shared responsibility of the provider, the Managed Care Plan and the State. In New York State, Managed Care Plans are required to establish a Special Unit charged with the prevention, detection, and investigation of fraud and abuse. Larger Managed Care Plans (over 10,000 enrollees) must also have a fraud and abuse prevention and detection plan (Compliance Plan).

The Special Unit makes sure that the Managed Care Plan does not pay claims for services rendered by ineligible providers. On a monthly basis, the Managed Care Plan must check their active network of providers against Office of the Medicaid State's excluded provider list as well as various other federal and State databases.

As we proceed with the implementation of managed care, we will have the opportunity to examine how the role of OPWDD billing and claiming reviews can be streamlined and coordinated with the activities of Managed Care Plans. OPWDD will work with the Office of the Medicaid Inspector General (OMIG) to ensure there is a coordinate approach to fiscal integrity with the advent of managed care for people with I/DD.

121. Respondents asked who completes the desk reviews and on-site readiness reviews of Managed Care Plans and urged the combination of OPWDD and the Office of Mental Health (OMH) systems with clinical and program experts to assess competency and evaluate the needs and determine resource allocation with care for individuals with complex needs.

DOH and OPWDD will convene teams to do both desk and on-site reviews for the applicants to be Specialized Managed Care Plans. We will assess the applicability of OMH as a team member or resource when needed.

122. Commenters requested additional information regarding the performance monitoring metrics with respect to the Managed Care Plans relating to the long-term supports and services provided?

This policy is in development and will be released when available.

123. Questions were raised regarding whether the CCO/HHs and HCBS providers will be audited by the Managed Care Plan and not by NYS once the full conversion occurs?

Providers in managed care environments will be subject to audit by Federal and State regulatory authorities, as well as Managed Care Plans.

124. A commenter asked what organization will the External Quality Review Organization (EQRO) be and how familiar they will be with the I/DD population? Will the EQRO collect data from consumers? Commenters stated it is not sufficient to give consumers surveys alone.

The External Quality Review Organization (EQRO) that is currently under contract with DOH will be the EQRO for the Specialized Managed Care Plans for the I/DD population. OPWDD will be working to ensure that the EQRO has the information and tools available to become fully aware of the specialized needs and care patterns of the I/DD population that will be enrolled in managed care.

125. Respondents requested more details on grievance/appeals procedures and mechanisms in Managed Care.

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

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

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

https://www.health.ny.gov/health_care/managed_care/complaints/

126. A commenter requested detailed information regarding managed care operations, transparency, accountability, safeguards/protections, the proposed capitation program, and medical care.

OPWDD is committed to working with stakeholders, including individuals and families as well as providers, to ensure transparency in the development and implementation of this transition. NYS has over 30 years' experience in providing managed care to the Medicaid population, including populations with special needs. More information regarding the program and how it works may be found at

https://www.health.ny.gov/health_care/managed_care/index.htm.

NYS has a Quality Strategy that outlines how Managed Care Plans are assessed and it is available publicly at:

https://www.health.ny.gov/health_care/managed_care/docs/quality_strategy.pdf.

The State also provides information on how Managed Care Plans perform. The New York State Managed Care Plan Performance Report provides clear, easy-to-read information on primary and preventive health visits, access to health care, and medical management of select chronic diseases. Information from a consumer satisfaction survey tells you what consumers think of their Managed Care Plan and

the quality of the services they received over the last year. The current reporting is available at: https://www.health.ny.gov/health_care/managed_care/reports/eqarr/.

- 127. It was recommended that OPWDD and DOH establish a procedure by which all decisions by Managed Care Plans involving termination or reduction of any services, will be reviewed by OPWDD and/or DOH *before* those decisions are issued. Decisions without a legally and factually acceptable basis must be rejected and the plans must be instructed to correct them.**

In the Plan qualification approval process, Plans are required to detail service approval and denial protocols and are required to follow strict notification guidelines as established by Federal and State law and regulations. Extensive monitoring and follow-up is included in State oversight of this policy area. The State does not intend, at this time, to review all denials prior to Plans determinations.

- 128. A commenter requested clarification on the impact of the Part 633 and 636 Regulations and if they will be modified when State moves to Managed Care.**

The current Part 633 regulatory provisions now in place for programs or services licensed or certified by OPWDD will continue for OPWDD-certified or licensed services that are reimbursed within a Managed Care Plan. The requirements for Person-Centered Planning contained in Part 636 will be incorporated into CCO/HH policy requirements and will also be required of Specialized Managed Care Plans.

- 129. Commenters stated that the current Ombudsman program has not been able to keep up or handle grievances or complaints, nor is it independent since it is funded by the DOH.**

While the Ombudsman program is funded by DOH, it is comprised of a group of nonprofit advocacy organizations, independent of DOH or any health insurance plan. Our goal is to ensure robust advocacy and we will work to ensure sufficient means for individuals and families to address issues. You may find more information at: https://www.health.ny.gov/health_care/medicaid/redesign/fida/ican.htm and <http://icannys.org/>.

- 130. Commenters stated that the Independent Consumer Advocacy Network (ICAN) has one specialized counselor assisting people with I/DD which is not enough and expressed frustration that additional options are not available.**

Currently, the Ombudsman works with the I/DD individuals enrolled in the FIDA-IDD only and, therefore, does not require extensive staffing. OPWDD will work with DOH to ensure that there are adequate resources available through ICAN for implementation and enrollment into Managed Care statewide.

- 131. Respondents cited an Office of Inspector General (OIG) report that recently identified that person-centered planning was not adequate in Managed Long-Term Care plans.**

OPWDD, in developing the Specialized Managed Care Plan Qualification Document, will ensure that person-centered planning is integral to the Care Management for the I/DD population and will monitor such.

Timelines

- 132. Commenters asked why one timeline indicates that a readiness review of Specialized Managed Care Plans will be in the spring of 2018, yet on page 31, the timeline indicates that voluntary enrollment in these plans won't begin until sometime in 2019.**

Plans will be expected to contract with a full complement of medical and OPWDD specialized providers to ensure capacity to serve the I/DD population. The Transition Plan will be amended to reflect the correct date of Spring 2019.

- 133. Multiple respondents felt that the planning and testing period for the implementation of managed care is inadequate and noted that there was a lack of detail regarding implementation of managed care.**

The process as outlined in the Draft Transition Plan includes a phased approach. The early phases are detailed in the plan, while later phases including managed care roll-out, will be released as details are developed and approved. OPWDD is committed to stakeholder involvement throughout the transition period. Page 40 of the Draft Transition Plan identifies the anticipated public comment periods for key documents related to the operations of Specialized Managed Care Plans.

OPWDD has been working closely with DOH, and will be working closely with CMS to ensure that timeframes are developed and manageable to ensure success with the implementation of the phased approach as outlined in the Draft Transition Plan.

- 134. Many commenters expressed a lack of support for the two-year transition period for mandatory enrollment to include residential services in the capitation rate. These commenters asked if OPWDD will consider establishing a care collaboration model, as OMH did, to look at implementation of VBP and potentially create pilot opportunities.**

The roll-out of Managed Care includes a period of voluntary enrollment followed by mandatory enrollment. We are reviewing options for risk-sharing by service type and key information will be forthcoming.

135. There were requests for information regarding the timing of the release of the Qualification Document for Specialized Managed Care Plan Applicants and if the plans be staffed with a full complement of medical specialists?

The Qualification Document will be released in August 2018 for public comment. The OPWDD Managed Care Transition Policy & Related Guidance will be published in Draft for Public Comment in January 2019. The later document is a more detailed document that will outline the operational requirements of the Specialized Managed Care Plans.

Attachment A

136. The State received many questions and recommendations related to Attachment A – Health Home Checklist, such as the inclusion of a space for the individual/family to sign confirming they reviewed the final document and how Care Managers will be trained to complete this checklist?

A signature line for the individual/family will be added to the CCO/HH Services Checklist. Trainings for Medicaid Service Coordinators on the CCO/HH Services Checklist and the enrollment process will begin in February 2018. As outlined in Attachment B, it is the responsibility of the CCO/HH to provide training on the CCO/HH core services. CCO/HHs must ensure Care Managers are trained in skill building areas and on the requirements for developing care plans that include HCBS and State Plan Services.

Attachment B

137. The State was asked to provide clear, understandable guidance regarding Health Home Care Management and Basic HCBS Plan Support.

OPWDD is working on clear, easy to understand letters and brochures that will be shared with stakeholders. These materials will outline the two service options, and will be translated into commonly used languages, other than English.

Attachment C

138. A commenter noted that many of these trainings should also be made available to Family Support Services Councils, family-based organizations, and peer-to-peer services as a communication strategy in support of well-informed individuals, families and representatives.

Many Care Coordination education and informational sessions are already on the agency's website, and available to Family Support Services Councils. Individuals, family members or stakeholder organization looking to learn more about the transition

to Care Coordination can view recorded informational sessions or download materials they are interested in learning more about. They can also sign-up on the web to “Join the Conversation” to receive information directly. Additionally, the website is continually being updated as more information is made available.

Attachment E

- 139. Commenters expressed concern that the current Life Plan format does not have all the elements required to address the needs of people in communities – thus, recommending that the current Life Plan template be modified to accommodate the needs of all potential enrollees. Respondents further stated that the Life Plan does not address the issues of need versus availability of services.**

The Life Plan is designed as a comprehensive plan that can identify the desired outcomes, strengths, interests and goals of the individual receiving services in any setting where they receive support.

There are similarities between the Life Plan and the current ISP but the Life Plan has some critical differences. OPWDD is conducting an information session on the Life Plan that will explain the differences more comprehensively. The Life Plan does not identify whether desired services are available, although there is a section of the electronic care planning system that can capture discussion among the care planning team.

- 140. Commenters noted that Life Plans are developed using integrated IT that allows for prompt real-time notification regarding any changes to the individual’s plan, to those providers in the individual’s network. Does sending and receiving notifications through an Electronic Health Record (EHR) portal meet this requirement?**

The sharing of real time comprehensive data will be developing over time and is not a “day one” requirement. The use of the portal will serve as the first step and initial requirement to promote enhanced communication. As Life Plans are completed and IT interfaces with service providers, the sharing of more detailed data/information will be achieved.