

Introduction

On June 30, 2017, the NYS Department of Health (NYSDOH) and the Office for People With Developmental Disabilities (OPWDD) published the Application for Care Coordination Organizations to serve as Health Homes specialized for individuals with intellectual and/or developmental disabilities (I/DD). Throughout this document, the Care Coordination Organization/Health Homes will be referred to as “CCO/HH”. The comment for this Application period closed on August 11, 2017, and over 95 individuals and organizations submitted comments. This document provides responses to public comments, organized by topic area, and describes the major changes made to the Application because of the public review. The updated Application is available at:

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

Major Changes to Application Based on Public Comment

The State appreciates the thoughtful comments submitted by numerous individuals and organizations. Many clarifying changes were made to the Application, based on those comments, including:

- Clarifying that CCO/HH standards and requirements that will be developed by the State and in accordance with the provisions of Part I will include individual protections and other requirements related to the provision of care management and person-centered planning that are now included in current OPWDD regulations.
- Reinforcing that the current regulatory requirements of OPWDD governing person-centered planning are consistent with the person-centered care planning requirements of the CCO/HH model. These include the requirement that the individual and their family and/or representative are at the center of all planning and must approve the Life Plan, as it is developed.
- Requiring the CCO/HH to create an individual and family advisory body formed by the CCO/HH as a representative council made up of individuals receiving services and their families and/or representatives. This advisory body will review CCO/HH outcomes and advise the CCO/HH leadership regarding the policies and CCO/HH operations.
- Clarifying that the CCO/HH will serve adults and children and will be expected to coordinate with School Districts for the children it serves.

Other changes made to the Application are described below in the responses to questions and comments.

Response to Public Comment

1. Implementation Timeline

- a. Comments were received requesting that additional information be included in the document regarding the implementation of CCO/HH services, and the need for a detailed timeline leading up to the July 1, 2018 implementation of CCO/HH services. Concern was raised regarding the engagement of individuals, families, and Medicaid Service Coordination (MSC) service coordinators.**

An anticipated general timeline is included in Section 2 of Part I of the Application. A more detailed timeline will be published later in the Fall of 2017. The Transition Plan, currently under development and which will be published for a 30-day public comment period, will outline the anticipated timeframes associated with the CCO/HH Application process, individual/family education and outreach activities, and staff preparation for the initiation of CCO/HH services. The Application was updated to reflect the publication of the Transition Plan.

- b. Several comments were received citing inadequate timeframes for readiness activities including, but not limited to network development, Information Technology (IT), and Application review and approval. A few respondents urged the State to consider a regional or staggered roll out, as there was concern that the outlined timeline may not be feasible.**

The Transition Plan will detail the activities and timeframes associated with the transition to CCO/HH services. The roll-out of CCO/HHs will be contingent upon the overall readiness of the selected CCO/HH Applicants in a given region. Thus, transition to CCO/HHs could occur on a regional basis. The primary consideration for full implementation of CCO/HH services is continuity of care for individuals and families.

2. Transition Issues for Individuals & Families

The State received numerous questions related to the CCO/HH transition. As required by the federal Centers for Medicare and Medicaid Services (CMS), the State is developing a separate CCO/HH Transition Plan which will be made available for a 30-day public comment in the Fall of 2017. The Transition Plan will detail activities beginning in January 2018 related to individual and family outreach, staff preparation and readiness, and the initiation of CCO/HH services.

- a. One responder commented that the CCO/HHs must include a Transition Plan in their Applications. In that process, families must be consulted for the development of the Transition Plan between the individuals' current service providers and the CCO/HHs future network, and all the elements described in the Application.**

As described above, a Statewide Transition Plan will be developed. As part of the CCO/HH Application process, the Applicant will provide information regarding all current Medicaid Service Coordination agencies with which it is working with. In addition, the Applicant will design policies and processes to ensure individuals' continuity of service provision as current service providers may/may not be included in the CCO/HHs network. The objective will be to maximize the working relationships of the CCO/HH with current MSC agencies and service providers across the region, to ensure the continuity of care for individuals and families.

- b. A respondent asked if following the transition to CCO/HH services, the individual will have a single Care Manager who will be his/her primary contact for questions about the Life Plan?**

Yes. The CCO/HH model requires that individuals and families be served by a single Care Manager, just as they are today.

- c. Several respondents asked for information on the enrollment process and stated that families, individuals, parents, and guardians will need more information and education to make an informed decision regarding CCO/HH services. There were multiple concerns regarding the education of individuals and families regarding this new program.**

The Transition Plan will provide significant detail regarding the activities and timeframes for transitioning to CCO/HH services, including outreach to individuals and families and education activities. An important factor in sharing information will be engaging the CCO/HHs and its MSC service coordinators, who will be expected to assist individuals and families throughout the transition process. Outreach and education materials will be designed in collaboration with the State, CCO/HHs and stakeholders. In addition, throughout the transition and as CCO/HHs become operational, resources will be available on the OPWDD and DOH websites, including Frequently Asked Questions (FAQs) and informational videos. Please see the following resources:

OPWDD:

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

NYSDOH:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/id/

Additional information is available in this document's section regarding Enrollment (see Section 6 below).

- d. Respondents asked what types of training will be offered to families and individuals who will be affected by this change?**

OPWDD will communicate important information with families and individuals throughout the transition process. The Transition Plan will provide details and timelines including outreach to individuals and families and education activities. This document will be shared for public input. The objective is to maximize the working relationships of the CCO/HH with current MSC agencies and service providers across the region, to ensure the continuity of care for individuals and families.

- e. Respondents questioned when the education process would begin, and requested that the State provide distribution materials to help MSC service coordinators educate families about the CCO/HH consistently. Certain respondents expressed that the discussion and education needs to be done by the State and not left to MSC agencies and the CCO/HH.**

The education process will begin in the Fall of 2017, and will accelerate with the initial designations of CCO/HHs in March 2018. The State, in partnership with the designated CCO/HHs and MSC agencies, will work to develop consistent materials to help educate families.

A primary goal of the transition is to ensure continuity of care to preserve the expertise of current Service Coordinators as their provider agencies transition to the CCO/HH model (i.e., become a CCO/HH Care Manager) and continue to serve their current members under the CCO/HH. In most cases, individuals and families will have the option to continue to work with their current MSC service coordinators.

- f. Respondents asked how informed consent will be secured before enrollment for individuals who have no family members and may lack capacity to sign for consent occurs.**

OPWDD and DOH are developing consent forms that CCO/HHs will use to enroll individuals and to authorize the sharing of information for supporting care planning and referrals. These forms will include a “Frequently Asked Questions” (FAQ) document explaining the enrollment process. Most recipients of Medicaid Service Coordination (MSC) and Home and Community Based Services (HCBS) Waiver services are either capable of consenting independently, or with support, or have a family member or representative who assists in this capacity. OPWDD will issue further guidance on the process for enrollment into CCO/HH services for individuals who do not have a family member or representative to make a decision. To ensure continuity of care for individuals as CCO/HHs are launched, individuals’ current Individualized Service Plans (ISPs) will remain in place until they are scheduled for update or unless a significant event occurs.

- g. Respondents expressed concern regarding the Developmental Disabilities Regional Offices’ (DDRO) Front Door process, including the referral process, provisional eligibility, documentation, enrollment, the interplay between CCO/HH and DDRO regarding eligibility and assessment, training, acuity appeal, and the how these processes will be affected by the transition to Managed Care.**

The DDRO Front Door process will work with CCO/HHs in most of the same ways that MSC agencies interact with the Front Door today. For new individuals entering the OPWDD system, the Front Door process will remain the same. Front Door staff will continue to facilitate completion of applications for OPWDD eligibility (including provisional eligibility) by referring individuals without established eligibility to the DDRO eligibility coordinators and/or the CCO/HH who can assist with the eligibility

process. Guidance will be provided to identify the roles and working relationships of the Front Door and the CCO/HH.

h. Will OPWDD DDROs be responsible for annual assessment and reviews (including after the move to Managed Care Organizations (MCO) or just initial eligibility?)

Once the enrollment into the CCO/HH is completed, further assessments, reassessments and care management services will be completed by the CCO/HH, as described in Part I of the Application.

3. MSC Staff Transition

a. Several respondents felt that the larger provider agencies were being favored over smaller agencies/providers and raised concerns about the uncertainty of staff regarding the transition to CCO/HH services.

The intent of the CCO/HH development is to ensure that leadership of these organizations are able demonstrate a commitment to the field of developmental disability services and a collaborative, regionally-based governance structure. The criterion for selecting CCO/HHs is designed to ensure the highest possible level of integration to support outcomes for people. The stated qualifications for Care Managers and the "grandfathering" of staff who now provide MSC services is intended to ensure that the intellectual and developmental disability (I/DD) field continues to improve services for individuals and families, while retaining staff who today work in the field as MSCs. The transition to CCO/HH services will be designed in such a way that will ensure continuity of care and culturally competent services for individuals and families and, to the extent possible, retain the existing relationships between MSC service coordinators and the individuals and families they serve. The State is drafting a Transition Plan that will address the MSC issue more completely and will be made public in Fall 2017.

b. Respondents suggested that MSC agencies should be able to work with existing Health Homes so that I/DD populations could transition to existing Health Homes, which would leverage infrastructure, agreements, and other resources. Multiple respondents questioned whether existing entities would need new Administrative Services Agreements (ASAs).

The model of Health Home services for individuals with I/DD requires that the Care Manager be directly employed by the CCO/HH within a transition period. Existing Health Homes may apply to become designated as a CCO/HH; however, these Applicants must demonstrate that they meet the standards described in the Application. ASAs are agreements between managed care plans and Health Homes (HHs). The State will provide further guidance on ASA requirements. For reference, applicants may review current ASA templates available at

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/administrative_health_home_services_agreement.pdf.

- c. **Respondents asked for additional detail regarding the staff training, topics and how the training would be funded and delivered. Some respondents suggested that we move toward Value Based Outcome measurement system and that all Care Managers go through Personal Outcome Measure (POMS) training. Other respondents identified the need for additional training on referral to community and social support services, health promotion, and relevant medical issues.**

CCO/HHs will be required to provide OPWDD-approved training for new employees and for current MSC service coordinators who transition to the CCO/HH program and do not meet the minimum education and experience requirements. New modules will be added to traditional MSC training to reflect enhancements of Health Home Care Management services. This training will be provided by the CCO/HH within six months of employing or contracting for the former MSC's services. Based on existing MSC's experience and this training, OPWDD expects that most MSCs will transition to new Care Manager roles. Care Manager education and experience requirements will be waived for existing MSCs who are determined by the CCO/HH to have the expanded skills and abilities necessary to provide Care Management. The elements of the OPWDD Core Training are being assessed for any changes necessary to reflect the delivery of CCO/HH services. The CCO/HH will evaluate the on-going training necessary to make sure the workforce is skilled in the delivery of CCO/HH care management services. Training topics will be further identified in the Transition Plan.

- d. **A respondent noted that there needs to be a high level of training to assist MSC service coordinators to take on the roles of Care Managers, which may cause a financial burden on the emerging CCO/HH. Setting up this new training infrastructure also requires financial commitment. From where will funds come?**

It is expected that transitioning MSC service coordinators have a level of experience and training that provides them with the necessary skill set to begin the transition to Care Manager roles. Today's MSC program includes requirements for OPWDD-approved training at the start of employment and for on-going professional development. Trainings may be offered by OPWDD staff, MSC agency staff or through other community resources. It is anticipated that all these training resources will continue to be available and that the CCO/HH will arrange for or directly deliver certain training, as well.

The per member per month (PMPM) financial projections and rate tiers for CCO/HH Care Management reflects the increased expertise and training that will be required, as well as other significant start-up costs. Since the release of the Draft Application, DOH and OPWDD have been fine-tuning a rate structure that will provide start-up

resources during the first 24 months of implementation. The CCO/HH rate tier structure are subject to CMS approval.

- e. Clarity was requested whether CCO/HHs could rent space in provider agencies to house Care Managers. Will there be any restrictions on the number of Care Manager work-sites per county and/or the designated regions?**

The CCO/HH must ensure that Care Managers are located throughout the region and are accessible to individuals and families. The CCO/HH must also maintain administrative authority over CCO/HH Care Management, as described in the Application. CCO/HHs can decide how they wish to secure office space and property to provide services; the CCO/HH must ensure that any property arrangements are consistent with Medicaid regulations.

- f. One respondent asked that OPWDD consider “grandfathering” required staff background checks, as it is estimated to cost the CCO/HH over \$300K if the background checks have to be duplicated.**

This issue is under legal review and evaluation.

- g. Questions were raised regarding staff qualifications and any available flexibility.**

The Care Manager qualifications will generally remain as described in the Application. Flexibility is allowed for current MSCs who do not currently meet the minimum educational standards to ensure continuity of care for individuals and families.

Based on the comments received, the Application will be updated to clarify the following Care Manager qualifications:

- The area of study for a Bachelor’s/Master’s degree is not defined by the State, this is left to the discretion of the CCO/HH.
- Relevant experience within the I/DD field can include any employment experience and is not limited to case management/service coordination duties. The CCO may propose other experience that could meet the requirements in its application and OPWDD will consider.
- Current MSC service coordinators are "grandfathered" to facilitate continuity of care for the individual receiving coordination. Documentation of the employee’s prior status as an MSC service coordinator may include a resume or other record created by the MSC agency or CCO/HH demonstrating that the individual was employed as an MSC service coordinator prior to July 1, 2018.

- h. One respondent stated that it is unrealistic to expect that adequate training for MSC service coordinators will be accomplished in advance of the July 1, 2018 start date. How this training is being funded was questioned, as was clarity on how current MSC service coordinators without the desired skill sets necessary will be able to transition their responsibilities.**

The CCO/HH will be responsible for training to ensure that Care Managers have capabilities as required by CCO/HH standards. The responsibilities of the Care Manager will be broader than today's MSC service coordinator. Yet, the MSC workforce is well versed on person-centered planning and routinely participates in professional development training, as is required for MSCs. The Transition Plan will outline certain training that must occur in advance of the July 1, 2018 start date. A calendar of training dates beginning January 2018 will be forthcoming. It is expected that the CCO/HH will assess the training needs of staff throughout its organization and make necessary trainings available to Care Managers as part of on-going operations.

- i. Respondents requested clarification regarding the role of the MSC supervisor and whether CCO/HHs will be required to contract with existing MSC provider agencies for their supervisory MSC staff.**

The agreement between existing MSC providers and the CCO/HH will include staffing arrangements for both the MSCs and MSC supervisors.

4. MSC Agency Transition Issues

- a. During the initial year of CCO/HH operation, when staff may still be working under the auspices of the former MSC agencies, which entity gets paid the per-member per-month (PMPM) rates – CCO/HH or MSC Agency?**

The CCO/HHs, not the MSC agencies, will directly bill Medicaid for Care Management services. CCO/HHs may have contracts with current MSC agencies for their MSC staff during the up-to-one year transition, and remuneration for the MSC services will be part of that contract. Payment to the MSC agency will be dictated by the agreement between the CCO/HH and the MSC agency.

- b. Are MSC agencies responsible for back-filling and onboarding new Care Managers when vacancies occur, or will this responsibility be absorbed by the CCO/HH?**

Until MSC agencies cease providing MSC services, they are responsible for actively back-filling and onboarding new MSCs. The State anticipates that the CCO/HH will be responsible for these personnel functions for new staff or may delegate these functions to the MSC agency for a time limited period.

- c. Multiple respondents requested clarification regarding the 12-month contract period for CCO/HHs and MSC service coordinators. Others questioned whether it could be indefinite for those entities that only provide MSC services.**

After July 1, 2019, all Care Managers (including former MSCs) must be directly employed by the CCO/HH. Those agencies that also provide HCBS Waiver services may continue to provide Waiver services, but will no longer provide any form of care coordination.

5. Eligibility

- a. Respondents noted the absence of conditions such as: Prader Willi, Traumatic Brain Injury (TBI), Fragile X and Rett Syndrome, from the list of I/DD Chronic Conditions. Concerns were raised that individuals with these conditions, who are currently eligible, would lose services.**

Individuals with diagnoses specified above will not lose eligibility for services with the implementation of CCO/HH services. The Application has been updated to reflect the July 25, 2017 inclusion of Prader-Willi syndrome in Mental Hygiene Law, 1.03 (22), as one of the potentially qualifying conditions for OPWDD eligibility. The remaining conditions on the list align with the named conditions in Mental Hygiene Law. Certain conditions, such as Fragile X Syndrome or Down Syndrome, would potentially qualify under the category of "Intellectual Disability" (ID) or "Neurological Impairment" (NI), and the Fragile X and Down Syndrome conditions would be coded as the cause, or etiology, or the ID or NI. The eligible CCO/HH chronic conditions are subject to CMS approval.

- b. Numerous comments requested clarification on the distinction between eligibility for Health Home (HH) and CCO/HH services as it relates to individuals with a single qualifying chronic I/DD condition as opposed to those with one I/DD chronic condition and an additional chronic condition.**

The CCO/HH will serve most individuals who qualify for OPWDD services and are I/DD-eligible, as determined by the OPWDD Front Door process. Children who are currently served in the OPWDD Care At Home Waiver or who meet the level of care (LOC) HCBS eligibility determination for either Medically Fragile or Medically Fragile and I/DD under the 1115 Children's Waiver will best be served by and will enroll in the NYSDOH Children's Health Home. Care at Home Case Management agencies are affiliating with children's Health Homes and will assist children with access to an array of HCBS services under the Children's 1115 Waiver. In addition, there are people who qualify for, but choose not to receive, OPWDD comprehensive HCBS Waiver services. Such an individual with a HH eligible I/DD condition and a second eligible HH chronic condition, may enroll in a designated Health Home that now

serves adults and/or children but they will not be able to receive I/DD specialized HCBS services.

- c. Respondents indicated that many individuals with I/DD diagnoses who do not meet OPWDD eligibility requirements could benefit from CCO/HH Care Management and proposed expanding the list of I/DD single qualifying conditions to close the service gap.**

The inclusion of the I/DD diagnoses in the NYS Health Home State Plan will expand the number of individuals who may qualify for CCO/HH services. An individual with a HH qualifying I/DD condition and a second eligible HH chronic condition would be eligible for HH services and may enroll in a designated Health Home that now serves adults and/or children.

- d. A respondent asked how one would know if a potential enrollee had received the appropriate DDRO determination necessary for CCO/HH eligibility and enrollment and how the DDRO and CCO/HH would work together.**

Individuals who have been determined eligible for OPWDD services are identified by a Restriction Exception (RE) 95 code in the Medicaid system. If a CCO/HH encounters an individual it believes would meet the CCO/HH requirements, the CCO/HH should refer the individual, their family and/or representative to the DDRO Front Door. Upon determination of OPWDD eligibility, the Front Door will provide the individual, their family and/or representative with a list of CCO/HHs accepting new enrollees in the county of residence and work to facilitate enrollment in a CCO/HH.

- e. There were a few questions regarding the current Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) program with respect to this transition. One respondent suggested that FIDA-IDD plan subcontract out the Care Management to a CCO/HH to ensure continuity of care.**

The FIDA-IDD plan provides comprehensive Care Management services. FIDA-IDD enrollees may not also receive CCO/HH services.

6. Enrollment and Opt Out Care Management

A few respondents supported a passive or “auto-enrollment” process for those already receiving MSC services who would be transitioning to CCO/HHs with their same MSC agency as a means of minimizing confusion and disruption services.

Individuals, their families and/or representatives will make informed decisions to enroll in a CCO/HH; they will be informed of the affiliation of MSC agencies and MSC service coordinators from which they currently receive services with new CCO/HHs to support the continuity of services. The Transition Plan, currently under

development and which will be published for a 30-day public comment period, will provide detail on the enrollment process.

- a. For those individuals with I/DD already enrolled in Managed Care, will there be an expectation/requirement that the Managed Care Organization (MCO) contract with a CCO/HH? If not, does that preclude such individuals from being enrolled?**

Individuals with I/DD who are currently enrolled in a Medicaid Managed Care plan for acute care benefits may also enroll in a CCO/HH. The CCO/HH Care Management service will be provided initially on a fee-for-service basis. The individual will remain in the MCO and will remain enrolled in a CCO/HH. The CCO/HH will bill directly to Medicaid for CCO/HH services and will be expected to coordinate with the MCO.

- b. Many respondents requested more information on the opt-out process, including the opt-out mechanism; what alternative services would be provided, by whom, at what rate; whether fire walls would be in place; and who their Care Managers would be.**

Individuals will have the choice of receiving Health Home Care Management from a CCO/HH in their region. The CCO will ensure that members that opt out receive the required HCBS case management. The Transition Plan will describe this opt-out process in greater detail and will be made available for public comment. HCBS case management (the “opt out” Care Management service) will be authorized under the 1115 Waiver. HCBS case management will be delivered by the CCO/HH, the designated entity for the delivery of the alternative opt-out Care Management. As with CCO/HH services, the CCO may contract with existing MSC agencies for up to a year (July 1, 2018 – June 30, 2019) for the delivery of opt-out case management services. Thus, whether an individual chooses to receive comprehensive Health Home or more limited HCBS case management, he or she can likely maintain his or her current MSC service coordinator with the July 1, 2018 transition. The payment rate for simple HCBS case management is under development and will be lower than rates for expanded Health Home Care Management.

- c. One respondent questioned whether the public could review and comment on consent forms prior to being finalized.**

DOH and OPWDD are developing consent forms and these will be reviewed and approved by DOH Counsel. Although the forms will not be posted for public comment, they will be made public in advance of the July 1, 2018 implementation date.

7. Children

a. Clarification was requested whether a CCO/HH will provide services to individuals of all ages with I/DD.

A CCO/HH must provide Care Management services to all individuals who have been identified as eligible to receive OPWDD services, including children and adults. The Application will be updated to reflect the importance of coordinating services with schools and other children's services provided.

As noted above, children with an I/DD diagnosis who are medically fragile, and are served today in the OPWDD Care At Home Waiver, or in the future will meet the Level of Care requirements for medically fragile children, will likely choose to be served in children's Health Homes.

b. Several respondents sought clarification regarding how the change to CCO/HHs might affect children. Issues included whether there would be provisional eligibility, as there is for children under age 8, and how this transition will affect children who currently have provisional status.

Provisional eligibility processes will not change for children. Children who currently have provisional status will keep that status, and will be enrolled into a CCO/HH along with the rest of the I/DD population.

c. Will children enrolled in Early Intervention (EI) be eligible for CCO/HH?

A child who is enrolled in EI and is eligible for CCO/HH services may enroll in the CCO/HH and receive Care Management. In these situations, the Care Manager acts in the role of both the EI ongoing service coordinator and the Care Manager.

d. Will OPWDD consider making an exception to the one year contract limit for CCO/HHs who contract with agencies who provide services to children with I/DD?

The one year contract limit applies to all agencies. Throughout the transition and implementation period, the State will monitor the capacity to provide specialized Care Management to highly specialized populations.

e. Respondents recommended that OPWDD outline care planning requirements for individuals with I/DD transitioning from school to adult services. For children, the Application's only reference to school is in community supports.

The Application will be strengthened to reflect that a partnership must be established between the CCO/HH and school for children enrolled in school.

In Section 11 of the Application, the education system will be identified on the list of entities the CCO/HH must partner with to ensure that the Individualized Education Plan (IEP) and 504 Plan are coordinated with the individual's Life Plan.

- f. **A respondent requested a break-out to reflect children and adults within each region who are currently receiving MSC or Plan of Care Support Services (PCSS).**

The requested table (below) will be added to the Application.

BREAKDOWN OF ADULTS AND CHILDREN PARTICIPATING IN MSC & PCSS		
OPWDD REGION	% ADULTS	% CHILDREN
1	71.5%	28.5%
2	70.9%	29.1%
3	75.8%	24.2%
4	67.5%	32.5%
5	81.5%	18.5%
STATEWIDE	72.1%	27.9%

Adults are age 21 or older. Children are below age 21.

8. Person-Centered Planning and the Life Plan

- a. **Several respondents requested clarification regarding the definition of Person-Centered Planning.**

Person-centered planning is defined as a process, controlled by the person receiving services, designed to ensure that everyone receiving HCBS benefits from the most individualized set of supports and services possible. A more detailed definition can be found in the person-centered regulations at Title 14 NYCRR 636 and in the FAQ located at:

https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning/faq

The person-centered planning process requires that individuals be satisfied with their planned activities, supports and services and that the Plan is finalized and agreed to with the individuals' written informed consent. A person-centered planning process also involves providing a method for the individual to request updates to the Person-Centered Service Plan, referred to as the Life Plan in CCO/HHs, as needed. This person-centered planning process is a Health Home Care Management requirement.

- b. **There were varied comments requesting additional clarification on the Life Plan.**

The Life Plan is a new and improved Person-Centered Planning format. It builds upon the ISP format now being used and expands it to capture additional information to address the comprehensive needs of individuals with I/DD. The Life Plan results from a comprehensive Person-Centered Planning process directed by the individual served, with assistance as needed, from a family member or representative. The Life

Plan integrates the continuum of physical/medical, behavioral health services, rehabilitative, long-term care, I/DD and social service needs and identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), I/DD service providers, the Care Manager and other providers directly involved in the individual's care. The Life Plan must be established within a health Information technology (HIT) system and integrated in design.

c. Respondents requested additional detail on requirements and expectations related to the timeframes for Life Plan Implementation.

For individuals, newly enrolling into CCO/HHs and not receiving MSC services, the CCO/HH will carry out the following actions within 60 days of enrollment:

- Meet with individual and complete the Person-Centered Planning using comprehensive assessment tools, and
- Convene an Interdisciplinary Team (IDT) meeting and complete the Life Plan.

For individuals receiving MSC services and transitioning to the CCO/HH, the existing care plan will remain in effect and continue to be implemented by all service providers and the CCO/HH. The CCO/HH will have until January 1, 2019 to convene the IDT and establish the initial Life Plan for each individual enrolled. This allows the individual's existing plan review schedule to remain in place, if appropriate and desired by the individual, their family and/or representative.

Changes and updates to the Life Plan must include changes in assessment data and health status including, but not limited to, the coordination of service changes, medication administration, or support services following hospitalization discharge or other sites of care change. The schedule for the Life Plan review will occur as it does today, with a formal annual review and re-review occurring two times a year. . Similar to the ISP, the Life Plan will be subject to continuous updating and monitoring by the Care Manager.

d. One respondent responded that although the Application states that the Life Plan is subject to "continuous updating," s/he questioned the necessity to hold a meeting to review and update the Life Plan if no one requests such a meeting.

The goal of maintaining a current Life Plan that reflects the individual's status and support needs/services in real time is intended to improve quality of life and supports for the individual receiving services through improved communication and information sharing. It is not the intent to have a Person-Centered Planning meeting any time there is an update to the Life Plan -- only as is required today as described in question (c) above.

e. Confirmation was requested on how the long-term connection between the current MSC service coordinator and individual will be maintained as, in certain cases, the MSC has become a stable relationship in the individual's life who may substitute for family.

OPWDD recognizes that many relationships between individuals receiving services and their MSC service coordinators are strong ones; the process for transitioning members is designed to ensure the maintenance of those relationships. CCO/HH applicants will be required to show how they will use existing MSC agencies and MSC service coordinators to ensure stability of relationships.

- f. Respondents requested clarification on the IDT including the role of the family and/or representative and the authority the team has. It was suggested by two respondents that natural supports, such as family and friends, be included in the development of the Life Plan if the individual chooses.**

It is expected that the individual, his/her family member and/or representative and his/her primary HCBS Waiver service providers (residential habilitation, day habilitation, etc.) participate as IDT members. The Life Plan is developed by the Care Manager with the individual and his or her family and/or representative using the Person-Centered Planning process. This is achieved with assistance from the individual's IDT, comprised of parties chosen by the individual to participate, as well as those upon which decision-making authority is conferred on the individual by State law.

The Life Plan represents a comprehensive document resulting from a Person-Centered Planning process directed by the individual with assistance, as needed, by a representative identified by the individual and in collaboration with the IDT. The representative/s could be natural supports such as family and friends.

- g. Several respondents questioned the necessity of the face-to-face planning meetings, noting that individuals should be allowed to choose their own level of involvement in the care planning process and that having medical staff be present at these meetings is unrealistic.**

The annual face-to-face meeting to review the ISP has been a long-standing requirement and will continue to be in the future with the review of the Life Plan. It is not a requirement that a physician is physically present at the annual review; however, it is important that the health needs of the individual are addressed and that the individual's physician is aware of the support and service needs of the individual.

- h. One respondent requested additional information regarding the interaction with the individual's primary care provider (PCP). Specifically requested was clarity regarding how coordination with the PCP can be facilitated in both the assessment process and development of the Life Plan. Will PCPs be reimbursed for their participation in planning and coordinating care through the CCO/HH? The Life Plan includes goals and timeframes for improving an individual's health, including interventions that will produce this effect.**

The Life Plan is an integrated care plan that includes physical health, home and community supports, social supports, behavioral health services etc. Primary care is one facet of that integrated care plan. The orders of PCPs, like other health providers, should be reflected in the Life Plan (e.g., medication regime), and the PCP should be consulted accordingly and be invited to participate in the IDT. It is the Care Manager's responsibility to communicate with the physician's office and other providers involved in the individual's care, as needed, to ensure that the Life Plan comports with the physician's assessment of need. The Application will be updated to reflect this change. The CCO/HH does not provide reimbursement to the PCP for its involvement in the care planning process.

- i. There were numerous comments regarding the 10-day period for a face-to-face meeting with the individual and their Care Manager, upon enrollment into the CCO/HH.**

The State has amended the application to remove this reference and clarified in question b of this section the timeframe for completion of the Life Plan for a new enrollee who is not transitioning from MSC services.

- j. Will the Life Plan be updated to include a description of the barriers that the individual has experienced that prevented her/him from meeting a desired goal, such as access to providers and/or Care Managers?**

Yes, if an individual experiences a barrier that prevented the achievement of a personal goal, it makes sense to describe the barrier in the Life Plan, as well as a potential solution for overcoming the barrier.

- k. Respondents questioned the inclusion of information in the Life Plan that may change frequently, such as employment and financial information, and requested OPWDD's consideration of this issue. For example, allowing this section of the Life Plan to be updated annually, or with a significant change or to allow for the inclusion of this information in a supplemental document such as the Supported Employment Plan (SEMP) for employment detail?**

The Life Plan must be regularly reviewed and maintained by the CCO/HH Care Manager and reflect the current services and needs of the individual. CCO/HHs may only bill when a billable Care Management Core service has been provided. Updates to the Life Plan should be made, as feasible, using professional judgment about what changes are significant, considering the specific challenges and activities experienced by the specific individual.

- l. Additional information was requested regarding health and wellness education and the possible expectation that the Care Manager will provide this. In addition, one respondent stated that people with I/DD will benefit from the health and wellness linkages; however, challenging behaviors and mental illness, also should be addressed. It was recommended that "behavioral challenges and psychiatric disease" be added to the list of community**

programs people can be linked to. In addition, there is no mention or inclusion of people with physical disabilities using durable medical equipment, or individuals with the severe behavioral challenges.

Yes, as described in Section 9 of Part I of the Application, the CCO/HH Applicant must demonstrate during the readiness review process how it will promote wellness and prevention by linking the individual with various community resources based on the individual's needs and preferences. In addition, and as described in this same section, the CCO/HH must demonstrate an accountability structure (contractual agreements) to support effective collaborations between behavioral health providers to address challenging behaviors and mental illness, as well as physical disabilities.

- m. Clarification was requested as to whether the State intends to share provider templates for CCO/HH policies and procedures? Concern was raised by one respondent that if each Health Home creates its own policies/procedures, it will result in inconsistency and create confusion, conflicts, and barriers to seamless service delivery.**

Each CCO/HH must develop policies and procedures that will be subject to review by the State and are consistent with State and Federal guidance. All CCO/HHs must follow the same guidelines and requirements, as outlined in the Application. The State will continue to provide updates to policies as implementation activities evolve, including details and clarifications to be shared in the Transition Plan.

- n. A request was made to clarify “safeguards and harm reduction supports”, including a backup plan if regular supports are not available.**

The Care Manager utilizing the Person-Centered Planning process must, in conjunction with the individual receiving services, develop a Person-Centered Service Plan/Life Plan that includes the risk factors and mitigation measures, including individual specific staffing, back-up plans and strategies, when needed. As part of the Person-Centered Planning process, strategies must be developed to address health and safety risks for the individual receiving supports. The goal of safeguard planning is not to eliminate all risk, but to find options that will help individuals to manage the challenges and associated risks involved in their life choices, including community participation. All safeguards must continue to be documented in the Life Plan; the safeguards section of the Life Plan must be comprehensive and can serve as the IPOP or safeguard section for habilitation plans. OPWDD has prepared a checklist to assist individuals, families, and providers to identify and discuss risks, informed choices, and safeguards. A copy of the Strengths and Risk Inventory can also be found on the OPWDD website at: <https://opwdd.ny.gov/node/5521>.

- o. There was a request for detail regarding the chance that an individual decides s/he does not want a full Life Plan or s/he only wants certain components. Further, a description is sought of what accommodations will be in place for individuals and families who decline to participate in the Person-Centered**

Planning process. Does the State envision that the individual will be managed via the Health Home or through some other means?

Individuals will have the choice of receiving Health Home Care Management from a CCO/HH in their region. Individuals who choose not to receive CCO/HH services will be provided HCBS case management services solely to coordinate their developmental disability services, as described in Section 6 above. In this instance, the Life Plan which would solely document HCBS services, is to be developed using Person-Centered Planning practices and would serve as the plan that is required by Person-Centered Planning requirements, as described above.

p. The Life Plan has many elements but lacks proof of concept and how it will be translated in service delivery.

The Life Plan is currently being used by Partner's Health Plan, a managed care plan in New York State, and was designed with OPWDD input. It has been used successfully in this context since 2014. The development of the Life Plan must be accordance with existing person-centered planning standards.

9. Assessment

a. Several respondents asked for clarification regarding the required comprehensive assessment that must be completed by the CCO/HH.

The Life Plan results from a comprehensive person-centered planning process directed by the individual served, with assistance as needed, from a family member or representative. The Care Manager must demonstrate that the member received the comprehensive assessment(s) needed to result in a Life Plan that integrates the continuum of physical/medical, behavioral health services, rehabilitative, long-term care, I/DD and social service needs; and identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), I/DD service providers, the Care Manager and others directly involved in the individual's support and care. One of the comprehensive assessments that will be used by the CCO/HH includes the CAS, if applicable. The Life Plan may will be informed by other assessments based on the needs of the individual.

b. Many respondents asked for clarify on the use of the Coordinated Assessment System (CAS) in the CCO/HH model.

As noted in the response above, the CAS will be used to inform the person-centered planning process that results in a comprehensive Life Plan. OPWDD will provide further guidance on the statewide roll-out and implementation of the CAS. The CAS will serve as the State-required functional needs assessment to inform the care planning purposes and development of the Life Plan. For information on the OPWDD-approved assessment tool please refer to:

https://opwdd.ny.gov/people_first_waiver/coordinated_assessment_system.

Please note: information relating to the statewide CAS roll-out will be provided by OPWDD as it becomes available.

c. Many respondents asked for clarity regarding the role of the DDP2 in the CCO/HH model.

At this time, the Developmental Disabilities Profile (DDP2) functional assessment will be used to inform the payment tiers structure for the CCO/HH program. Once the CAS roll-out is complete, the model will be adjusted to rely on the CAS to inform the payment tiers algorithm.

Again, OPWDD's existing policies and procedures for assessment processes remain in place for the transition to CCO/HHs. For more information on the DDP2 please refer to <https://opwdd.ny.gov/node/1662>.

d. One respondent suggested that the completion of a comprehensive assessment that identifies medical and behavioral health requires the assessment be performed, in part, by medical and behavioral licensed clinicians. If the Care Manager does not meet the necessary qualifications to complete the assessment, would it be possible for the dedicated Care Manager to complete the components that are in their scope of practice and then coordinate the completion of the assessment with additional medical and mental health professionals who are employed within the CCO/HHs?

Yes, the CCO/HH must engage medical and mental health experts who can support Care Managers and are available to consult, as needed, to complete the comprehensive assessment. It is anticipated that Care Managers will be fully trained on the administration and completion of the comprehensive assessment and will utilize the clinical expertise of the CCO/HH team to confer where appropriate.

e. A respondent requested additional detail on the content of the comprehensive health assessment and suggested that it should also refer to an individual's social and emotional needs.

OPWDD agrees that social and emotional needs must be considered in the comprehensive assessment process and will be providing further detail on the expectations and requirements of the comprehensive person-centered planning process.

f. A respondent also requested clarity regarding cultural competence and communication needs being addressed throughout the comprehensive person-centered planning process.

Section 7(d) "Requirements for care planning meetings" and (e) "I/DD Health Home Care Manager Qualifications" of Part I of the Application describe expectations for cultural competency during the planning process.

- g. Several respondents suggested that the individual and/or family/representative should be able to review results of DDP2 and CAS, not simply a summary.**

The State will continue to explore policies and procedures for sharing assessment information and tools with stakeholders.

- h. Responders commented that the addition of a family assessment is key to understanding the individual's health, wellness, functioning and needs. In addition, it was recommended that the Application include an affirmative statement that the health and well-being of the family is directly related to the success of the individual's Life Plan, therefore, CCO/HHs must provide access and linkage to supports for families including, but not limited to, those funded by OPWDD's Family Support Services (FSS).**

At each stage of the individual's life, the family plays a key and ever-changing role. The Care Manager will develop the individual's Life Plan with the individual and his/her family or representative. Based on the needs of the individual and his/her family and/or representative, the Life Plan may include supports for the family (e.g., Family Education and Training (FET), respite and other community based service options).

- i. Please define if there is a source document in which we can determine the standard deviation equivalents of the health and behavior Individual Service Planning Model (ISPM) scores we can access in CHOICES? Agencies need to begin to figure out the tiers of the individuals served, to negotiate with the CCO/HHs.**

OPWDD intends to modify CHOICES so that CCO/HHs are provided with a roster of authorized enrollees and their authorized tier levels on a monthly basis, prior to the start of the following month's services. This functionality has not yet been built, however, and this information is not currently available in CHOICES. In terms of fiscal planning in advance of implementation, OPWDD recommends that prospective CCO/HH Applicants assume an initial case mix in the general alignment with the statewide averages presented in the table below. Given the expectation that CCO/HHs strive for a capacity of at least 5,000 individuals on implementation, use of the statewide averages for financial planning purposes should be reasonable and financially reliable.

Health Home Tier	Projected % of Statewide Population
1	27%
2	58%
3	10%
4	5%

10. Advocacy

- a. **One responder requested information regarding the requirements for language interpreters in the planning process and how will that be funded. Specifically, who would be responsible for the cost and where would the money come from?**

The CCO/HH will be required to communicate and share information with individuals and their families and/or representatives with consideration for language, literacy and cultural preferences. The CCO/HH will ensure continuity of care and a comprehensive and culturally sensitive person-centered planning for all CCO/HH enrollees. CCO/HH Applicants will undergo a readiness review and must demonstrate cultural competence to support the diversity of the population within each covered region. If interpretation services are needed, the CCO/HH is expected to provide for the service with the available funding in the CCO/HH monthly payment.

- b. **One respondent requested clarity regarding the State's expectation that CCO/HHs to maintain Call Center functionality.**

The CCO/HH must provide access to a staff person 24 hours/7 days a week to provide information and emergency consultation services. The implementation of this requirement must be outlined in the CCO/HH policy & procedure manual.

- c. **A respondent suggested that increased participation with the families, caregivers, and the Joint Advisory Council (JAC) may increase transparency. In addition, another respondent felt that both the JAC and the Medicaid Managed Care Advisory Review Panel (MMCARP) have not been kept in the loop regarding this initiative. One respondent questioned how the State would ensure the commitment of the various stakeholders, and suggested a panel of individuals receiving services, including parents, providers, and advocates to get feedback.**

The Joint Advisory Council (JAC) has been routinely consulted regarding the development of IDD-specialized Health Home services. Information regarding these meetings can be viewed at:

https://opwdd.ny.gov/opwdd_services_supports/people_first_waiver/opwdd-joint-advisory-council-managed-care.

The State is committed to a transparent decision-making process and will continue efforts to keep the public informed. Several comments were received regarding the need to ensure the on-going involvement of stakeholders in the CCO/HH operations. To that end, Section 7(g) of the Application has been updated to reflect the requirement that each CCO/HH form an advisory body made up of individuals receiving services and their families. This advisory body will report to the CCO/HH governing body, will meet on at least a quarterly basis, will advise CCO/HH leadership regarding policies and operations and quality outcomes.

- d. A request was made to clarify what safeguards will be put into place to ensure that individuals are not steered to HCBS services operated primarily by agencies that manage the CCO/HHs?**

As part of the State's monitoring, oversight and re-designation process of CCO/HH, OPWDD's Division of Quality Improvement (DQI) will continue to implement Person-Centered reviews that address choice of service and choice of service provider. The CCO/HH is also responsible for the monitoring, oversight, and quality improvement of its services. In addition, the development of the electronic Life Plan will provide new tools for monitoring the responsiveness of care planning and service provision.

- e. Respondents asked if Independent Ombudsman services would be available to CCO/HH enrollees.**

Ombudsman services are associated with Managed Care and assist people with questions or concerns about care planning and service provision in Managed Care. The CCO/HH will operate initially in a fee-for-service environment and, therefore, there will not be an Ombudsman function for CCO/HHs.

11. Willowbrook

- a. A respondent stated that provision of services to Willowbrook class clients is a specialized service and should be allowed to be provided by an experienced coordinator from the downstream agencies. Please confirm that there is an expectation that a CCO/HH will uphold this standard of care for the Willowbrook parties, and clarify if there a possibility of changes to the Willowbrook caseloads due to your tiering system.**

Willowbrook class members are accorded inclusion into the special group status, which will place the members into the highest Tier. Regardless of developing health and service programs, compliance to the Willowbrook Injunction must be in place and ensured, including caseload standards.

- b. Expectations for the Care Manager are significantly different from MSC service coordinator, and require a level of sophistication that takes time to build for Willowbrook. These individuals are very complicated medically and behaviorally and will require Life Plan modifications regularly along with intensive care coordination. How will the State support this learning and development for all the current MSC service coordinators that will move into this advanced care coordination role?**

OPWDD is committed to fostering an informed transition that protects individuals who have complex medical and behavioral needs. The Willowbrook Permanent Injunction affords specific rights that will not be abridged. OPWDD is in the early stages of developing a CCO/HH education program that would address the needs of

individuals with complex medical and behavioral needs, including Willowbrook class members.

- c. One respondent requested clarity on whether they will be required to have an ASA or Business Associates Agreement (BAA) with the Consumer Advisory Board (CAB - Willowbrook representatives).**

The CCO/HH must comply with the requirements of the Permanent Injunction and collaborate with the CAB for all individuals who are represented or co-represented by the CAB. Additional guidance relating to the formal agreements that may be required will be available in the future.

12. Governance & Regional Coverage

- a. A respondent asked if CCO/HH Applicants that are current lead Health Homes need to demonstrate that they are controlled by one or more non-profit organizations with a history of providing services to the I/DD population, or is this a requirement solely of the provider (such as employment arrangements, job qualifications, 10K caseload minimums, IT standards with Life Plans, etc.)?**

Yes, all CCO/HH Applicants, including all currently designated Health Homes that submit a CCO/HH Application, must meet the governance requirements included in the Application.

- b. A respondent recommended that the Application should be modified regarding the possible partnership with existing Health Homes. Rather than indicating that Applicants "may" form partnerships and governance structures that leverage existing Health Home infrastructure, the respondent recommended that Applicants be strongly encouraged and that a preference be given to those Applicants that do so.**

This is not a change that will be made in the Application.

- c. Concern was raised that experience does not equate to competence or expertise. It was recommended that Applicants demonstrate all three. Competence and expertise implies deep understanding of the complexity and unique needs of the populations requiring differing approaches to planning and interventions plus the use of evidence based practices. One responder requested that OPWDD consider expanding eligibility parameters to include all entities that have experience providing services to individuals with I/DD and can offer additional capabilities that may not currently exist within the system.**

OPWDD and DOH have considered experience, competence, and expertise in determining the levels of each necessary for approval as a CCO/HH. The Agency will take into consideration past reports, and quality care history of those agencies

and providers applying for approval as a CCO/HH. The parameters regarding the 51% control requirement will not change.

- d. Respondents noted that the proposed governing structure and eligibility requirements appear to limit New York's ability to incorporate other organizations with valuable experience performing the functions of a CCO/HH, and with current infrastructure assets, into the CCO/HH program.**

The proposed standards and network requirements allow existing organizations to partner with entities that have experience delivering and coordinating services for individuals with I/DD. This will be part of determining network adequacy of CCO/HH Applicants.

- e. A respondent asked if CCO/HH Applicants need to have experience in providing only OPWDD HCBS Waiver, or does this include any HCBS Waiver services (i.e.: Nursing Home Transition and Diversion (NHTD), Traumatic Brain Injury (TBI) etc.)?**

The Application states: "CCO/HH Applicants must demonstrate they are controlled (at least 51 percent) by one or more non-profit organizations with a history of providing or coordinating developmental disability, health, and long term care services to individuals with I/DD, including MSC and/or long term supports and services (LTSS)." NHTD and TBI Waiver service delivery do not qualify under these requirements.

- f. One respondent requested clarification regarding what changes would be needed for existing HHs and Care Management Agencies (CMAs). It was suggested that currently designated HHs should not be allowed to apply until they can prove success and quality care management for their currently enrolled population.**

Applicants may form partnerships and governance structures that leverage existing Health Home infrastructure (even if the existing Health Home is not seeking designation as CCO/HH) to efficiently maximize the use of existing administrative and technology investments to mitigate and minimize start-up efforts. This includes contractual arrangements to leverage back-office arrangements related to billing, electronic health records, and meeting the Health Home required Health Information Technology (HIT) core requirements. In addition, the Applicant's performance will be considered during the review process prior to designation.

- g. One respondent stated that the ability of a proposed CCO/HH to provide Person-Centered care should be a primary determinant of the Application process (regardless of the CCO/HH's ability to serve 5,000 or 10,000 lives). A determination of CCO/HH eligibility based entirely on ability to serve numbers of lives (5,000 or 10,000) could erode the quality care provided to isolated cultural and linguistic subpopulations. Why would a focus on quality and**

Person-Centered services require the capacity to serve 5,000 to 10,000 individuals, particularly for culturally or linguistically unique populations?

Successful CCO/HH Applicants must demonstrate that they can serve all communities in a region by delivering culturally competent, Person-Centered Care Management. The ability to deliver care planning that is integrated across systems and supported by technology requires certain efficiencies that are related to the number of individuals served. The State will expect that CCO/HHs can serve all communities in a region by developing partnerships with existing agencies with the necessary experience.

- h. A respondent noted that the State's expectation of the governance structure and leadership of an CCO/HH is to have board members and officers who have prior experience overseeing and operating entities that have delivered (or still deliver) HCBS services. Please provide clarification regarding how is this conflict free. Would these individuals need to be separated from those entities? If so, for how long before governing a CCO/HH?**

The CCO/HH's mission is to deliver high quality Health Home care management services for the I/DD population. The success of the organization will be evaluated based on this mission, and the Board members must put the interests of the CCO/HH before their personal and other professional interests when acting on behalf of the CCO/HHs in a decision-making capacity. In addition, each CCO/HH must form an individual and family advisory body formed by the CCO/HH as a representative counsel made up of individuals receiving services and their families and/or representatives.

- i. If there are not enough Applicants to ensure consumer choice in a region, how will the State proceed? How will capacity to serve individuals be measured? One respondent felt that providing coverage in an entire DDRO region is counterproductive, and recommended County/Region. How many CCO/HH entities will be permitted in each region to provide choice and what happens if there is only one?**

The State anticipates that there will be at least two CCO/HHs in each region. If there is only one approved CCO/HH, there will be ample choice of Care Managers and providers within the CCO/HH to ensure choice. Individuals may choose to receive solely HCBS case management if they elect not to receive more comprehensive CCO/HH services.

- j. A respondent asked for clarification regarding individuals who have a MSC in an agency in one district, but receive certified residential services from another. In which region, will that individual be enrolled with a CCO/HH?**

CCO/HH enrollment will be based upon the region in which the individual lives.

13. Readiness Review & Operations

- a. **A respondent advised that staff who will be completing the review of the CCO/HH Applications must have a knowledge base about people who have I/DD. In addition, there was concern regarding the lack of availability for review of Part II from stakeholders.**

Initial reviews of the Applications will be completed by experienced staff at the DOH and OPWDD who are familiar with the unique needs of the I/DD population, the services and providers unique to the population to be served, and the requirements of the Health Home Care Management program. Part II of the Application consists of the questions that will be used to determine if the Applicant meets the criteria outlined in Part I of the Application.

- b. **Who could apply to be a CCO/HH? Can an entity still apply if they did not submit a Letter of Interest (LOI)? Will the LOIs be made public?**

Entities that are interested in becoming a CCO/HH were asked to submit non-binding letters of interest. Each entity that submitted a LOI is being asked to provide additional information to demonstrate ability to meet governance and MSC affiliation requirements. Once the entity responds with the needed information, the entity will be identified on the NYSDOH website. We anticipated that this activity would be complete in September, with the beginning of the CCO/HH Application process. If an LOI is not posted or one was not submitted, it does not preclude an entity from applying for designation as a CCO/HH.

- c. **Clarification was requested on the readiness review, application, and approval process. What do the readiness activities entail, and how will these activities be assessed by the State? What will the timeline be for the "contingent designation?" Could it be approved in one county within the region and not another if the county base of Care Managers isn't in place?**

Readiness activities will apply to CCO/HHs that are contingently designated based upon State review and approval of their Applications. Readiness activities will include ensuring:

- Completion of policies and procedures to implement the CCO/HH in accordance with the requirements of Part I of the Application;
- Compliance with Federal and State requirements and regulations;
- Compliance with State directives and guidance;
- Network adequacy, including Business Associate Agreements (BAAs), Data Use Agreements (DUAs), or network commitment letters with other network service providers,
- Readiness of MSC service coordinators and Care Managers; and
- Readiness activities will also include systems readiness (e.g., the ability to bill and timely make payments to Care Managers, electronic Life Plan etc.).

The State will perform readiness reviews and formally designate CCO/HHs that are ready to operate.

- d. Regarding the number of lives a successful CCO/HH Applicant must have, a commenter noted that it would be in the State's best interest for all Applicants to provide a financial plan, developed in an OPWDD approved format, to demonstrate fiscal viability and sustainability.**

The requirement for submitting a financial plan and planning document for Applicants covering between 5,000 and 10,000 lives is in place to ensure the fiscal viability of the Applicants and their ability to meet the program standards and adequately serve the individuals who may enroll. We expect that competent organizations with the ideal enrollment will be financially viable.

- e. At the point of startup, what is the expectation in terms of numbers of enrollees? Is a ramp up acceptable?**

At the time the entity applies to be a CCO/HH, it must demonstrate it has sufficient potential enrollment, based on its affiliations with MSC providers.

- f. Several respondents were concerned about the lack of case load limits in the Application.**

During the initial year of operation, the quality and individual and family satisfaction of the provision of CCO/HH services will be carefully assessed. During this time, the State is generally providing Care Managers the flexibility to manage caseloads according to the individual's needs, and is not mandating caseload requirements for individuals that have acuity in the CCO/HH per member per month (PMPM) rate Tiers 1-3. For Tiers 1-3, the financial projections were based on caseloads of 42, 32 and 26, respectively, per Care Manager. Due to enrollees' higher support needs, Care Managers serving individuals that have an acuity in Tier 4 CCO/HH services will be required to maintain a caseload level of no greater than 20 individuals per Care Manager. Once the initial year ends and OPWDD assesses CCO/HH operations, OPWDD will consider whether caseload requirements are necessary.

- g. CCO/HHs will be expected to develop policies and procedures that deliver the Health Home core services in a manner that meets the Person-Centered needs of individuals with I/DD. Please define the "manner" that meets the Person-Centered needs of individuals with I/DD. What, if anything, will be done to prove to the public that the CCO/HHs have developed such policies and procedures as mentioned above?**

Meeting the Person-Centered needs of individuals with I/DD requires that supports and services are based on and satisfy the individual's interests, preferences, strengths, capacities, and needs. Consistent with the Health Home core services requirements, they must be designed to empower the individual by fostering

development of skills to achieve desired personal relationships, community participation, dignity, and respect. In reviewing CCO/HH Applications, the review team will consider the comprehensiveness of the Application and the demonstrated ability of the provider to meet the standards and requirements of the person-centered planning process. Prior to final designation, Applicants will be required to submit their Policies and Procedures for review by the State.

More information regarding person centered planning is available at:
https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning.

As part of the State's monitoring, oversight and re-designation process of CCO/HH, OPWDD's Division of Quality Improvement (DQI) will survey using the Person-Centered Protocol formally identifying non-compliance and issuing citations consistent with routine survey activity.

- h. Respondents asked for clarification regarding the evaluation criteria that the State will use for CCO/HHs care plan adequacy. Please explain how the State will manage or expect the use of data from multiple sources in this process.**

During the readiness review process, the State will conduct on-site visits to view and assess the Applicant's Care Coordination system including the electronic Life Plan. The Life Plan record will be reviewed against person-centered planning standards, as adopted within DOH contract specifications and the State will confirm the document contains the prescribed sections as outlined in the CCO/HH Application. As noted in the Application, the CCO/HH must have the capacity to share Life Plan data in the form and format of the OPWDD data definitions. As the quality strategy continues to develop, the data collection process will be outlined.

- i. Will OPWDD provide templates for the policies and procedures and accountability structure to support the desired collaborations? Concern was raised by one respondent that if each Health Home creates its own policies/procedures, that will give rise to creating conflicts and barriers to services and service providers. Please provide clarification.**

It is the responsibility of the CCO/HH to develop policies and standards that adhere to State CCO/HH guidelines and requirements. All CCO/HHs must follow the same guidelines and requirements outlined in the Application, along with any further guidance or standards that may be issued by the State. The State will monitor adherence to CCO/HH State standards and requirements through the re-designation process. This will help to ensure compliance with State requirements, as well as create a baseline level of uniformity among CCO/HHs.

- j. Please clarify billing for individuals who come into CCO/HH from facilities listed in the Application. Will the CCO/HH have specific enrollment dates (e.g. enrollment on the 1st of the month?)**

CCO/HH enrollment will mirror the MSC service coordinator model in that it will be effective the first day of the month.

k. Will there be outreach criteria /numbers goals like the current Health Home Model?

Due to the DDRO Front Door process, there will be no State generated lists of potentially eligible CCO/HH enrollees. Consistent with that decision, there also will be no outreach or case finding billings for CCO/HHs.

l. Clarification was requested regarding the expectations for CCO/HH regarding transitions to/from a hospital and the supports necessary for the individual to remain out of the hospital once discharged?

Transitional care activities of the CCO/HH include follow up with hospitals (inpatient and emergency department) upon notification of an individual's admission and/or discharge to/from a, hospital, emergency department or rehabilitative setting.

CCO/HHs will:

- Facilitate discharge planning from an emergency department, hospital/residential/rehabilitative setting.
- Notify/consult with discharge treating clinicians, as necessary, assist with scheduling follow up appointments.
- Link the individual with community supports to ensure that needed services are provided.
- Follow up post discharge with individual and his/her family to assist with education about post discharge care and future needs/goals.

m. Please detail how family support and advocacy will be funded in the new model, and what level of investment will be required of the CCO/HH. Please define further for clarification (will it be implemented and how).

A CCO/HH is an entity that provides Care Management, but does not authorize, prior approve or pay for other services that an individual receives. Individuals and families will continue to access services funded through Family Support Services and other non-Medicaid or unpaid resources. The CCO/HH will help connect individuals and families to these resources.

n. A respondent commented that the section on Individual and Family Supports makes no mention of housing or transportation.

The Application will be updated to reflect the expectation that the person-centered planning process will include an exploration of housing preferences and transportation needs.

o. Respondents requested clarity on the meaning of "referral" in the Health Home core service, Referral to Community and Social Supports Services.

Respondents stated that the term "referral" does not describe the connection resulting in a delivery of services.

The CCO/HH payment is for Care Management and does not provide financial compensation to service providers. As a result, the State cannot mandate that a provider serve an individual that has been referred to them. The Care Manager is responsible for facilitating a connection to a provider to address the need for services.

- p. A respondent raised a concern that "caregiver counseling or training" is another layer of expectations that can overtax the Care Manager and asked that the State define expectations in this area, as well as the level of documentation that would be required.**

The Care Manager does not provide this service directly; he/she may refer family members and caregivers to an organization that can provide education, counseling and training in support of the individual. The documentation requirements will be further clarified in policy.

- q. Requests were made to further define and clarify the meaning of "enrollee support members" referenced in the explanation of the Health Home core service, Referral to Community and Social Support Services and to explain how the CCO/HH will work collaboratively with counties to achieve community connectedness.**

"Enrollee support members" refers to family members and/or representatives, and other natural supports whom the individual has identified to participate in the care planning process. The CCO/HH is expected to work collaboratively with Local Government Units, as MSC providers do today, regarding available and appropriate community services, based on enrollee's assessment of need.

- r. A request was made to further define and provide examples of evidence-based clinical tools and best practices that have been established for the I/DD population.**

Evidence-based clinical tools are those that have been demonstrated to be effective in teaching knowledge and skills that lead to improved health self-advocacy and health behavior. Discussion of some of the available studies and resources are identified in a publication, *The State of the Science of Health and Wellness for Adults With Intellectual and Developmental Disabilities*. This publication is available through the National Institute of Health:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677669/>

s. Several respondents asked for clarification on what constitutes a billable Health Home service.

To bill, a CCO/HH must provide at least one of the six Health Home core services outlined in Section 9 of the Application and meet the face-to-face requirements, as applicable. For individuals new to service, the Health Home must provide the standards outlined in Section 10 to bill the one-time payment.

t. There was a request to have the higher PMPM that is available in the first month be extended as it takes more time to engage with this population. Would the OPWDD consider this?

No. The one-month transition fee in OPWDD's proposed approach to CCO/HHs is modeled after payment standards that exist today under MSC. OPWDD will commence funding the new program at the proposed rates, but will work with the NYSDOH to review, on an on-going basis, the adequacy of the payment levels, as the program gains experience.

u. Respondents requested clarification on whether an individual may continue seeing a provider that may not be within the CCO/HH's network of providers and, if once enrolled, whether the CCO/HH can propose a change of medical providers, if it is in the best interest of the individual.

Individuals may continue to see their current medical providers. However, if a referral is necessary, the Care Manager is responsible for making the referral and to support integrated care, that referral may be with a network partner. The individual, however, is not required to use providers that collaborate with the CCO/HH.

14. Network Requirements

Several respondents have asked for further clarification regarding contracts and agreements required among between CCO/HHs, CMAs, and network providers. In addition to the information provided below, more detailed guidance will be provided to Applicants that receive contingent designation.

On Day One of CCO/HH implementation, the CCO/HHs will manage their networks, which are comprised of the following:

- **The Care Management Network** - Current MSC agencies, referred to as Care Management Agencies (CMAs)
- **Network Service Providers** - The CCO/HH must establish a network of partnerships with various service providers to meet the requirements of the Health Home Care Management model and support effective Health Home Care Management and coordination for all enrollees.

Care Management Agency (CMA) Network

a) Respondents requested clarification on what types of agreements are necessary between the CCO/HH and CMA (today's MSC Agency).

At the time the CCO/HH applicant submits its Application, it must identify the MSC agencies with which it will be contracting for the delivery of the CCO/HH Care Management services (i.e., the CMAs). The CCO/HH Application will include a section for identifying these CMA agencies.

To share Medicaid personal health information (PHI), a CCO/HH must enter into a Business Associate Agreement or BAA, which will be submitted and reviewed as part of readiness. All Care Management Agencies will require a BAA. Please note that if a network provider accesses such PHI, it will also be required to attain a BAA. The BAA and additional guidance will be forthcoming.

Network Partners

a. One responder requested clarification regarding the form of the network partner commitment letter, whether it will be standardized, and when it will be required.

Applicants seeking to become CCO/HH will be required to complete and attest to network adequacy to ensure that it has linkages to the full array of services to members. CCO/HH Network Partners must commit to prioritizing CCO/HH referrals for services, and there must be documentation of this formal agreement. To confirm these linkages between the downstream network partners and the CCOs, a network partner commitment letter or other documentation will be required.

Network commitment letters will not be required as part of the application process. Rather, contingently designated CCO/HHs must submit network partner commitment letters during the readiness review process prior to final designation. Network sufficiency will ultimately be evaluated during the readiness period prior to initiation of CCO/HH services.

The State may provide a Network Partner Commitment Letter template. Guidance regarding the deadline of submission for Network Partner Commitment Letters will be forthcoming.

b. Will Support Brokers and Fiscal Intermediary (FI) agencies be included in the partner commitment letters?

Fiscal Intermediaries are a Medicaid HCBS Waiver provider and, therefore, the CCO/HH applicant will seek from them network partner commitment letters. Brokers currently may be independent contractors paid by the FI and, therefore, will not have network partner commitment letters with the CCO/HH.

Other Data Sharing Agreements

a. Will the CCO/HH have a data sharing agreement with NYSDOH?

Yes. Data Use Agreements (DUAs) and Business Associate Agreements (BAAs) are required between the CCO/HH and the Department of Health and allow for the exchange of Medicaid member information. More information will be forthcoming.

15. Quality

a. A respondent raised OPWDD's use of the survey process to support the "early alert" identification of providers that have had substantial and ongoing deficiencies; will these providers be allowed to become part of a CCO/HH? How will OPWDD continue their monitoring of these agencies?

Agencies undergoing Early Alert review will not be excluded from participation in the transition to CCO/HH services, to ensure continuity of care for individuals and families. With the implementation of CCO/HH services, the OPWDD Division of Quality Improvement (DQI) will continue its activities related to certification and surveillance.

b. Please provide additional information regarding valued outcomes. Specifically, if a valued outcome must be tied to a service, can the same one be tied to many services or each tied to only one service? In addition, one respondent asked for clarification why valued outcomes did not include residential preferences.

This expectation is not changing with the implementation of CCO/HH services. HCBS Waiver services must relate to at least one of the individual's valued outcomes. It is expected that the valued outcomes are derived from the person-centered planning process and are found in the profile section of the Life Plan.

As noted in the Person-Centered Planning Regulation FAQ at: (https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning/faq), the CCO/HH Care Manager is responsible for ensuring that the Person-Centered Plan includes documentation that the individual is satisfied with his or her current living arrangement and, if not, that there is active planning to assist the individual to make a change.

c. One respondent suggested that the use of the term "most integrated setting" be changed to "least restrictive setting." In addition, this section appears to be silent on integration of Self-Directed Services into the Health Home Model. Please provide additional information.

The reference in the Application is drawn from OPWDD's valued outcomes and, therefore, the Application will not be amended. Individuals who self-direct their HCBS services will be eligible for CCO/HH services.

- d. One respondent stated that to allow individuals the dignity of risk, CCO/HH processes should include appropriate follow-up and wrap around supports. To achieve this, there should be an additional outcome, satisfaction survey, or incentives to support this activity. One respondent felt that there needs to be a statewide discussion on full community integration involving acceptance of risk.**

The person-centered planning process requires that strategies be developed to address health and safety risks for the individual receiving supports. The goal of safeguard planning is not to eliminate all risk, but to find options that will assist individuals to manage the challenges and associated risks involved in their life choices, including community participation. The Life Plan will enable an individual and his/her support team to identify potential risks and vulnerabilities and develop safeguards to help him/her achieve outcomes or goals that s/he consider to be meaningful and purposeful. The safeguard planning process should not result in overprotection, preventing individuals from leading lives they consider to be significant and productive. The OPWDD has prepared a checklist to assist individuals, families, and providers to identify and discuss risks, informed choices, and safeguards. A copy of the Strengths and Risk Inventory can also be found on the OPWDD website at <https://opwdd.ny.gov/node/5521>.

- e. Is it the expectation that the CCO/HH become Council on Quality and Leadership (CQL) accredited, and will the CCO/HH be responsible for completing Personal Outcome Measures (POMs) interviews? If so, please clarify the frequency and how will this information be shared with providers. Please consider the time and cost associated with reliable POMs interviews and the CQL accreditation.**

The CCO/HH is not required to be CQL accredited. The CCO/HH Applicant, in its Application, must outline how it will deliver quality services and conduct performance management and quality oversight of Care Management services.

- f. Questions were raised concerning oversight of the Life Plan. For Life Plan accuracy and oversight, please describe if there will be an audit protocol available for review, and describe assurances that plans are reviewed for person-centeredness.**

OPWDD has implemented the Person-Centered review protocol and is using that tool for individuals who have an ISP and for people who are today enrolled in the FIDA I/DD plan. The FIDA I/DD uses a Life Plan for its enrollees. OPWDD intends to use the Person-Centered review protocol with the implementation of CCO/HH services, and will evaluate whether future changes are needed.

- g. There was a recommendation that there be a satisfaction survey completed by individuals and family members.**

The Division of Quality Improvement (DQI) Person-Centered review protocol involves interviews with individuals and families to ascertain satisfaction. The State will work with CCO/HHs to assess individual satisfaction.

- h. One respondent noted that transitioning to a value-based payment (VBP) model requires significant changes in data capture and provider behavior. The process is further nuanced by the number of indicators that need to be captured as well as provider capabilities. To enable a successful transition to VBP, it was recommended that the State consider a partner who has experience implementing and managing such programs.**

The State agrees that the development of value based payment (VBP) models requires careful consideration, including input from stakeholders and technical expertise. OPWDD and NYSDOH are initiating a planning process to identify a few key metrics on which VBP initially can be based, and potentially amended over time. Measures must be meaningful, actionable and feasible to collect.

The establishment of a consistent Person-Centered Plan/Life Plan with a standardized framework for identifying Person-Centered desired outcomes lays the groundwork for pursuing a VBP strategy that drives Person-Centered outcomes. VBP will be implemented through managed care. As part of this process, providers over time will increase their IT capabilities and pursue culture change and other organizational adjustments to maximize the opportunities that VBP presents.

OPWDD/DOH will be working with stakeholders to ensure VBP metrics relating to OPWDD services are meaningful and sensitive to the needs of all individuals in the service delivery system. Any measure that is selected for VBP must be feasible to collect, in most cases using secondary data sources

- i. Multiple respondents noted that 6/7 metrics are related to health care, which is not balanced and does not sufficiently include social determinants. Several respondents made specific recommendations for inclusion. Respondents felt the metrics were not Person-Centered but rather promote efficiency of data collection. Clarification was requested.**

The CCO/HHs will follow the Health Home requirements for service and quality oversight. Indeed, early experience with care coordination in the I/DD system suggests the critical importance of capturing and addressing social determinants of health, and linkages with broader health care sector. There are many ways to accomplish this review within the quality framework that will be followed.

- j. Respondents asked about how certain terms would be defined such as “transitioning to a more integrated setting” and “employment.”**

Specific definitions for future quality metrics and VBP development have not yet been drafted.

- k. A respondent stated that most of the quality measures identified are not applicable to all potential I/DD enrollees and that other measures should be added that pertinent. Please clarify what measures are pertinent to which population sub-sets (especially for children).**

It is important to recognize that Health Home quality measures are different, but may be related to, VBP measures. The quality measures identified relate to CCO/HHs and not VBP. It is not anticipated that initial CCO/HH or VBP measures will drill down to specified sub-populations. We recognize that the issue of metrics for the non-adult population requires further discussion. The key initial quality and outcome measures that are recommended for adoption will include the entire population that is served through OPWDD, and not solely those who move from 24/7 settings.

- l. Respondents requested that OPWDD provide clarity as the Request for Application (RFA) seems to be Person-Centered, but the outcomes that will be central to VBP are dedicated to outcomes like DSRIP outcome measures. In addition, please explain how current OPWDD reporting requirements and current HH standards would translate to CCO/HH and whether CCO/HHs would have to conform to both.**

The quality measures identified relate to CCO/HHs and not VBP. VBP measures for managed care will be developed in the near future. CCO/HH measures are consistent with many of the policy objectives identified for DSRIP. It is OPWDD's intent to support NYS' Medicaid Roadmap, at the same time we identify how to best capture measures that relate to a primary objective for OPWDD service – person-centeredness. CCO/HH quality measures are different, but may be related to, VBP measures that are developed in the future.

- m. Several respondents indicated that the cited CQL POMS domains don't reflect the most recent changes and stated that there are now 5 factors with updated language.**

The CQL/POMs indicators were updated in June, after the release of the draft Application. OPWDD will update the Application to reflect these new changes.

- n. Please clarify OPWDD expectations regarding the Quality Improvement (QI) requirements and how we intend to measure qualitative goals, for example, a respondent questioned whether CCO/HHs would have to employ a Quality Assurance (QA) system or team. In addition, one respondent requested additional detail regarding how assessments or reports will be conducted, how frequently the reports to OPWDD must be submitted, and whether the results will be shared with the CCO/HH.**

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 to receive CCO/HH services. CCO/HHs must provide timely, comprehensive, high quality health home services 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 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/health_home_policy.htm

- o. One question was received asking how performance and quality metrics would apply to dual eligibles and whether there would be any difference for individuals not exclusively enrolled in Medicaid or those enrolled in private insurance accessing Medicaid as wrap around for Waiver services. Clarification was requested.**

Dual eligible enrollees will be included in the Quality and Process Metrics for the I/DD Health Home Population (Section 15 of Draft Application). If indications of services are found in the Medicaid data, duals will also be included in the Inpatient, Emergency Department and Primary Care Provider utilization measures and Process Measures listed here:

https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/measures.pdf.

Dual eligible enrollees will not be included in the remaining measures on the Health Home Performance Measure set.

16. Information Technology

- a. Is it necessary to link to all Regional Health Information Networks (RHIO)/Qualified Entities (QEs) separately or is it appropriate to connect with one QE that has access to all enrollees via SHIN-NY?**

According to the Final Standards (6h), approved CCO/HH organizations must commit, on Day One, to joining a Qualified Entity (QE), previously known as a regional health information networks (RHIOs) to access a data. An envisioned future state, once the standards and capabilities exist, will be for CCO/HH to also exchange care plan data elements.

The expected Day One implementation would include a plan for the CCO/HH to access their enrollee's clinical data via the Statewide Health Information Network for New York (SHIN-NY). An envisioned future state, once the standards and capabilities exist, will be for CCO/HH to also exchange care plan data elements with their QE/RHIO. Currently, a CCO/HH who enters into a Participation Agreements with their QE/RHIO can gain access to an enrollee's clinical information and QE services if the service provider has a Participant Agreement in place. The Participation Agreement sets forth the terms and conditions governing the operation

of the QE and the rights and responsibilities of the Participants and the QE with respect to the QE, in accordance with SHIN-NY privacy and security policies and procedures¹. Once a Participation Agreement is in place, the QE will work with the participant organization to provision access to authorized users and provide training for the QE/RHIO services. CCO/HHs are only expected to establish a Participation Agreement with one QE/RHIO.

b. What RHIO/Health Information Exchange (HIE) message types are required vs. optional for connectivity?

Upon entering into a QE/RHIO Participation Agreement, the CCO/HH can immediately derive benefits to manage their enrollee's care coordination. The key benefit for QE/RHIO participants is the ability to access all enrollees' data through a single patient look-up function. This patient search function via the QE/RHIO portal will provide the CCO/HH with results culled from all participating providers across the region and state. This information can be used to inform the Life Plan. Access to a QE/RHIO also allows participants to exchange Direct secure messages between providers and receive alerts for enrollee hospital admissions, discharges, and transfers. It is expected that the CCO/HH work towards a direct interface between the QE/RHIO and Electronic Health Record (EHR) to facilitate a single sign on solution to streamline the exchange of information between care team members.

c. One respondent requested the inclusion of a requirement that the Health Homes Care Management software allow for data exchanges, consistent with the Health Homes file specification, from downstream provider EHRs either via a direct connection or an import file.

Data exchange between the CCO/HH and its service providers is dependent upon the platform each entity adopts. The approved CCO/HH's must have a means to obtain clinical data from their service providers for purposes of developing the Life Plan. Coordination and integration of the clinical data between the care coordination organization platform and a service provider's system for the transfer of data needed to inform the Life Plan is the responsibility of the CCO/HH organization.

For clinical service providers, their electronic health record system must qualify under the Meaningful Use provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The provider system must also have the capability to send a Continuity of Care Document (CCD) to the SHIN-NY in compliance with the Statewide Policy Guidance. Service providers that are not clinical would still be required to share information with the CCO/HH to inform the Life Plan, but not from an electronic health record. There is no file specification standard for the data share between a CCO/HH and their service providers as long as the Life Plan elements as prescribed by OPWDD in the CCDD are captured accordingly.

¹ https://www.health.ny.gov/technology/regulations/shin-ny/docs/privacy_and_security_policies.pdf

Approved CCO/HHs will be required to share Life Plan data electronically with OPWDD in the data format prescribed by OPWDD (See Appendix E titled Care Coordination Data Dictionary).

Approved CCO/HHs will be required to send claims transactions from their billing solution direct to Electronic Medicaid of New York (eMedNY) via the standard 837i transaction format. CCO/HHs are required to validate their enrollees from the monthly roster as provided by OPWDD.

- d. Several comments included the need for the consideration of one statewide technology solution. In addition, it was recommended that this technology receive funding from NYS.**

At this time, there is no plan for a universal statewide technology solution to support care coordination. Each approved CCO/HH must adopt a care coordination platform in accordance with the requirements as set forth in this Application.

- e. Please clarify the expectation that enrollees will have access to their Life Plans and accessing their clinical information "through a web-based portal." Please detail how the Life Plan & clinical info will be accessed.**

Care coordination/Electronic Health Record (EHR) platforms adopted by the approved CCO/HHs must have the capability for individuals/ families and their IDT to access their Life Plan and supporting documentation via a secure portal. A portal is a web-based access point that requires a user to establish a unique account with the individual's CCO/HH organization.

Authorized users would access their individual information via a secure website as determined by the CCO/HH. When accessing the portal, the system would prompt for a username and password to authenticate the user into the system. Users would have to obtain authorization from the CCO/HH of the enrolled individual and access would be limited to that individuals/ families and their IDT. Users would be restricted to access only their information via secure link and/or password protected access once authenticated into the portal.

Specifics of the design and how to obtain access is at the discretion of the CCO/ HH based on its technical solution.

17. State Agency Role

- a. Clarification was requested regarding the specific roles and responsibilities the Department of Health (DOH) and the Office for People with Developmental Disabilities (OPWDD) will play with respect to the expansion and subsequent implementation of the CCO/HH model and if the roles will change once the CCO/HH is "live".**

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. The 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 CCO/HHs and monitor the CCO/HHs adherence to State and Federal legal, statutory and regulatory requirements. In addition, DOH and OPWDD will monitor the Health Homes for quality and quality outcomes of the individuals they serve.

- b. A request was made for additional clarification with respect to the State support and enforcement regarding the expectation of the CCO/HH to collaborate with medical professionals. This could include strengthening the language in the Application, and/or providing detail on technical assistance availability and education to the CCO/HH staff.**

The Care Manager is expected to communicate and collaborate regularly with the individual's providers. Prior to CCO/HH implementation, DOH/OPWDD will provide webinars on the Health Home Standards and Requirements. In addition, DOH/OPWDD staff will be available for technical assistance throughout the implementation process.

18. Policy Issues

- a. How will changes (repeal, replacement, or amendment) of the Affordable Care Act (ACA) affect this new OPWDD initiative? Does OPWDD have a "contingency plan"?**

The development of CCO/HH services will strengthen the I/DD service system and better meet the needs of individuals and families for integrated care. We are committed to proceeding with CCO/HH development to meet these important outcomes. If there is a change in Federal law, we may need to consider different implementation strategies.

- b. Respondents are generally unclear on how this model achieves conflict free case management. While it is made clear in the Application that once full implementation of the CCO/HH is achieved that those providing Care Coordination services cannot also provide HCBS services, it has not been clear to families that the CCO/HH entities will likely be partnerships between organizations and agencies that DO provide HCBS services. The governance structure of any designated CCO/HH should be transparent to all stakeholders. Please provide more detail.**

While CCO/HHs will not be providing HCBS services to CCO/HH enrollees, the HCBS providers will be affiliated with the CCO/HH and the individual's Life Plan will provide for referrals and linkages to the needed HCBS services. The State has been

ensured that the CCO/HH program, which will operate under the State's 1115 Waiver, provides for the necessary firewalls to ensure conflict free care.

- c. Is the State concerned that implementation of CCO/HH services on a less than statewide basis will not meet Federal expectation for conflict free case management?**

We anticipate that a transition plan, even if it involves a regional phase-in of Health Homes, that results in statewide coverage of CCO/HH services will meet Federal requirements. The implementation of the current Adult Health Home model was implemented regionally over an 18-month period.

- d. Please provide clarification regarding Plan of Care Support Services (PCSS) as a Waiver service and how this be handled. Can PCSS be eliminated and all those individuals receive Care Management in Tier 1?**

People who are enrolled in PCSS will have the option of either receiving CCO/HH Care Management or receiving opt out HCBS case management from a State Designated Entity.

- e. Respondents suggested adding use of sign language or video capture to meet communication needs. What is the definition of "prevalent language"?**

Part I of the Application, Section 13 has been updated to include sign language close captioning or video capture. Through the Governors Executive Order there are State identified prevalent languages that the CCO/HH must provide translated materials in. In addition to those, the CCO/HH must provide materials when a least 5 percent of the target population speaks a language other than English.

- f. One respondent questioned whether the State will provide supports to help CCO/HHs achieve the communication standards for oral and written materials. A recommendation was for OPWDD to create material for distribution to ensure consistency regarding this initiative.**

This is a CCO/HH responsibility.

19. Managed Care

- a. Several comments related to the move to Managed Care for the I/DD population, including a suggesting that the State review Tennessee's process for incorporating individuals with I/DD into Managed Care/HCBS; identifying a timeline for transitioning and/or connecting the CCO/HHs to the MCO's, as well as a contingency plan should the CMS approval be delayed; duration of the transition period, whether families would have to change their Plan if already enrolled in an MCO providing CCO/HH; and the concern that MCOs may not be ready to handle the complex needs of the I/DD population.**

The State's system of services for people with I/DD must change to better integrate services, promote the better use of resources to meet growing and changing needs, and become truly Person-Centered. OPWDD has a five-year plan that will bring a new era of opportunity and life-long security for people with I/DD. An important step in this transformation is the transition to change the authority under which Home and Community Based Services are delivered into the 1115 Waiver. The Waiver was updated to reflect public comments received through the public comment period which ended on August 25, 2017.

- b. Concern was raised by a few respondents that the proposed model will not provide choice of CCO/HHs or providers. Will current MSC and provider agencies be encouraged to partner with multiple CCO/HH Applicants in their regions (and ultimately, multiple MCOs) as was the case for the HH and Health Homes Serving Children (HHSC) implementation?**

MSC agencies may only partner with one CCO/HHs for the delivery of CCO/HH Care Management. However, service providers other than those providing Care Management in a region will likely be affiliating with multiple CCO/HHs in a region.

20. Miscellaneous

- a. A question was raised about why OPWDD/NYSDOH left out the “the programmatic objectives of the People First Transformation” and only included the “State standards and requirements.”**

As described in the Application, the expansion, tailoring, and implementation of New York's Health Home care management model to serve individuals with I/DD will assist in implementing the Transformation Panel's 61 recommendations. Those recommendations are designed to bring more choice and flexibility to the provision of comprehensive care management and assessment and, ultimately, other services. The Performance Management and Quality Metrics section of the application indicates that the CCO/HH will be expected to collect and report I/DD-specific outcome data demonstrating the degree to which individuals live in the most integrated setting, including the Transformation goals of increasing the number of people employed, self-directing, and living in the community.

- b. Providers would benefit from a tool that collects and provides updated information about available community services and programs. Such a tool enhances member experience, helps families address multiple needs, and improves the care coordination process. Recommendation that the State seek an integrated online, one-stop resource to support providers and individuals with I/DD and their families. Can this be provided?**

There are several community information and referral resources that are available on a statewide basis. CCO/HHs will be required to assess these resources.

c. A definition of “Emergency Consultation Services” was requested.

Emergency Consultation Services are included within the HH Core Service category of Care Coordination and Health Promotion Core Service. The CCO/HH ensures 24 hours/seven days a week availability to a Care Manager to provide information and emergency consultation services. The CCO/HH must provide a 24-hour emergency telephone number to each individual served and have a reliable system in place to ensure that each individual has been provided with this number. The emergency number will be answered by a staff person who will be able to provide support to the individual calling. If the individual is calling in regards to a behavioral and/or mental health crisis, and receives NY Systemic, Therapeutic, Assessment, Resources and Treatment (START) services, the Care Manager can connect the caller to his/her NY START team. If the individual is not connected to a START team the Care Manager should refer the individual to other local crisis supports (911/mobile crisis, etc.) and the Care Manager can make a referral, on the individual’s behalf, during regular business hours to his/her local START team.

d. Please detail the OPWDD Family Support Services’ role in this new plan and how will oversight of the Advisory Councils throughout the State be affected. Roles for each need to be continued and clearly defined.

OPWDD State-funded Family Support Services, will continue with the implementation of the CCO/HH and the role of the Advisory Councils will not change. The Care Manager will assist people to access programs and services funded by Family Support Services just as MSC service coordinators do today.

e. Clarification and additional detail was requested regarding the definition of “evidence based referrals.”

The Application will be revised to use the term “referral.”