



**Department  
of Health**

**Office for People With  
Developmental Disabilities**

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## **Care Coordination Organization/Health Home (CCO/HH) Application to Serve Individuals with Intellectual and/or Developmental Disabilities**

[https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/idd/](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/)

**New York State Department of Health**

**New York State Office for People With  
Developmental Disabilities**

**October 6, 2017**

## Introduction

The New York State Department of Health (DOH) and the New York State Office for People With Developmental Disabilities (OPWDD), herein after referred to as “the State,” is working to expand and tailor the Health Home care management program to serve Individuals with Intellectual and/or Developmental Disabilities (I/DD). I/DD tailored Health Homes will also be known as Care Coordination Organization/Health Homes (CCO/HHs). OPWDD’s vision is that I/DD tailored Health Homes will serve as important regional leaders in the development of specialized managed care options for individuals with I/DD.

Part I of this Application provides stakeholders and qualified parties interested in becoming designated by the State as a CCO/HH with important information about the Health Home care management program, including:

- The important role designated CCO/HHs will have in providing person-centered, integrated care management to the I/DD community and their option to have a leadership role in the development and implementation of specialized I/DD managed care plans to facilitate the transition of the I/DD population to managed care;
- The anticipated schedule for CCO/HH designation, readiness and implementation activities;
- How the existing Health Home model, including Health Home eligibility criteria, will be tailored to meet the unique needs of the I/DD population; and
- State requirements and standards for serving the I/DD population in Health Homes and delivering the six core Health Home services, including:
  - Comprehensive assessments for the I/DD population to identify medical, behavioral, social and community services;
  - Using a Life Plan to create and implement the Health Home person-centered plan and comprehensive planning process required by the Health Home model;
  - Health Home Health Information Technology (HIT) and other systems requirements;
  - Per member, per month (PMPM) rates for CCO/HH;
  - Care Manager and network requirements; and
  - Performance management and quality oversight.

## Application Attachments and Appendices

Part I of this Application includes the following Attachments and Appendices.

<b>Application Attachments and Appendices</b>	
Attachment A & B	<i>Completed</i>
Attachment C	Health Home Model Graphic
Attachment D	Health Home Network Partner Information
Attachment E	Mercer Data Summary
Appendix A	Care Coordination Organization (CCO/HH) Glossary
Appendix B	Care Management Payment Level Tiers

## **Application Review Process**

Applications will be reviewed by a team of State staff from DOH and OPWDD. In reviewing Applications, the review team will consider the comprehensiveness of the Application. Areas of review and focus will include: the comprehensiveness of the Applicant's partner network, including the inclusion of qualified Care Managers and current Medicaid Service Coordinators (MSC), and providers' expertise in providing physical, behavioral health and community supports services to the individuals with I/DD; the demonstrated ability to meet the standards and requirements of the CCO/HH, including the delivery of the six core services; and the demonstrated ability to promote inclusion and cultural competence by establishing sufficient partnerships with entities serving various cultural groups in the region in which the CCO/HH will be designated to operate.

Based on the Applicant's demonstrated level of comprehensiveness and competency, a CCO/HH will be "contingently designated" to serve individuals with I/DD, subject to the completion and review by the State of readiness activities and any other requirements identified by the State team. Upon completion and approval of those activities by the State, the CCO/HH will be formally designated and may begin operations.

### **Part I of the I/DD Health Home Application**

#### **1. Programmatic Goals and Role of CCO/HHs in the I/DD Medicaid Transformation**

OPWDD is committed to helping individuals with I/DD live richer lives, and creating stronger person-centered services, now and into the future. In furtherance of this commitment, in 2015, the Commissioner formed a Transformation Panel of individuals receiving services, family members, providers, and advocates, designed to chart a course for the future of our system. The panel released a set of recommendations, designed among other things, to assist OPWDD in the transition to managed care.

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 CCO/HH model and its requirements will provide the strong stable person-centered approach to holistic service planning and coordination required to ensure the delivery of quality care that is integrated and supports the needs of individuals with I/DD. Health Homes designated to serve individuals with I/DD will also be known as Care Coordination Organization Health Homes (CCO/HHs) and are referred to as such throughout this Application.

The delivery of specialized Health Home services to individuals with I/DD will be the first phase and foundation for the transition to managed care serving the I/DD population. It is anticipated that CCO/HHs will develop the capacity and transition from the provision of Health Home care management to specialized Managed Care Organizations (MCOs) or enter agreements with existing MCOs to provide care management to individuals with I/DD.

Designation of an entity to serve as a CCO/HH does not guarantee subsequent approval as an I/DD MCO; nor is CCO/HH designation contingent on the willingness of an entity to further develop an I/DD MCO plan. The State will initiate a separate process for establishing CCO/HH's as managed care plans, including managed care plan standards and network requirements. The final design for I/DD MCOs and the transition of OPWDD HCBS services and its service population to managed care will be described in an amendment to the Medicaid Redesign Team 1115 waiver and is subject to approval by the Centers for Medicare and Medicaid Services (CMS). The authority to expand the Health Home model to serve individuals with I/DD is also subject to CMS approval.

**2. Final Schedule for the Implementation of Care Coordination Organizations/Health Homes to serve IDD**

<b>Final Schedule for the Implementation CCO/HHs to serve Individuals with I/DD</b>	
<b>Activity</b>	<b>Due Date</b>
Final Health Home Application to Serve Individuals with I/DD Released	October 6, 2017
Due Date to Submit Health Home Application to Serve Individuals with I/DD	November 30, 2017
Review and Approval of Health Home Applications to Serve Individuals with I/DD by the State	December 1, 2017 to February 28, 2018
Health Home and Network Partner Readiness Activities	March 1, 2018 to June 30, 2018
State Webinars, Training, and Other Readiness Activities	Through June 30, 2018
Transition to CCO/HH Care Management for individuals with I/DD	July 2018

The Transition Plan, which will be published for a thirty-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.

**3. New York's Health Home Care Management Model and Expanding and Tailoring the Health Home Model to Serve individuals with I/DD**

Under the authorization of the Affordable Care Act, New York's State Plan with the CMS, and State-issued requirements and standards tailored to meet the unique needs of populations (adults, children under 21 and now individuals of all ages with I/DD), New York's Health Home care management model provides comprehensive person-centered management and planning to Medicaid enrollees with authorized chronic conditions. Health Home is an optional Medicaid benefit and individuals have a choice of a Health Home and Care Manager.

**4. Health Homes in New York State and Health Home Eligibility Requirements**

The initial implementation and approval of the State Plan for Health Homes by CMS in 2012 envisioned that Health Homes would initially serve adults, expand to serve children (2016), and then expand to serve individuals with I/DD. There are currently 34 Health Homes designated to operate in New York for coordination of services for individuals who primarily have two or more chronic conditions, a serious mental illness (SMI) or serious emotional disturbance

(SED), complex trauma or HIV/AIDS. Each serve one or more counties in the State (i.e., a Health Home's designated service area), and more than one Health Home may be designated to operate in the same county. To date, New York has designated Health Homes to serve adults, children (defined as individuals under 21), or both. There are 13 Health Homes that serve adults and children, 3 serve only children and 18 serve only adults.

Under the current Health Home State Plan, to be eligible for Health Home care management, an individual must be enrolled in Medicaid and have two or more chronic conditions or a single qualifying condition of:

- HIV/AIDS,
- Serious Mental Illness (SMI adults) or Serious Emotional Disturbance (SED children), or
- Complex Trauma (children)

Chronic conditions (from the following major categories of 3M™ Clinical Risk Groups (CRGs)) include: Alcohol and Substance Abuse, Mental Health Condition, Cardiovascular Disease (e.g., Hypertension), Metabolic Disease (e.g., Diabetes), Respiratory Disease (e.g., Asthma), and Body Mass Index BMI >25 (adults), BMI at or above the 85th percentile for children, and other chronic conditions. For individuals to be eligible for Health Home they must also meet the following appropriateness criteria:

- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Have inadequate social/family/housing support, or serious disruptions in family relationships;
- Have inadequate connectivity with the healthcare system;
- Does not adhere to treatments or have difficulty managing medications;
- Have recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- Have deficits in activities of daily living, learning or cognition issues; or
- Are concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home.

To expand the Health Home model to serve individuals with I/DD, the State plans to submit for CMS approval an 1115 Waiver Amendment and a State Plan Amendment (SPA) that will expand the Health Home eligibility criteria to include the following categories of I/DD chronic conditions:

***Developmental Disability Health Home Chronic Conditions Categories***

1. Intellectual Disability
2. Cerebral Palsy
3. Epilepsy
4. Neurological Impairment
5. Familial Dysautonomia
6. Prader-Willi Syndrome
7. Autism

- Individuals (adults and children) who have at least one of the I/DD Health Home chronic conditions listed above and that have received a determination made by OPWDD that such I/DD condition results in a substantial handicap to their ability to function normally in society (with onset prior to age 22 and likelihood of indefinite continuation) (i.e., Individuals who are eligible for OPWDD Home and Community Based Services (HCBS) and meet level of care criteria) will be eligible for Health Home services and will be served in a CCO/HH designated to serve individuals with I/DD. Individuals who meet these criteria are eligible for HCBS and Health Home services.
- Through the receipt of service authorizations and other eligibility documentation from CCO/HHs that have worked with children and families providers, OPWDD, through its Developmental Disability Regional Office (DDROs) Front Door, will be responsible for reviewing eligibility documentation establishing that an individual has a I/DD qualifying chronic condition and meets the functional limitations that constitute a substantial handicap defined by Section 1.03 (22) of the New York State Mental Hygiene Law for enrollment in a CCO/HH, as well as for OPWDD HCBS services. The OPWDD Front Door process will remain in place when the I/DD population transitions to Managed Care. However, managed care plans will work with CCO/HH to manage the utilization of HCBS services and ensure their enrollees receive the appropriate services.
- Individuals who have at least one of the I/DD Health Home chronic conditions categories listed above (and have not received an OPWDD determination that such I/DD condition results in a substantial handicap to their ability to function normally in society and/or are not receiving OPWDD HCBS) and one or more other non-IDD eligible chronic conditions and meet the Health Home appropriateness criteria are eligible for Health Home services. Individuals in this Health Home eligibility group who are 21 and over may be served by Health Homes designated to serve adults and those under 21 may be served by Health Homes designated to serve children. Health Homes will be responsible for verifying and documenting Health Home eligibility criteria for this group of individuals.
- Individuals who are currently being served under the OPWDD Care at Home (CAH) Waiver#NY.40176 and the DOH CAH Waiver #NY.4125 that will transition to Health Homes or who will meet the “level of care” criteria (i.e., the medically fragile I/DD population) established in the proposed Children’s Section 1115 Medicaid Redesign Team Waiver and are eligible for Children’s HCBS will be served in Health Homes currently designated to serve children. Health Homes will be responsible for verifying and documenting Health Home eligibility criteria for this group of individuals.
- Individuals who are determined, by the OPWDD Front Door process, to be eligible for Health Home and OPWDD HCBS services, and decline OPWDD HCBS services but opt to receive Health Home care management may be served in Health Homes designated to serve adults or children.
- Individuals who are enrolled in the FIDA I/DD Plan receive comprehensive care management that is comparable to the requirements of the Health Home model. To avoid the duplication of services, individuals enrolled in FIDA I/DD Plan may not be enrolled in Health Home.

## **5. The Health Home – the Role of the Primary Governance Entity**

The Health Home model (Attachment C) includes a primary governance entity (i.e., entities interested in becoming designated CCO/HHs) that is responsible for administration and oversight of the Health Home, including:

- Developing and maintaining a Health Home partner network s, including current Medicaid Service Coordination (MSC) agencies that will transition to Health Home care management

agencies (CMAs) and employ Care Managers who are qualified to provide care management to Medicaid individuals with I/DD. The CCO/HHs will be required to have commitment letters with providers of physical, behavioral health services, developmental disability, long term services and supports, HCBS, regional START (Systemic, Therapeutic Assessment, Resources and Treatment) teams, and specialty providers that will provide and implement the services included in the Health Home person-centered Life Plan. See section 11 of this Application for details on network requirements;

- Entering contractual relationships with MSC agencies or upon initiation of Health Home services, directly employing MSC service coordinators who will transition (as a Care Management Agency for up to a year) to Health Home and other qualified Care Managers to provide Health Home care management. See section 10(e) regarding requirements for CCO/HH Care Managers;
- Entering Administrative Services Arrangements (ASAs) with managed care plans to provide Health Home care management to individuals already enrolled in managed care plans (as may be applicable for a small part of the I/DD population)
- Monitoring adherence to Health Home standards and requirements tailored to meet the needs of individuals with I/DD;
- Ensuring Care Managers are knowledgeable and qualified to serve individuals with I/DD;
- Performing quality oversight and performance management;
- Implementing training and education of Health Home Care Managers;
- Health Home billing and billing systems;
- Identifying comprehensive assessments for individuals with I/DD to identify medical, behavioral, and social and community services;
- Requiring and employing a standardized Life Plan to be used by Care Managers, which will be known as the Life Plan and is described herein, to develop and meet the care planning requirements of the Health Home program;
- Meeting the Health Home HIT requirements as described herein, including the development and use of an electronic Life Plan that meets the I/DD Health Home standards; and
- Use of and/or development of systems as may be required by the State to meet the Health Home requirements.

## **6. Who Can Apply to be a CCO / Health Home?**

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). New York State's expectation is that the governance structure and leadership of the I/DD Health Home (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State; prior experience in overseeing and operating entities that have delivered MSC or HCBS waiver services to individuals with I/DD, and are in good standing with the State.

Currently designated Health Homes that can demonstrate a governance structure that has been expanded to have at least 51 percent of its controlling interests represented by one or more non-profit organizations with a history of providing or coordinating developmental disability services, long term care and health services to individuals with I/DD, including MSC and LTSS, may submit an Application to expand their current Health Home designation to serve individuals with I/DD.

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 HIT core requirements.

**7. Regional Designation of I/DD Health Homes**

The State anticipates it will designate CCO/HHs to serve regional areas that are defined and in alignment with OPWDD DDROs. Those regions are defined as follows:

**Region 1** – Allegany, Cattaraugus, Chautauqua, Chemung, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Schuylar, Seneca, Steuben, Wayne, Wyoming, Yates

**Region 2** – Broome, Cayuga, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, Otsego, St. Lawrence, Tioga, Tompkins

**Region 3**- Albany, Columbia, Dutchess, Fulton, Greene, Montgomery, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, Westchester

**Region 4** – Bronx, Kings, Queens, New York, Richmond

**Region 5** – Suffolk, Nassau

The State’s goal is to provide CCO/HH services statewide, including a choice of CCO/HH in a region wherever possible. Applicants will be required to identify the OPWDD region or regions in which they intend to operate. CCO/HH Applicants are expected to apply for designation in all counties in an OPWDD Region. An Applicant may request designation to serve part of an OPWDD Region on an exception basis, provided the counties are contiguous and that approval of the CCO/HH coverage area supports the State’s goal of statewide coverage and choice of CCO/HH.

Successful Applicants must demonstrate that the CCO/HH will have the capacity to provide Health Home care management and deliver the Health Home core services to individuals who live in all counties within the area in which the CCO/HH is approved to operate. It is anticipated that successful CCO/HH Applicants will demonstrate the capacity to serve 10,000 enrollees. Applicants with a capacity to serve at least 5,000 enrollees may be considered for designation; however, such Applicants will be required to share a financial plan for review and consideration.

The table below shows the number of individuals with I/DD who are enrolled in care management (both Medicaid Service Coordination and Care Plan Support Services) by OPWDD Region in 2016.

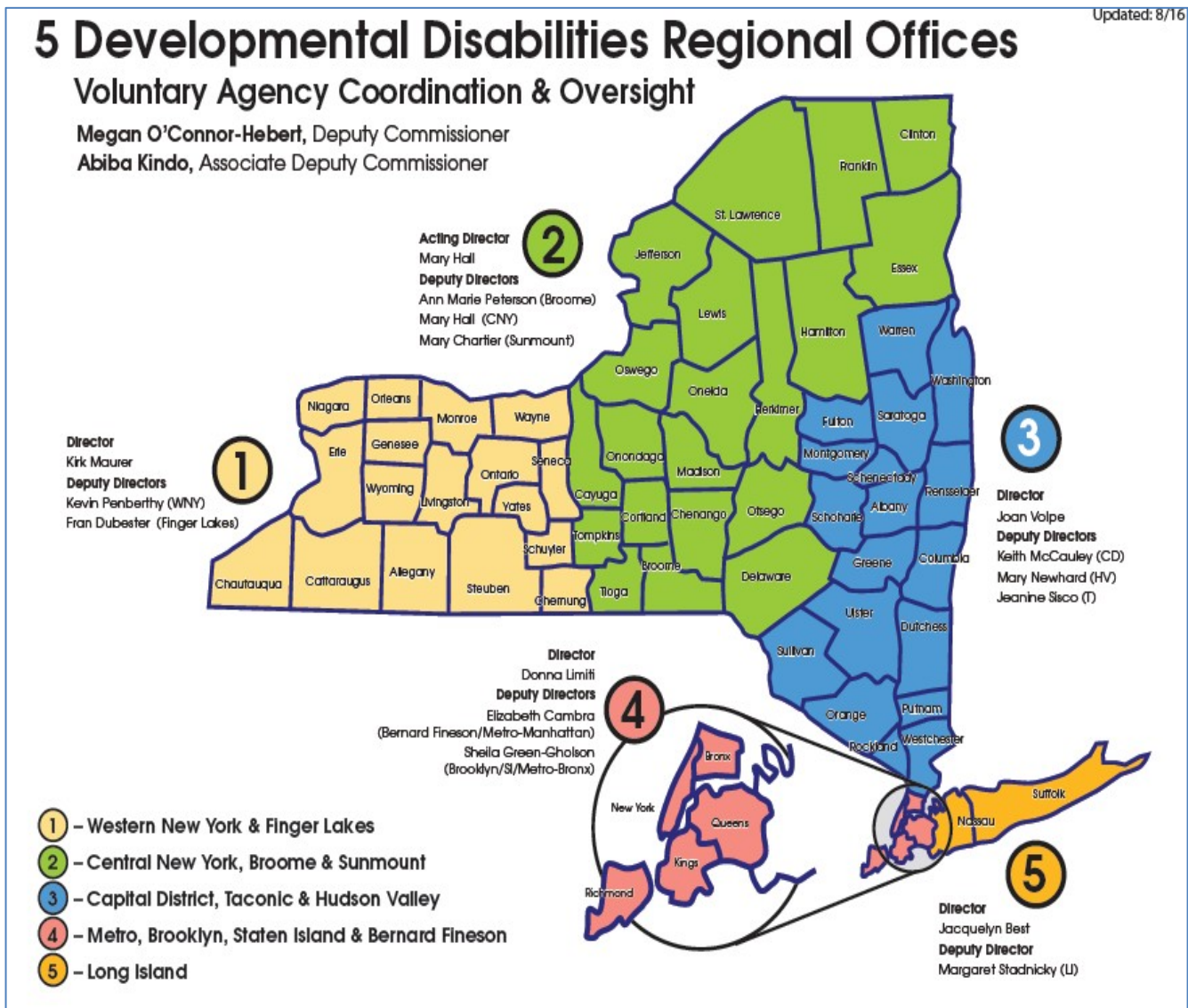
OPWDD Regions # of Individuals in MSC and Support Services (2016)					
Region 1	Region 2	Region 3	Region 4	Region 5	Total
21,025	15,439	19,639	31,465	10,931	98,499



In addition, the table below illustrates the number of adults and children served by Region.

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%
<b>STATEWIDE</b>	<b>72.1%</b>	<b>27.9%</b>

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



## 8. Regional Phase-in of the Designation and Implementation of CCO/HH to serve I/DD

It is anticipated that the designation and implementation of the CCO/HH will be phased in on a regional basis. Approval of and enrollment into CCO/HHs will happen through a regional rollout, as determined by the State during the Application and review/approval process. The ultimate process and phase-in schedule for designation and implementation will primarily be driven by CCO/HH readiness.

## 9. Health Home Core Services and Requirements

The State Plan and State Standards and Requirements require the following six Health Home core services be provided by designated Health Home providers. 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, the Valued Outcomes of OPWDD and the programmatic objectives of the People First Transformation, and meets State standards and requirements as defined below.

### OPWDD's Valued Outcomes

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

### 1. Comprehensive Care Management

CCO/HHs will be required to have policies and procedures in place to create, document, execute and update individualized, person centered plans of care for each enrollee (the Life Plan). The Life Plan is the person's care plan that is electronic and supported by a care planning information system. The information system includes elements that are part of the Life Plan and other information needed to support comprehensive care management. Throughout this document, the term Life Plan includes those electronic data elements that are part of the Life Plan and that support the comprehensive care management services. The goal of initial and ongoing assessment and care management services is to integrate primary, behavioral and specialty health care and community support services in a manner that addresses all clinical and non-clinical needs, promotes wellness and management of chronic conditions in pursuit of optimal health outcomes and supports enrollees' wishes.

CCO/HHs will be required to ensure that comprehensive health assessments and tools are identified and employed to identify the health and behavioral health care, community supports, and other services required to meet the needs of the enrollee with I/DD. In addition, CCO/HHs are also required to ensure all comprehensive Life Plans prepared for CCO/HH enrollee include such services and, at a minimum, all the elements of the Life Plan

described herein.

Comprehensive care management services include the following activities and must be reflected and documented in each Life Plan.

1a. A comprehensive health assessment that identifies medical, mental health, chemical dependency, developmental disabilities and social service needs.

1b. The individual's Life Plan integrates the continuum of medical, behavioral health services, rehabilitative, long term care, developmental disabilities and social service needs and that clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), developmental disability providers, Care Manager and other providers directly involved in the individual's care.

1c. The individual and their family and/or representative and those chosen by the individual to play a central and active role in the development and a means for execution of his/her Life Plan. Parties should agree with the goals, interventions and time frames contained in the plan.

1d. The individual's Life Plan clearly identifies primary, specialty, behavioral health, I/DD, and community networks and supports that address his/her needs.

1e. The individual's Life Plan clearly identifies family members and other supports involved in the enrollee's services. Family and other supports are included in the plan and execution of care as requested by the individual.

1f. The individual's Life Plan clearly identifies goals and timeframes for improving the enrollee's health and health care status, independence and community integration, and the interventions that will produce this effect.

1g. The individual's Life Plan must include outreach and engagement activities that will support engaging enrollees in care and promoting continuity of care.

1h. The individual's Life Plan includes periodic reassessment of the individual's needs and clearly identifies the enrollee's progress in meeting goals and changes in the Life Plan based on changes in the enrollee's need.

## **2. Care Coordination and Health Promotion**

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

Health promotion services include, but are not limited to, the following:

- Providing to enrollees' education of their chronic condition
- Teaching self-management skills
- Conducting medication reviews and regimen compliance
- Promoting wellness and prevention programs by assisting Health Home enrollees with resources that address exercise, nutrition, stress management, substance use reduction/cessation, smoking cessation, self-help recovery resources, and other wellness services based on enrollee needs and preferences

2a. The CCO/HH provider is accountable for engaging and retaining CCO/HH enrollees in the coordinating and arranging for the provision of services, supporting adherence to treatment recommendations and monitoring and evaluating an enrollee's needs, including prevention, wellness, medical, specialist and behavioral health treatment care transitions, I/DD services, LTSS, and social and community services where appropriate through the creation of an individual's Life Plan.

2b. The CCO/HH will assign each individual a dedicated Care Manager who is responsible for coordinating all aspects of the individual's care and overall management of the Life Plan. The CCO/HH Care Manager is clearly identified in the enrollee record. The individual cannot be enrolled in more than one care management program funded by the Medicaid program.

2c. The CCO/HH must describe the relationship and communication between the dedicated Care Manager and the treating clinicians that assure that the Care Manager can discuss with clinicians on an as needed basis, changes in enrollee condition that may necessitate treatment change (i.e. written orders and/or prescriptions) update.

2d. The CCO/HH must define how it will document care decisions when conflicting treatment is being recommended or provided.

2e. The CCO/HH has policies and procedures and an accountability structure (contractual agreements) to support effective collaborations between primary care, specialist, behavioral health and developmental disability providers, referrals and follow-up and consultations that clearly define roles and responsibilities.

2f. The CCO/HH supports continuity of care and health promotion through the development of a treatment relationship with the enrollee and the interdisciplinary team of providers.

2g. The CCO/HH supports care coordination and facilitates collaboration through the establishment of regular case review meetings (i.e., person-centered Life Plan review), including all members of the interdisciplinary team on a schedule determined by the CCO/HH and enrollee. At a minimum, the schedule for the Life Plan review will occur as it does today, which requires the plan is reviewed at least twice each year. The CCO/HH provider has the option of utilizing technology conferencing tools including audio, video, and/or web-deployed solutions when security protocols and precautions are in place to protect PHI (Personal Health Information).

2h. The CCO/HH ensures 24 hours/seven days a week availability to a Care Manager to provide information and emergency consultation services.

2i. The CCO/HH will ensure the availability of priority appointments for enrollees to medical and behavioral health care services within their CCO/HH provider network to avoid unnecessary, inappropriate utilization of emergency room and inpatient hospital services.

2j. The CCO/HH promotes evidence based wellness and prevention by linking enrollees with resources for smoking cessation, diabetes, asthma, hypertension, self-help recovery resources, and other services based on individual needs and preferences.

2k. The CCO/HH has a system to track enrollee information and care needs across providers and to monitor enrollee outcomes and initiate changes in care as necessary, to address enrollee need.

### **3. Comprehensive Transitional Care**

This Health Home core service includes the facilitation of services for the individual and their family and/or representative when the individual is transitioning between levels of care (including but not limited to hospital, nursing facility, Intermediate Care Facility (ICF), rehabilitation facility, community based group home, family or self-care) or when an individual is electing to transition to a new Health Home provider. This involves developing relationships with hospitals and other institutions and community providers to ensure and to foster efficient and effective care transitions. Hospitals are required to have procedures in place for making Health Home referral available to individuals seeking treatment in a hospital emergency department. CCO/HH should work together to establish processes to make and receive referrals from hospitals. Note: Health Home care management services may only be billed in the month of admission or discharge to an inpatient facility, including a hospital or psychiatric hospital, or ICF. This core service also includes care planning for individuals with I/DD transitioning from school to adult services, life changes (employment, retirement, other life events), or when an individual is electing to transition to a new CCO/HH provider or a new Care Manager within the same CCO/HH.

3a. The CCO/HH has a system in place with hospitals and residential rehabilitation facilities in their network to provide the Health Home prompt notification of an enrollee's admission and/or discharge to/from an emergency room, inpatient, or residential/rehabilitation setting.

3b. The CCO/HH has policies and procedures in place with local practitioners, health facilities, including emergency rooms, hospitals, and residential/rehabilitation settings, providers and community-based services to help ensure coordinated, safe transitions in care for its individual enrollees who require transfers in the site of care.

3c. The CCO/HH utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the enrollee, family and/or representative, and local supports.

3d. The CCO/HH has a systematic follow-up protocol in place to assure timely access to follow-up care post discharge that includes at a minimum receipt of a summary care record

from the discharging entity, medication reconciliation, timely scheduled appointments at recommended outpatient providers, Care Manager verification with outpatient provider that the enrollee attended the appointment, and a plan to outreach and reengage the enrollee in care if the appointment was missed.

#### **4. Individual and Family and Support**

This Health Home service includes coordinating of information and services to support enrollees and enrollees' family and/or representative to maintain and promote quality of life, with a focus on community living options. CCO/HH's will provide access and linkages to supports for families. Individual and family support services include the following activities:

- Providing education and guidance in support of self-advocacy.
- Providing caregiver counseling or training, including promotion of skills to provide specific treatment regimens to help the individual improve function, obtaining information about the individual's disability or conditions, and assistance to navigate the service system.
- Identifying resources to assist individuals and family members in acquiring, retaining, and improving self-help, socialization and adaptive skills.
- Providing information and assistance in accessing services such as: self-help services, peer support services, housing, transportation; and respite services.

4a. An enrollee's individualized Life Plan reflects enrollee and their family and/or representatives preferences, education and support for self-direction, self-help, and other resources as appropriate.

4b. An enrollee's individualized Life Plan is accessible to the individual and his/her family and/or representative based on the individual's preference either electronically and/or via mail.

4c. The CCO/HH utilizes peer supports, support groups and self-care programs to increase an enrollee's and his/her family and/or representative's knowledge about his/her disease, engagement and self- management capabilities, and to improve adherence to prescribed treatment

4d. The CCO/HH discusses advance directives with the enrollee and their families or caregivers.

4e. The CCO/HH communicates and shares information with enrollees and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences.

4f. The CCO/HH gives the enrollee and if they agree, their family members access to Life Plans and options for accessing clinical information.

#### **5. Referral to Community and Social Support Services**

This Health Home core service includes providing information and assistance to engage and refer enrollees and enrollee support members (including family members and/or

representatives and others as determined by the enrollee) to community based resources, (regardless of funding source) that can help meet the needs identified on the enrollee's person-centered Life Plan. This core service is intended to include activities that connect and monitor individual's community activities and opportunities, develop relationships with others, and foster independence and integration, including employment.

5a. The CCO/HH identifies available community-based resources and actively manages appropriate referrals, access, engagement, follow-up and coordination of services.

5b. The CCO/HH has policies, procedures and an accountability structure (contractual agreements) to support effective collaborations with community-based resources, which clearly define roles and responsibilities.

5c. The Life Plan should include community-based and other social support services as well as healthcare, long term supports and services and I/DD services that respond to the enrollee's needs and preferences and contribute to achieving the enrollee's goals.

## **6. Use of Health Information Technology to Link Services**

CCO/HH are required to meet the following HIT standards in the delivery of the Health Home core services. The CCO/HH Life Plan must meet the requirements and standards of the Life Plan (described in more detail in section 7 of this Application) and, as required by the HIT requirements described herein, be an electronic Life Plan.

As feasible, the CCO/HH must make use of available information systems and access data through the regional health information organization/qualified entities to conduct Health Home processes, that comply with the Initial Standards described below, including the capacity to access state-identified systems and provide a care management system to ensure the availability of information necessary to carry out the CCO/HH core services. To be designated CCO/HHs, Applicants must provide a written plan to achieve compliance with the "Final Standards" described below within six months of program initiation.

### **Initial Standards:**

6a. CCO/HH has structured information systems, policies, procedures and practices to electronically create, document, execute, and update a Life Plan for every enrollee.

6b. CCO/HH has a systematic process to follow-up on tests, treatments, services and referrals, which is incorporated into the enrollee's Life Plan.

6c. CCO/HH has an electronic record system which allows the enrollees health information and Life Plan to be accessible to the interdisciplinary team of providers and which allows for population management and identification of gaps in care including preventive services.

6d. CCO/HH makes use of available HIT and accesses data through the RHIO/QE to conduct these processes, as feasible.

In addition, as of the initial date of operation:

- The CCO/HH must ensure the Life Plan employs the Care Coordination Data Definitions (CCDD). The (CCDD establishes data standards between the OPWDD and comprehensive care coordination providers. These standards allow care coordination providers to share necessary Life Plan data with OPWDD. The current CCDD (see: [https://opwdd.ny.gov/opwdd\\_services\\_supports/care\\_coordination\\_organizations/definitions](https://opwdd.ny.gov/opwdd_services_supports/care_coordination_organizations/definitions)) is a continually evolving document and will progressively advance as the CCO/HH program evolves and is implemented and the I/DD population transitions to managed care. OPWDD will engage stakeholders during the CCO/HH application public comment period to align with Federal and State Health Home standards and quality measures.
- The CCO/HH must use systems provided by the State to verify OPWDD and Health Home eligibility, enroll and track enrollees in the CCO/HH, capture the individual's choice for CCO/HH, conduct comprehensive assessments, calculate CCO/HH rate tiers and generate CCO/HH enrollee rosters.
- Based on preliminary assessment by the State, CCO/HH will be required to provide a case management software solution and access to State systems as described in the following table. Additional guidance and detail regarding the use of State systems is now included in the Final Application. The State is now assessing the feasibility of modifying the Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS) for the CCO/HHs. Currently, it is anticipated that following an initial start-up of CCO/HH and a transition period, CCO/HHs will be required to use the MAPP HHTS to track enrollment of enrollees as indicated in the table below.



**Preliminary Assessment of System Uses and Requirements for CCO/HHs**

<b>System</b>	<b>System Description</b>	<b>Day 1 Use</b>	<b>Future Use</b>
<b>CHOICES</b>	CHOICES is the software application provided by OPWDD for purposes of accessing an individual’s record that includes their DD eligibility status, enrollment status, consent verification, Developmental Disability Profile (DDP) assessment, Coordinated Assessment System (CAS) summaries and related outcomes including HCBS service authorizations	<ul style="list-style-type: none"> <li>Record individual’s choice of CCO/HH</li> <li>Process CCO/HH Enrollments and Dis-enrollments</li> <li>Review DDP2 assessment outputs including CCO/HH rate tiers</li> <li>Verify HCBS services authorized by OPWDD</li> <li>Confirm CCO/HH consent</li> <li>Access CAS assessment summaries</li> <li>Verify pertinent enrollee information included in their demographic profile</li> <li>Download enrollee roster</li> <li>Complete LOC</li> </ul>	<ul style="list-style-type: none"> <li>Verify HCBS services authorized by OPWDD</li> <li>Verify pertinent individual information</li> </ul>
<b>Tracking And Billing Systems (TABS)</b>	TABS is the State system of record storing information on individuals receiving OPWDD HCBS services	<ul style="list-style-type: none"> <li>Calculates the CCO/HH rate tier based on data from DDP2 assessment and other enrollee characteristics</li> <li>CCO/HH rate tiers will be included on enrollee roster that the CCO/HH will download from CHOICES</li> <li>CCOs will not have direct access to the TABS, but will have access to pertinent TABS data through CHOICES.</li> </ul>	<i>Phased out</i>

**Preliminary Assessment of System Uses and Requirements for CCO/HHs**

<b>System</b>	<b>System Description</b>	<b>Day 1 Use</b>	<b>Future Use</b>
<b>CCO/HH HIT Systems Capability (e.g., EHR Life Plan, Billing systems etc.)</b>	The system used by the CCO/HH to manage the Life Plan and support the operation of HH core services in accordance with Health Home standards and as prescribed by the State	<ul style="list-style-type: none"> <li>• Upload/Record enrollee roster from CHOICES</li> <li>• Develop and maintain an individual’s Life Plan as defined by the State and Health Home standards and requirements</li> <li>• Process and track enrollments for downstream providers</li> <li>• Timely bill for services and remit payments to Care Managers in accordance with NYS Medicaid processes</li> <li>• Generate quality measures reports</li> </ul>	<ul style="list-style-type: none"> <li>• Continue all Day 1 Uses and further enhancements as may be required</li> </ul>
<b>MAPP/HHTS</b>	Performance management system that provides tools to Health Homes to support providing care management	Not available on Day 1	<ul style="list-style-type: none"> <li>• Process CCO/HH Enrollments and Dis- enrollments</li> <li>• CCO consent verification and management</li> <li>• Quality Analytics</li> </ul>
<b>Uniform Assessment System-New York (UAS-NY)</b>	UAS is the NYS assessment system containing the CAS tool, which has been specifically developed to capture the unique needs of individuals with I/DD in New York State	CAS is not fully implemented Statewide but for individuals who have been assessed using the CAS, providers will review information in UAS through CHOICES	<ul style="list-style-type: none"> <li>• CAS implemented Statewide</li> <li>• CCO/HHs will have access to view the initial CAS for purposes of aiding in service planning</li> <li>• CCO/HHs will be conducting CAS re- assessments through UAS</li> </ul>

- Provide the capability for individuals, families, providers and the State to access, via a secure web-based portal, the Life Plan and to view or upload documents

and input information to the Life Plan, including but not limited to, clinical notes, progress notes and other related documentation.

- CCO/HH has a billing system that allows for timely claims submission to the State's Medicaid management information system and payment to Care Managers.
  - CCO/HH IT capability to develop and produce reports, where applicable and as described in Section 14 - Performance Management and Quality Metrics, of this Application.
  - CCO/HH IT capability must maintain interoperability with other defined State systems using NYS ITS approved protocols.
- CCO/HH IT capability must provide access for individuals/families to the Life Plan and other related documentation via a secure portal that includes digital signature and bi-directional communications functionality for the approval and management of the Life Plan between the enrollee and the CCO/HH.
  - CCO/HH IT capability must capture the individual's consent, electronically share changes to demographics and service adds, edits, and deletions as prescribed by OPWDD.

**Final Standards:**

6e. CCO/HH has structured interoperable information technology systems, policies, procedures and practices to support the creation, documentation, execution, and ongoing management of a Life Plan as defined by OPWDD for every enrollee.

6f. CCO/HH uses a health record system that qualifies under the Meaningful Use provisions of the HITECH Act, which allows the enrollee's health information and Life Plan to be accessible to the interdisciplinary team of providers. If the CCO/HH does not currently have such a system, it will provide a plan for when and how they implement one.

6g. CCO/HH will be required to comply with the current and future version of the Statewide Policy Guidance ([https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/policy/shinny.htm](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/policy/shinny.htm)) which includes common information policies, standards and technical approaches governing health information exchange.

6h. CCO/HH must commit to joining regional health information networks or qualified health IT entities for data exchange and includes a commitment to share information with all providers participating in a Life Plan. RHIOs/QE (Qualified Entities provide policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).

6i. CCO/HH will support the use of evidence based clinical decision-making tools, consensus guidelines, and best practices to achieve optimal outcomes and cost avoidance, as well as supporting the enrollees personal life goals and valued outcomes.

In addition, the CCO/HH must adhere to all State and Federal legal, statutory, and regulatory requirements.

## 7. Other Health Home Standards and Requirements

This section of the Application includes other important standards and requirements designated CCO/HHs will be responsible for implementing and monitoring, including:

- a) Minimum Standards and Requirements for Health Home Life Plans
- b) Assessment Requirements
- c) Requirements for Monitoring and Implementing the Life Plan
- d) Requirements for Care Planning Meetings
- e) I/DD Health Home Care Manager Qualifications and Requirements
- f) Requirements for Willowbrook Class Members
- g) Advisory Body that reports to the CCO/HH leadership and is made up of individuals served by the CCO/HH and their family-members and/or representatives.

### a) Minimum Standards and Requirements for Health Home Life Plans

In delivering the six core Health Home services, including the provision of an integrated and electronic person-centered Life Plan, CCO/HHs must, at a minimum, include the elements of OPWDD's Life Plan for all integrated services and providers, including OPWDD HCBS. The current regulatory requirements of OPWDD regulations governing person-centered planning are consistent with and reflected in the person-centered care planning requirements of the CCO/HH model. More information about person-centered planning is available at

[https://opwdd.ny.gov/opwdd\\_services\\_supports/person\\_centered\\_planning](https://opwdd.ny.gov/opwdd_services_supports/person_centered_planning) .

Additional information and requirements as deemed necessary by the CCO/HH may be added. In completing the Life Plan, Health Homes and Health Home Care Managers will be required to adhere to the Health Home core services, Health Home requirements and standards, include all integrated services in the Life Plan (physical, behavioral, HCBS and other community and social supports), and satisfy the Health Home HIT standards for preparing, implementing and monitoring the electronic Life Plan. The minimum standards and requirements for the Life Plan included herein also meet the Center for Medicare and Medicaid Services (CMS) care plan requirements for providing home and community based services (HCBS) authorized under the 1115 Waiver (as proposed to, and subject to approval of CMS).

The Health Home Life Plan represents a comprehensive document resulting from a person-centered planning process directed by the individual served, with assistance as needed by a representative identified by the individual and in collaboration with the care coordination team. The Life Plan is an understandable and personal plan for implementing decisions made during planning and includes all service and habilitation plan components. The person and his or her family and/or representatives are at the center of all planning. The Life Plan must be finalized and agreed to with the individual's written informed consent.

For individuals who are transitioning from Medicaid Service Coordination (MSC) or Plan of Care Support Services (PCSS) to CCO/HH services at the beginning of CCO/HH service delivery, there will be a schedule for the transition of the person's Individualized Service

Plan (ISP) to the Life Plan. This timeline will be presented in a Transition Plan that will be published in the Fall of 2017 for public comment. For all other individuals who are newly entering OPWDD services and CCO/HH services, the development of the Life Plans will proceed according to the schedule outlined here.

For all new enrollees to the CCO/HH, within 60 days of an individual being enrolled in a CCO/HH the Care Manager shall conduct a face-to-face-meeting with the individual his or her family and/or representative to perform a comprehensive assessment, convene the Interdisciplinary Team (IDT) and the development of the enrollee's Life Plan using a person-centered planning process. As described in more detail below, at a minimum, the Life Plan must include:

- Description of the person;
- Desired quality of life, health, and functional outcomes; including incorporating information derived from a robust person-centered planning process and assessments (inclusive of the state sanctioned assessment);
- Observable/measurable action steps to achieve outcomes that will be taken by the person, paid and unpaid service providers, and other persons who will support the person;
- Pertinent demographic information regarding the enrollee;
- Safeguard description and supports needed to reduce the likelihood of harm including a detailed back up plan for situations in which regularly scheduled paid or unpaid supports are unavailable or do not arrive and evacuation in an emergency;
- Employment status;
- Services, including physical, behavioral health, and HCBS long term services and supports the individual will receive;
- Relevant information pertaining to behavioral support that is needed;
- Relevant information regarding physical health conditions and treatment;
- Frequency of planned Care Manager contacts needed; and
- Steps that must be taken by the individual in the event of an emergency
- Reasonable accommodations needed

#### **I. Demographics and Profile**

##### Identifying Information

This section of the Life Plan captures information of the Health Home enrollee, including full name of the individual, Medicaid number or CIN number, address, the CCO/HH in which the individual is enrolled, name of lead CCO/HH Care Manager and care management agency, Initial Life Plan date, and Life Plan review dates.

This section should include information specific to the individual's employment status. Employment information must include his/her employment status. This section tracks the employment setting, the hours worked, and average wage.

##### Profile Information

This section of the Life Plan captures the Health Home enrollee's home, work,

relationships, and health and educational profile. Each of these sections includes question and answer fields as well as free text to provide a person-centered narrative that captures personal history and appropriate contextual information, as well as a description of skills, abilities, aspirations, needs, interests, things that make the person happy, challenges, pre-school and school age services etc., learned during the person-centered planning process, a record review, and any assessments completed.

The profile should describe the person and his/her current interests, needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action. The profile is not a static history of the person. It is updated regularly to accurately reflect the person's changing needs and goals.

## **II. Outcomes and Support Strategies**

This section of the Life Plan must capture the following information: goal description, valued outcomes, action steps, responsible party, service type, timeframe for action steps, special considerations (if applicable), and Personal Outcome Measures. Evidence of achievement will be reflected in monthly notes from assigned providers. Specifically, requirements of this section include but are not limited to:

- **Goal Description:** A free text section that must provide the specific details around the person's goal/valued outcome.
- **Valued Outcome:** Valued outcomes are the person's chosen life goals and are the driving force behind the services and supports the person receives. The valued outcomes should simply state what the person wants to achieve. List the person's valued outcomes that derive from the profile and planning process. There must be at least one valued outcome for each HCBS Waiver service the person will be receiving. The Waiver Service is "authorized" only where the service relates to at least one of the person's valued outcomes.
- **Valued outcomes within the Life Plan must link to one of the 21 defined Council on Quality and Leadership (CQL) Personal Outcome Measures (POMS).** See section 14 of this Application and <https://c-q-l.org/the-cql-difference/personal-outcome-measures> for more information about CQL and POMS.
- **Action Steps/Objectives:** The specific supports and services related to each goal/valued outcome. Objectives are the measurable (i.e. observable) action steps that are aimed at achieving the valued outcome. Action steps should be written so that they can be measured and evaluated. Action steps will lead to the specific approaches, activities and services that are provided.
- **Responsible Party:** Identify the individual(s) who will be responsible for implementing and documenting progress toward the goal, which needs to relate to authorized-funded services, natural supports, and community resources.
- **Service Type:** This includes natural supports, Residential Habilitation, Day Habilitation, Community Habilitation, Supported Employment, Pre-

Vocational Services, Respite, Adaptive Devices, Environmental Modifications, Family Education and Training (FET), Fiscal Intermediary Services, Broker Services, Community Transition Services, Intensive Behavioral Services, and health and long term care services, etc.

- Timeframe for Each Action Step: Indicate the date the goal is anticipated to be achieved.
- Special Considerations: If applicable this is a free text area to provide information regarding health and safety concerns that may need to be considered in assisting the individual to achieve his/her valued outcome. There may be instances where an individual receiving services chooses not to follow specific medical or treatment advice, information relative to decisions of this nature should be included with in this section.
- Personal Outcome Measures (POMS): Identify the POM that best fits with the goal and valued outcome as determined by the individual, Care Manager and/or the care coordination team.

### **III. Individual Safeguards/Individual Plan of Protection (IPOP)**

This section of the Life Plan focuses on the development of supports to assist the Health Home enrollee in maintaining desired personal safety. Supports that help achieve safety and reduce risk should support health and the person's needs and interests.

Safeguards are actions to be taken to prevent risk and to promote good health. Support staff, as appropriate, must have knowledge of the person's health and safety support needs and the planned actions to meet those needs. All required Safeguard domains identified in the Care Coordination Data Descriptions need to be actively assessed and addressed in the Life Plan, if needed.

When developing safeguards the Health Home Care Manager must evaluate, with the individual, whether there are opportunities that the individual wants to engage in that could be determined as risky. This involves analysis of the perceived risk, not being based on the person's ability, but on the ability to provide support in addressing risk.

To evaluate risk and the individual's responsibility and ability to calculate the risk, the following factors should be considered:

- Weighing the benefits to the individual and the rights of the individual against the risk
- Ways to empower the person to improve their ability to make informed decisions through education and self-advocacy skills
- Evaluate possible resources and environmental adaptations that can allow the person to take the risk, but mitigate potential hazards

### **IV. HCBS Waiver and Medicaid State Plan Authorized Services**

This section of the Life Plan includes a listing of all HCBS Waiver and State Plan services that have been authorized for the individual. CCO/HHs will be required to ensure that these services have been authorized by the

appropriate entity (i.e., DDRO or LDSS). For each HCBS service, the waiver service provider, the service type, frequency of support of service, duration of the support of service, and the effective dates must be identified.

**V. All Supports and Services; Funded and Natural/Community Resources**

This section is meant to identify the services and support givers in a person's life along with the needed contact information. For the Medicaid funded services identified above this section will list specific contact information for the appropriate representative for those services. Other service providers outside of Waiver and State Plan services should be listed in this section along with type of service and current contact information. Additionally, all Natural Supports and Community Resources that help the person be a valued individual of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations should be listed with contact information as appropriate.

This section of the Life Plan should contain people, places, or organizational affiliations that are a resource to the Health Home enrollee by providing supports, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization as well as a contact number and address of each.

Examples of services to be reflected in the integrated and comprehensive Life Plan include but are not limited to: Primary Care Physician, Dentist, Psychologist, Podiatrist, Psychiatrist, START services, Dermatologist, ACCES-VR, and HCBS Waiver Services. Each of these services received by the individual must also include the name, contact number and address of the service provider and any individual that will participate in interdisciplinary team meetings.

**b) Requirements for Monitoring and Implementing the Life Plan**

As required by the comprehensive care management core Health Home service, Health Home enrollees must be comprehensively assessed, using one or more tools, to identify medical, mental health, chemical dependency, social and emotional needs. CCO/HHs will be required to ensure that comprehensive assessment tools are employed to identify the health, behavioral health, community supports and other services required to meet the needs of the person with I/DD. In addition, CCO/HHs are also required to ensure all comprehensive Life Plans prepared for CCO/HH enrollee include such services identified by the assessments.

In addition to the CCO/HH's assessment tool(s) that may be used to comprehensively assess the needs of the CCO/HH enrollees, every CCO/HH enrollee must be assessed by the CCO/HH Care Manager using the Developmental Disabilities Profile (DDP) 2. The DDP must be conducted at least annually, or more frequently if the person experiences a significant change by the CCO/HH Care Manager.

Once fully implemented, the CCO/HH will be required to transition from the DDP-2 to



the Coordinated Assessment System (CAS) and adhere to the above timeframe for completion. The CAS is housed in the State's Uniform Assessment System-New York (UAS-NY). The CCO/HH will be required to ensure Health Home Care Managers complete State required CAS training and adhere to the person-centered administration protocols.

When the Coordinated Assessment System (CAS) is initially performed, and administered by OPWDD, the CCO/HH will coordinate and facilitate the inclusion of the individual's legal guardian(s)/actively involved family member(s). When the CCO/HH administers subsequent updates to the CAS, the Health Home CCO/HH provider must ensure Care Managers have met the State-defined CAS qualifications and training requirements and adhere to the person-centered administration protocols. Upon completion of a CAS, either by OPWDD or the CCO/HH, the CCO/HH must review the CAS with the enrollee and/or family as part of the person-centered planning process utilized for the development of the Life Plan.

**c) Requirements for Monitoring and Implementing the Life Plan**

The Health Home Life Plan is a comprehensive, person-centered care plan. It integrates the continuum of physical/medical, behavioral health services, rehabilitative, long-term care, I/DD and social service needs, including pre-school and school-age services for children. The plan also clearly identifies the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), I/DD service providers, School Districts, the Care Manager and other providers directly involved in the individual's services. The Health Home Life Plan is subject to continuous updating and monitoring by the Health Home Care Manager as Health Home services are delivered each month. Changes and updates to the Health Home 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. It is the Care Managers responsibility to communicate with the physician's office as needed to ensure that the Life Plan comports with the physician's assessment of the person's needs. The Life Plan is comprehensively reviewed to assess the results and /or effect of the delivered supports and services on the person's and family member's satisfaction; functional/clinical status; and quality of life outcomes. The results of the assessment should be used to determine whether any changes are needed to the Life Plan and the person's supports and services to effectuate desired outcomes and results.

**d) Requirements for Care Planning Meetings**

The CCO/HH enrollee shall lead the planning process and participants of the planning meeting and the Health Home Care Manager shall ensure the participants are chosen by the individual. The Care Manager shall also ensure all Life Plan reviews and updates use a person-centered planning process that provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. The enrollee's cultural background shall be recognized and valued in the planning process. If support for the planning process is needed from a language translator or a sign language interpreter, then such

support must be arranged by the CCO/HH.

- i. All person-centered planning meetings, Health Home Life Plan updates and /or review meetings must occur at times and locations of convenience to the individual.
- ii. No less than annually, a person-centered planning review meeting must occur face-to-face, and all enrollees of the interdisciplinary team must participate. Members of the interdisciplinary team, other than the enrollee and the Health Home Care Manager, have the option of utilizing technology conferencing tools including audio, video, and/or web-deployed solutions when security protocols and precautions are in place to protect PHI (Personal Health Information). See section 10 for additional information regarding face-to-face meetings and requirements.
- iii. Review and updates of the Health Home Life Plan must also occur when the person or the person's representative requests that information be changed or added and/or when the need for supports and services change. The Life Plan should change as the person changes. A planning meeting should be arranged to include people chosen by the individual including family members and others as determined by enrollee and occur in a timely response to the request to hold a meeting.
- iv. The Life Plan will be considered approved when it is agreed to with the individual and/or representative's written informed consent and the Health Home Care Manager has signed the plan.
- v. The Health Home Care Manager shall sign and date the Life Plan, along with any updates. The enrollee's Care Manager shall ensure that the enrollee and/or representative reviews, signs and dates the Life Plan, as well as any significant updates. The individual, family members and/or representatives must be informed by the CCO/HH of the method in which he/she can request updates to his/her Life Plan as needed or wanted.

#### **e) I/DD Health Home Care Manager Qualifications and Requirements**

CCO/HH Care Managers who serve adults and children with I/DD must meet the following qualifications:

- a) A Bachelor's degree with two years of relevant experience, OR
- b) A License as a Registered Nurse with two years or relevant experience, which can include any employment experience and is not limited to case management/service coordination duties OR
- c) A Master's degree with one year of relevant experience.
- d) Current MSC service coordinators are "grandfathered" to facilitate continuity for the person 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 person was employed as an MSC Service Coordinator prior to July 1, 2018.

CCO/HH Care Manager qualifications will be waived for existing Medicaid Service Coordinators (MSCs) who apply to serve as Care Managers in CCO/HHs. CCO/HH will be required to provide Health Home core services training for current Medicaid Service Coordinators (MSC) that transition to the Health Home program and do not meet the

minimum education and experience requirements. Such training shall be provided by the Health Home within six months of contracting with an MSC. Based on existing MSC's experience and this training, it is anticipated that most MSCs will transition to Care Manager roles.

To ensure a smooth transition, during the first year of operations CCO/HH Care Managers, with appropriate firewalls and supervisory structures in place, former MSC agencies may provide I/DD Health Home care management services and through a contract with a CCO/HH as a CMA if the CCO/HH chooses. CCO/HH will be responsible for developing an infrastructure that supports the effective delivery of person-centered care management services and will need to define the supervisory structure and qualifications that will support that infrastructure. After one year of operation, all Care Managers (including former MSCs) providing care management under a designated I/DD Health Home must be directly employed by the CCO/HH and may not provide HCBS, except for agencies that are operated by a federally recognized Tribe.

CCO/HHs are required to ensure that all CCO/HH Care Managers are qualified to provide and meet the standards and requirements of CCO/HH care management and deliver the six core Health Home services. All CCO/HHs must ensure Care Managers are trained in skill building areas identified below and can employ the skills aligned with each area in the delivery of Health Home care management. The State will provide CCO/HH with further guidance on standards for meeting these requirements and CCO/HHs will be required to submit their training plans to the State.

The State will provide additional guidance on CCO/HH standards and requirements, including information on requirement for Care Manager and supervisors criminal background checks.

Skill Building Area	Skill
1. Values Person-Centeredness and Communication	<ul style="list-style-type: none"> <li>a. Advocate on behalf of the individual</li> <li>b. Define person-centered care planning</li> <li>c. Value informed choice, the mission of the Office for People With Developmental Disabilities (OPWDD), and ethics and conflict of interest</li> <li>d. Demonstrate belief in person with developmental disability</li> <li>e. Recognize Individual and family needs</li> <li>f. Encourage communication and individual engagement techniques</li> <li>g. Promote self-advocacy and the ability to self-direct</li> <li>h. Understand Health Literacy</li> </ul>
2. Builds Relationships and Establishes Communication within Care Coordination Team and among Providers	<ul style="list-style-type: none"> <li>a. Build positive relationships among team members</li> <li>b. Promote communication among team members</li> <li>c. Demonstrate ability to listen, communicate verbally and in writing and facilitate meetings</li> <li>d. Manage team conflict and mediation</li> </ul>
3. Promotes Community Orientation	<ul style="list-style-type: none"> <li>a. Connect individuals and families to community resources including housing, transportation and residential preferences</li> <li>b. Support individuals and families as they seek resources in the community</li> <li>c. Coordinate and provide access to long-term care supports and services</li> <li>d. Develop and maintains knowledge of community supports and services</li> </ul>
4. Culturally Competent	<ul style="list-style-type: none"> <li>a. Recognize individuals' and families' cultural needs/factors that influence choices and engagement in services</li> <li>b. Provide culturally appropriate and person and family-centered services</li> <li>c. Communicate with individuals and families in a culturally competent manner</li> <li>d. Promote inclusion</li> </ul>
5. Knowledge of Developmental Disabilities, Chronic Disease and Social Determinants of Health	<ul style="list-style-type: none"> <li>a. Possess knowledge of characteristics of common developmental disabilities, understand chronic disease and co-morbidities including mental health and substance abuse disorders</li> <li>c. Recognize and address health and safety issues including social determinants of health</li> <li>d. Possess ability to act quickly, assess and act accordingly in crisis situations</li> <li>e. Coordinate and provide access to chronic disease management; including knowledge of self- management skills</li> <li>f. Promote a high quality of life</li> </ul>
6. Knowledge of Community Supports and Services, New Models of Care, and Healthcare Trends	<ul style="list-style-type: none"> <li>a. Develop and maintain knowledge of OPWDD, community, and natural supports and services; including housing and employment services</li> <li>b. Understanding of the U.S. healthcare system and new models of care</li> <li>c. Knowledge of entitlements, benefits and how to access such services</li> <li>d. Ability to assess individuals' and families' needs</li> <li>e. Knowledge of care coordination</li> <li>f. Coordinate and provide access to preventive and health promotion services, mental health and substance abuse services and transitional care across settings</li> <li>g. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines</li> </ul>

Skill Building Area	Skill
7. Understand Ethics & Professional Boundaries	<ul style="list-style-type: none"> <li>a. Knowledge of ethical and professional responsibilities and boundaries</li> <li>b. Participate in opportunities for continued training and education</li> <li>a. Demonstrate professional work habits including dependability, time management, independence and responsibility</li> </ul>
8. Promote Quality Improvement	<ul style="list-style-type: none"> <li>a. Understanding of quality improvement methods and process</li> <li>c. Provide quality driven, cost-effective, culturally appropriate services</li> </ul>
9. Understand Health Information Technology	<ul style="list-style-type: none"> <li>a. Demonstrate capacity to use Health Information Technology to link services, facilitate communication among team members and between the care coordination team and individual and their family and/or representatives</li> <li>b. Basic technology skills and understanding of health records</li> </ul>
10. Proficient in Documentation & Confidentiality	<ul style="list-style-type: none"> <li>a. Knowledge of confidentiality and guidelines; including ensuring Health Insurance Portability and Accountability Act (HIPAA) compliance</li> <li>b. Develop and maintain the person-centered Life Plan that coordinates and integrates all of an individual's clinical and non-clinical health-care related needs and services; including monitoring and implementation of the Life Plan</li> <li>c. Develop and maintain appropriate records; including maintain documentation of required training</li> </ul>

**f) Willowbrook**

CCO/HH services provided to Willowbrook class members must comply with requirements for reporting, investigation, implementation of preventative actions, and other needed follow-up on incidents which pose a risk to the health and safety of the class member's as p e r the Permanent Injunction. Information regarding the Permanent Injunction is available at:

[https://opwdd.ny.gov/opwdd\\_resources/willowbrook\\_class/willowbrook\\_permanent\\_injunction](https://opwdd.ny.gov/opwdd_resources/willowbrook_class/willowbrook_permanent_injunction)

**g) Advisory Board**

CCO/HH will form a representative counsel made up of individuals receiving service and their families and/or representatives. This advisory body will review CCO/HH outcomes and advise the CCO/HH leadership regarding policies and CCO/HH operations.

## 10. CCO/Health Home Payments and Billing Standards

The preliminary care management per member per month (PMPM) rates for CCO/HH described in this Application and the proposed methodology for a tiered PMPM rate structure are draft and subject to review and approval by CMS and the State. The draft rates will include rates for the first month of enrollment and rates applicable to each month of enrollment thereafter. Due to the nature of the Health Home enrollment process for I/DD individuals, there will be no outreach PMPM for individuals with I/DD enrolled in CCO/HHs.

The tiered HH PMPM rates for the first month of enrollment are adjusted to include:

- Initial Medicaid application (if needed), and
- Gathering of documentation and records to demonstrate I/DD diagnosis, that such I/DD condition results in a substantial handicap to their ability to function normally in society and level of care determination.

The tiered rate structure for CCO/HH service is based upon the acuity/functional capability status of the individual, whether the individual lives in a certified residential setting or in their own or family home, is a member of a 'special group status' that includes the individual's status as a Willowbrook class member. Initially, acuity will be derived from an algorithm using the Developmental Disabilities Profile 2 data. The State has developed a new State-approved assessment tool, known as the Coordinated Assessment System (CAS). Upon Statewide implementation of the CAS, the CAS will be used to determine the enrollee's rate tier. The methodology for determining the enrollee's rate tier is described in Appendix B.

The preliminary, draft CCO/HH payment tiers, subject to approval by the State and CMS are as follows:

CCO/HH Tier	PMPM for First Month of Enrollment		CCO/HH Care Management PMPM Payments	
	DDRO Regions 1-3	DDRO Regions 4-5	DDRO Regions 1-3	DDRO Regions 4-5
Tier 1	\$950	\$1,012	\$317	\$337
Tier 2	\$950	\$1,012	\$386	\$412
Tier 3	\$950	\$1,012	\$468	\$498
Tier 4 and Willowbrook	\$950	\$1,012	\$598	\$637

The State has proposed to CMS that additional funds be included to augment the above rates to support start-up and implementation activities for the initial 24 months of CCO/HH operation. Once approved, the above fee table will be published with the updated rates.

The quality and individual and family satisfaction of the provision of CCO/HH services will be carefully assessed during the initial year of operation. During that time, the State is generally providing CCO/HH Care Managers the flexibility to manage caseloads according to the enrollee's needs, and is not mandating caseload requirements for enrollees that have acuity in the CCO/HH

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, HH Care Managers serving enrollees 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.

### **CCO/HH Billing Standards**

The monthly Health Home I/DD PMPM payment to the CCO/HH is contingent upon the CCO/HH Care Manager providing at least one billable Health Home service. Care management activities and billing services should be documented and reflected in the Life Plan.

In addition to the monthly documentation of at least one Health Home core service, Care Managers must also adhere to the following face-to-face meeting requirements:

- For HH enrollees in Tiers 1-3, the CCO/HH Care Manager must have at least one face-to-face meeting with HH enrollee each quarter (January – March; April – June; July – August and September – December).
- For HH enrollees in Tier 4, the Care Manager must have a monthly face-to-face meeting with the HH enrollee.

### **CCO/HH Payment Flow and Payment Attestations**

Until the I/DD population transitions to managed care under an 1115 authorization, the CCO/HH will be responsible for submitting claims to the State and remitting payments to the Health Home Care Manager for all individuals enrolled in CCO/HH, including any enrollees that may be enrolled in a managed care plan today.

As part of the readiness review process, successful CCO/HH Applicants will be required to attest, in writing, and demonstrate, they have billing systems in place that can submit timely billable information to eMedNY via the 837 EDI, and when or where and when or where applicable be prepared to modify 837i submission to Medicaid Managed Care Plans. In preparation for the transition to Medicaid Managed Care the CCO/HH and their downstream providers must have both an MMIS and National Provider Identification number to ensure timely remittance and payment.

Additional service, revenue and HCPCS codes with modifiers will also be necessary. CCO/HH will be required to remit payments to care management agencies within 15 days of receiving payments from the State or Managed Care Plan.

## **11. CCO/HH Network Requirements, and State and Provider Agreements**

To provide comprehensive, timely and high quality Health Home services, CCO/HH providers are expected to develop and maintain a network of partnerships with cross-system 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. CCO/HHs must partner with medical care providers (e.g. primary care, ambulatory care, preventive and wellness care, FQHCs, clinics, specialists, hospitals, rehabilitation/skilled nursing facilities, pharmacies/medication management services, home health services, chronic disease self-management and enrollee education services, education system etc.); developmental disability service providers;; long term supports and service

providers; dentists; behavioral health care providers (e.g. acute and outpatient mental health, substance abuse services and rehabilitation providers, etc.); regional STARTS teams, community-based organizations; School Districts; and social services providers (e.g. public assistance support services, housing services, etc.).

Each CCO/HH must have a linkage agreement with the START team in the Region where they are providing coordination services. More information regarding the START program is located on the OPWDD website at <https://opwdd.ny.gov/ny-start/home>. START programs and contacts are posted at <https://opwdd.ny.gov/ny-start/regional-start-liaisons-contact-list>.

Applicants will be required to submit information outlined in Attachment D for each provider that agrees to be a member of the CCO/HH network. CCO/HHs will be required to document the commitment of network partners to be part of the CCO/HH network. Such documentation may take the form of network provider commitment letter to receive and prioritize CCO/HH referrals and provide services that are part of the Life Plan. Provider network data summaries are available for interested applicants' information in Attachment E.

CCO's will be encouraged to obtain and maintain linkages with Delivery System Reform Incentive Program (DSRIP) Performing Provider Systems (PPS).

**Data Use Agreements, Business Associate Agreements, Administrative Services Agreements, Network Provider Agreements**

CCO/HHs Serving Individuals With I/DD will be required to attain Data Use Agreements (DUAs), and Business Associate Agreements (BAAs) to formalize relationships, share data, and provide and bill for Health Home services.

Data Use Agreements (DUA) are between CCO/HH and the Department of Health (the Department) and allow for the exchange of Medicaid member information.

Business Associate Agreements (BAAs) are between CCO/HH and Care Management Agencies (CMAs) and are required to share information between CCO/HH and CMAs. A DUA must be in place prior to entering BAAs.

Managed care plans are encouraged to enter Administrative Services Agreements (ASA) for I/DD individuals enrolled in plans today (i.e., prior to the full transition of the I/DD population under the 1115 waiver authorization to Managed Care) and partner with the CCO/HH in the enrollee's care. Plans may use an ASA template provided by the State or their own ASA (subject to approval by the Department of Health). The State will provide plans and CCOs further guidance.

Contractual agreements must be in place with all organizations for which there is a financial arrangement prior to the first request for reimbursement.

CCO/HHs will be required to document the commitment of network service providers to be part of the CCO/HH network. Such documentation may take the form of network provider commitment letter to receive and prioritize CCO/HH referrals and provide services that are part of the Life Plan.

**12. General Enrollment Information and Individual Consent to Enroll**



Health Home care management is an optional benefit and individuals have the right to choose a Health Home. The State is the process of developing CCO/HH consent forms. The forms will govern enrollment and the sharing of information among service providers and the interdisciplinary team engaged in implementing the enrollee's Life Plan.

The enrollment process to transition from MSC to CCO/HHs is designed to ensure that services to individuals with I/DD are not disrupted and there is continuity of care between the person receiving services and their current coordinator. Once a CCO/HH is initially designated and prior to implementation, the Health Home CMAs (many of whom will be today's MSC provider agencies and will transition to providing CCO/HH care management) can begin to reach out to individuals and families and educate them on the benefits of enrolling in a Health Home. With Health Home consent, individuals receiving MSC services will be enrolled in a CCO/HH for which the MSC has established a contractual relationship with to provide Health Home care management services. The State will provide individuals, families and CCO/HH additional guidance on procedures to transition individuals from MSC to CCO/HH upon approval by CMS of the State Plan for CCO/HHs and the transition of the 1915(c) HCBS services to the 1115 Waiver.

Individuals will be able to request a different CCO/HH and Health Home Care Manager/MSM prior to being enrolled in the CCO/HH and at any time following initial enrollment. Selecting a different CCO/HH may result in the need to choose a different Care Manager and vice versa. Eligible individuals not currently enrolled in an MSC program have the option to enroll with CCO/HH of their choice.

For individuals who opt not to receive CCO/HH services but chose to receive HCBS, needed case management services will be available from a State designated entity. CCO/HHs will be State designated entities and will be responsible for arranging and providing care management to these individuals, and continuing to build and foster relationships with the individual and the family to help encourage interest and participation in the more comprehensive Health Home care management program. The State will develop a separate fee schedule for the providing HCBS case management to individuals who opt out of Health Home. Care management agencies that may be engaged by the CCO/HH to provide care management for individuals who opt out of CCO/HH services cannot also provide Home and Community Based Services for individuals, except for agencies that are operated by a federally recognized Tribe.

### **13. Requirements for Communicating and Sharing Information with I/DD CCO/HH Enrollees**

As required by the Support for Families Health Home core service, the CCO/HH and HH Care Manager must communicate and share information with enrollees and their families and other caregivers with appropriate consideration for language, literacy and cultural preferences, including sign language, closed captioning and/or video capture. In meeting that HH core requirement for individuals with I/DD, the CCO/HH must provide all notices, forms, video's and informational materials to enrollees in a manner and format that can be easily understood, (i.e., must be provided in plain language and be accessible to the Health Home enrollee).

- The CCO/HH must have in place procedures to help enrollees understand Health Home consent forms;

- The CCO/HH must have in place procedures to help enrollees understand the required elements and benefits of the Life Plan;
- The CCO/HH, when developing policies and procedures as well as written materials, shall take into consideration the unique needs of individuals with I/DD;
- All written materials must be written in twelve (12) point type at a minimum and prose written in clear, simple, understandable language at the 4th to 6th grade reading level;
- The CCO/HH shall make its written information available in those prevalent non-English languages in its service area. Languages spoken by at least 5 percent of the target population, or 50 enrollees, whichever is less, will be included for translation;
- The CCO/HH shall make oral interpretation services available free of charge to each enrollee. This applies to all non-English languages, not just those that the State identifies as prevalent;
- The CCO/HH shall notify enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services; and
- The CCO/HH's written materials must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The CCO/HH shall inform all enrollees that information is available in alternative formats and how to access those formats.

#### **14. Performance Management and Quality Metrics**

A critical requirement and responsibility of the CCO/HH is performance management and quality oversight. CCO/HH are responsible for ensuring that high quality Health Home care management services are delivered to its enrollees. To assist Health Homes, Care Managers and plans monitor quality and performance, as well as track and report key performance measure to CMS and stakeholder, the State has developed a comprehensive set of performance measures. The performance measures monitor overall quality and the degree to which the Health Home model, as authorized under the Affordable Care Act, is meeting its goals, including:

- Reducing utilization associated with avoidable (preventable) inpatient stays
- Reducing utilization associated with avoidable (preventable) emergency room visits
- Improving outcomes for individuals with I/DD through care coordination (health as well as personal/social outcomes)
- Improving Disease-Related Care for Chronic Conditions
- Improving Preventive Care
- Improving Transitional Care
- Reducing utilization associated with inpatient stays.

For a list of these performance measures please see insert [https://www.health.ny.gov/health\\_care/medicaid/program/medicaid\\_health\\_homes/assessment\\_quality\\_measures/docs/measures.pdf](https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/assessment_quality_measures/docs/measures.pdf). Note that these measures do not require separate data collection efforts on the part of the CCO/HH.

In addition to these measures, the State has added the following performance metrics tailored for individuals with I/DD. These measures will be reviewed as part of the State's ongoing stakeholder engagement.

## Quality and Process Metrics for the I/DD Health Home Population

### Goal: Improve outcomes for individuals with I/DD through care coordination (health/personal/social)

Measures	Data Source	Measure Description
Implementation of Council on Quality Leadership (CQL) Personal Outcome Measures (POMs)*	CCO reporting	Percentage of Life Plans that have minimum of two POM measures. <i>CCO must record in Life Plan Personal Outcome Measures (POM) drawn from CQL reporting guidelines. Life Plan must reflect at least three personal goals, of which two must be POM directed.</i>
Implementation of personal safeguards	CCO reporting	Percentage of Life Plans that reflect personal safeguards for all enrollees. <i>CCO must record personal safeguards in Life Plan</i>
Transitioning to a more integrated setting	Claims TABS	Of those enrollees who are in a 24-hour certified setting, the number/percentage of enrollees who move to a more integrated setting
Employment	CCO reporting	Of those enrollees who indicate in their Life Plan they choose to pursue employment, the number/percentage of individuals who are employed (compared to the previous reporting period). <i>CCO will record enrollee progress and verify support to find and maintain community integrated employment in Life Plan.</i>
Self-direction	Claims	Of those enrollees who select self-direction as indicated in the Life Plan, the number/percentage of individuals who enroll in self-direction) compared to the previous reporting period). <i>CCO will identify those who choose to self-direct their supports and services with either or both employer authority and budget authority in the Life Plan.</i>

### Goal: Improve Preventive Care

Measures	Data Source	Measure Description
Bladder and Bowel Continence	CCO reporting CAS	Of those enrollees with an identified bladder/bowel health risk, the number/percentage of those that have a Life Plan in place that includes recording of support or device needs bowel/incontinence tracking protocol, bowel/incontinence management protocol. <i>CCO will report risk based on initial screening.</i>
Falls	CCO reporting	Of those enrollees with an identified risk of falls, the number/percentage of enrollees who have a Life Plan that includes supervision, contact guarding, adaptive equipment, environmental modifications or other-directed support. <i>CCO will report risk based on initial screening.</i>
Choking	CCO reporting	Of those enrollees with an identified risk of choking, the number/percentage of enrollees who have a Life plan with safeguard(s) including modified consistency of foods and/or liquids, avoidance of high risk foods, requires supervision, formal training/dining plan required. <i>CCO will report risk based on initial screening.</i>

**Goal: Improve Transitional Care**

Measures	Data Source	Measure Description
Supporting individuals' transition from institutional settings to community settings	CCO reporting Claims CAS	Of those enrollees who move to a setting other than a 24-hour certified setting, the number/percentage of transitions identified in TABS/claims compared to number/percentage of care transition records transmitted to Health Care Professionals by the CCO. <i>CCO must report enrollee transitions from 24-hour certified setting to community placement/setting.</i>

**The Council on Quality Leadership Personal Outcome Measures**

Personal Outcome Measures focus on the choices people have and make in their lives. The 21 Personal Outcome Measures developed by CQL are organized into 5 key indicators and experiences that people and their families have said are most important to them as shown below:

**My Human Security**

1. People are safe
2. People are free from abuse and neglect
3. People have the best possible health
4. People experience continuity and security
5. People exercise rights
6. People are treated fairly
7. People are respected

**My Community**

8. People use their environments
9. People live in integrated environments
10. People interact with other individuals of the community
11. People participate in the life of the community

**My Relationships**

12. People are connected to natural support networks
13. People have friends
14. People have intimate relationships
15. People decide when to share personal information
16. People perform different social roles

**My Choices**

17. People choose where and with whom they live
18. People choose where they work
19. People choose services

**My Goals**

20. People choose personal goals
21. People realize personal goals

From the Council on Quality and Leadership (CQL), 2017

The CCO/HH will also 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.

Data regarding evaluating this metric will include:

- # people employed;
- # people supported to self-direct their services;
- # people who are supported in independent, integrated living settings; and
- # people who have moved from a certified setting into a less restrictive environment.

CCO/HHs will be designated for an authorized period (e.g., three years) and will be evaluated and monitored by the State. Performance management efforts by the State, including participation from OPWDD's Division of Quality Improvement, will include site re-designation surveys, evaluation of performance and quality metrics discussed above, and review of policies and procedures and adherence to Health Homes standards and requirements. The State will be seeking input from CCO/HH regarding the re-designation process and intends to work collaboratively with CCO/HHs and Managed Care plans on performance management processes, goals and objectives.

The State expects the quality measures used to monitor and performance manage the Health Home program will evolve over time, particularly as the I/DD population is moved to managed care and VBP arrangements emerge.

## **15. Value Based Payments (VBP)**

The New York State DSRIP program aims to fundamentally restructure New York State's healthcare delivery system, reducing avoidable hospital use by 25 percent, and improving the financial sustainability of New York State's safety net. To further stimulate and sustain this delivery reform the State has committed to making at least 80 – 90 percent of all payments made from Managed Care Organizations (MCOs) to providers will be captured within VBP arrangements by 2020. The goal of converting to VBP arrangements is to develop a sustainable system, which incentivizes value over volume. The Centers for Medicare and Medicaid Services (CMS) has approved the State's multiyear VBP Roadmap, which details the menu of options and different levels of VBP that the MCOs and providers can select and also outlines how the State sets quality measures per VBP arrangement.

As part of its larger stakeholder engagement process around VBP, NYS convened an Intellectually/Developmentally Disabled Clinical Advisory Group (CAG) to discuss the implications of VBP for this unique population. These discussions culminated in a Progress Report (December 2016) which discussed potential VBP arrangement design, quality measures, and attribution methodology. NYS will be continuing to hold meetings with the VBP Workgroup, the primary stakeholder engagement committee providing input on this transition. Issues such as the role of VBP in the transition of the individuals with I/DD to Medicaid Managed Care and outcome metrics will continue to be a topic of discussion for this body. Providers serving individuals with I/DD should expect VBP to play a major part in the migration of this population into managed care. OPWDD plans to focus specifically on wellness of the I/DD population and will begin stakeholder outreach to design an initiative linking the achievement of wellness outcomes to the I/DD VBP strategy.



## Appendix A

### Care Coordination Organization/ Health Home (CCO/HH) Glossary

**Coordinated Assessment System (CAS)** – An assessment tool specifically tailored to capture the unique health and support needs of individuals with developmental disabilities in New York State. The CAS is used to help develop the Life Plan for I/DD individuals in Health Home. The CAS is being implemented in phases and until it is implemented Statewide, the DDP2 will be the assessment tool used to determine Health Home PMPM rates and for the development of the Life Plan where applicable.

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

**Conflict-Free Care Management (CFCM)** - Federal Home and Community-Based Settings rule, 42 CFR 441.301(c)(1)(vi), effective March 2014 requires that “Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.” The intention of this Federal rule is to ensure that case management services are person-centered and promote the service recipients’ interests, not those of the provider agencies.

**Delivery System Reform Incentive Payment (DSRIP) Program** - The main mechanism by which New York State is implementing the Medicaid Redesign Team (MRT) Waiver Amendment. DSRIP’s purpose is to restructure the health care delivery system and reinvest savings into the Medicaid program, with the primary goal of reducing avoidable hospital use by 25 percent over five years.

**Developmental disability** – A severe, chronic disability which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual's functioning in several major life activities.

**Front Door** – The Front Door refers to the process by which OPWDD connects people to the services they need and want by providing assistance in navigating the steps involved in determining OPWDD eligibility, identifying needs, goals and preferences and developing a plan for obtaining those services.

**Home and Community-Based Services (HCBS)** – Home and community-based services (HCBS) services provide opportunities for individuals to receive services in their own home or community rather than institutions or other isolated settings.

**Interdisciplinary Team (IDT)** – The team of individuals that will provide person-centered care management to enrollees. The team must be comprised of the individual and/or their family member and/or their representative, Care Manager, primary providers of developmental disability services and other providers either as requested by the enrollee and/or their family member and/or representative .

**Intellectual Disability** – A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers a range of everyday social and practical skills.

**Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/ID)** – Is a certified residential facility that provides comprehensive services and supports for individuals with I/DD.

**Long Term Supports and Services (LTSS)** – Services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals and administering medications.

**Medicaid** - A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources and/or high cost medical conditions.

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

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

**Medicaid Service Coordination (MSC)** – Is a Medicaid State Plan service that helps people with developmental disabilities and their families in gaining access to necessary supports and services. MSC is provided by qualified service coordinators and uses a person-centered planning process in developing, implementing and maintaining a person-centered service plan. MSC agencies will transition to Health Home care management under contractual arrangements with I/DD-tailored and designated Health Homes (CCO/HHs).

**New York State Office for People With Developmental Disabilities (OPWDD)** - Is responsible for coordinating services for more than 128,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. It provides services directly and through a network of approximately 750 nonprofit service agencies. Supports and services, including Medicaid funded long-term care services, such as habilitation and clinical services, as well as residential supports and services, are primarily provided in community settings across the State. In addition to these Medicaid services, OPWDD also provides New York State-funded family support services.

**People-First Transformation** - The New York State Office for People With Developmental Disabilities (OPWDD), in consultation with the State Department of Health (DOH), the Centers for Medicare & Medicaid Services (CMS), and other stakeholders, identified and developed significant programmatic and fiscal improvements to the service system through an initiative called the “People First Transformation”. This document identifies a series of shared goals to improve opportunities for individuals with developmental disabilities in the areas of employment, integrated living, and self-direction of services.

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

**Regional Health Information Organization (RHIO)** – a local hub where a region’s health information is stored and shared. These RHIOs are the backbone of the SHIN-NY, providing the services that make secure, vital access to an enrollee’s health information possible statewide.



**START (Systemic, Therapeutic Assessment, Resources and Treatment) -- NYSTART is a community-based program that provides crisis prevention and response services to individuals with intellectual and developmental disabilities who present with complex behavioral and mental health needs, and to their families and others in the community who provide support. NYSTART is not a separate system and does not replace existing services. More information regarding the START program is located on the OPWDD website at <https://opwdd.ny.gov/ny-start/home>. START programs and contacts are posted at <https://opwdd.ny.gov/ny-start/regional-start-liaisons-contact-list>.**

**Transformation Panel** - A diverse group of stakeholders called together by OPWDD to examine the challenges in implementing the agency's Transformation Agenda, offering managed care in the OPWDD system and ensuring its long-term fiscal sustainability for people currently receiving services and those who may need to access services in the future, and offering clear and actionable recommendations to guide OPWDD's path forward.

**Value-Based Payments (VBP)** - The New York State Delivery System Reform Incentive Payment (DSRIP) Program aims to fundamentally restructure New York State's healthcare delivery system, reducing avoidable hospital use by 25 percent, and improving the financial sustainability of New York State's safety net. To further stimulate and sustain this delivery reform the State has committed to making at least 80 – 90 percent of all payments made from Managed Care Organizations (MCOs) to providers will be captured within VBP arrangements by 2020. The goal of converting to VBP arrangements is to develop a sustainable system, which incentivizes value over volume. The Centers for Medicare and Medicaid Services (CMS) has approved the State's multiyear VBP Roadmap, which details the menu of options and different levels of VBP that the MCOs and providers can select and outlines how the State sets quality measures per VBP arrangement.

## Appendix B

### Preliminary Draft Rate Tiers for Care CCO/HHs

The preliminary, draft rates below are subject to approval by CMS and the State.

The process for determining rate tiers for Health Home care management includes determining a care coordination needs/intensity level and the residential/living setting.

Three components are used to assign a care coordination need/intensity level. These include the Developmental Disabilities Profile-2 (DDP2) Health Score, the DDP2 Behavior Score, and special group status membership. The Health and Behavior scores are assigned a point value depending on where these scores fall on the continuum of possible scores (see Table 1 and Table 2 below).

**Table 1: Health Score Care Coordination Need Score**

Health Score Range <sup>2</sup>	Point Score
Under 1.24 SD	0
1.25 – 2.24 SD	0.5
2.5 SD and Above	1.25

**Table 2: Behavior Score Care Coordination Need Score**

Behavior Score Range <sup>1</sup>	Point Score
0	0
Above 0, under 1.24 SD	0.5
1.25 – 1.74 SD	1
1.75 SD and Above	2.5

The special group statuses include: self-directing with budget authority; Willowbrook class member status; START participants, and special population (i.e., those living in a special setting: CIT/LIT/RIT/MDU/Autism Unit). Membership to one, or more, of these special groups are also assigned a set point value (see Table 3 below).

**Table 3: Special Group Status Care Coordination Need Score**

Special Status	Point Score
Self-Directing with Budget Authority	1.0
Special Population (e.g., CIT)	2.5
Willowbrook Classmember	2.5
START Services	2.5

\*The Health and Behavior Score ranges are based on set amount of variation (i.e., standard deviation (SD)) from the average health or behavior score

Next, the corresponding special group status, health, and behavior point scores\* are summed and individuals are assigned to either the Standard, Enhanced, or Enhanced Plus Care Coordination Need level (see Table 4 below).

**Table 4: Total Score and Care Coordination Need Level**

Level	Total Score
Standard	0 to .99
Enhanced	1.0 to 2.4
Enhanced Plus	2.5 and above

Individuals are then grouped into one of two residential settings: community living or certified residential setting. Certified residential settings include Intermediate Care Facilities (ICFs), Individualized Residential Alternative (IRAs), Community Residences (CRs), Family Care, and Developmental Centers. Community living included all other settings (including Individualized Supports and Services (ISS). Once the care coordination need level and living setting are determined, a care coordination tier is assigned (Table 5 below).

**Table 5: Care Coordination Tiers**

Care Coordination Tier	Living Setting	Care Coordination Need Level
Tier 1	Certified Residential	Standard
		Enhanced
Tier 2	Certified Residential	Enhanced Plus
	Community Setting	Standard
Tier 3	Community Setting	Enhanced
Tier 4	Community Setting	Enhanced Plus

Tier 1 includes those living in certified residential setting falling in standard or enhanced care coordination levels. Tier 2 includes those living in certified residential settings falling into the enhanced plus care coordination level and those living in the community with standard care coordination level. Tier 3 includes those living in the community falling in the enhanced care coordination need level. Tier 4 includes those living in the community falling into the enhanced plus care coordination need level.