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

PART II

CHECKLIST

APPLICATION DUE DATE: November 30, 2017

Please utilize this checklist and note inclusion/completion of the applicable elements in the Application by checking the adjacent box. A complete Application and all required elements must be submitted as required for review.

☐ **CCO/HH Application to Serve Individuals with Intellectual and/or Developmental Disabilities- Part II**

☐ **CCO/HH Network Partner Form (Attachment D)**
(http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/part_1_attachment_d.xlsx)

☐ **Section K: CMS CCO/HH Provider Functional Requirement Attestation**

☐ **Section L: Other Federal and State Requirements Attestation**

☐ **Submission of Application and Attachment D to hhidd@health.ny.gov. In the subject of line of the email, please indicate "Submitted CCO/HH Application – [YOUR ORGANIZATION'S NAME]".**
NOTE: submit documents in PDF format, do not scan and attach

The undersigned certifies that the information submitted in this CCO/HH Application and any attached pages are true, accurate, and complete. The CCO/HH applicant agrees to comply with all current and future CCO/HH rules, payment and operational policy, regulations and directives of the NYS Department of Health, Office for People With Developmental Disabilities, and CMS. The CCO/HH applicant also agrees to notify the NYS Department of Health and the Office for People With Developmental Disabilities of any changes that may occur either as a CCO/HH Provider or with any changes of providers/subcontractors within the CCO/HH network.

CCO/HH Name

Authorized Signature

Date

Print Name

Title

Instructions to the Applicant:

This Application is for currently designated Health Homes (HH) and other Medicaid providers seeking State designation to provide care management under the New York State HH model as tailored to serve the unique needs of individuals with intellectual and/or developmental disabilities (I/DD). Please refer to Part I: CCO/HH Application to Serve Individuals with Intellectual and/or Developmental Disabilities Application for CCO/HH requirements to assist with completion of Part II. Responses to this Application will be used to assess your organization's ability to become a Designated CCO/HH Serving individuals with intellectual and/or developmental disabilities (I/DD). Formal designation as a CCO/HH provider is contingent upon State and federal approvals.

Electronic Submission of Applications:

All Applicants must submit Part II of the Application and the CCO/HH Network Partner Form, Attachment D, (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/part_1_attachment_d.xlsx**) electronically. Please be advised, you should periodically save your work while completing the Application. Prior to submitting your Application, please ensure that you have responded to every field. Attach the completed Application, CCO/HH Network Partner Form, and a signed cover letter from an authorized representative in an email addressed to** hhidd@health.ny.gov**. In the subject of line of the email, please indicate "Submitted Application – [YOUR ORGANIZATION'S NAME]". This Application is due November 30, 2017.**

Application Information:

Organization Name:

NPI:

MMIS ID:

Corporation Name (optional):

Correspondence Address:

City:

Zip Code:

County:

Licensure /Certification Number (if applicable):

Organization Primary Contact Person for the Application:

Primary Contact Person Title:

Telephone Number:

Email:

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 CCO/HH's Application. Areas of review and focus will include: verifying the applicant meets the minimum qualifications (governance structure and regional coverage and capacity), the comprehensiveness of the Applicant's network of partners, including the inclusion of qualified Care Managers and current Medicaid Service Coordinators (MSC); providers' expertise in providing developmental disability, physical, behavioral health and community supports services to 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; and generally the provisions outlined in Part I of the Application.

Notification Process

The State will formally notify each Applicant of the disposition of their Application. 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 the activities by the State, the CCO/HH will be formally designated and may begin operations.

General Instructions

Please note that responses to all required questions must be thorough and complete. Responses must be fully contained within this electronic Application, except where specifically otherwise indicated. In completing your Application, please consider the information and requirements provided in Part I of this Application.

Section A. Minimum Qualifications for Submitting this CCO/HH Application

To meet the minimum qualifications to submit an Application to be a CCO/HH the Applicant must demonstrate that it meets the following two requirements described below:

I. Governance Structure, and

II. Regional Coverage and Capacity to Serve Minimum Number of Individuals

Applications that do not meet these minimum qualifications will not be reviewed. The State will notify Applicants who do not meet the minimum qualifications.

I. Governance Structure

CCO/HH providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements. CCO/HH Applicants must submit information that demonstrates 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 Medicaid Service Coordination (MSC) and/or long term care supports and services (LTSS). New York State's expectation is that the governance structure and leadership of the CCO/HH (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State, prior experience in overseeing and operating entities that have delivered MSC or HCBS waiver services to individuals with I/DD, and are in good standing with the State.

Currently designated CCO/HHs 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 persons with I/DD, including MSC and LTSS, may submit an Application to expand their current CCO/HH designation to serve individuals with I/DD.

Applicants may form partnerships and governance structures that leverage the existing CCO/HH infrastructure (even if the existing CCO/HH is not seeking CCO/HH designation) 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 CCO/HH Health Information Technology (HIT) core requirements.

The CCO/HH Model Graphic (Attachment C of Part I) includes a primary governance entity (i.e., entities interested in becoming designated CCO/HHs) that is responsible for administration and oversight of the CCO/HH, including those requirements outlined in Part I: CCO/HH Application to Serve Individuals with Intellectual and/or Developmental Disabilities.

Governance Structure (Questions)

A.1. Please describe the governance structure of your proposed CCO/HH to serve individuals with I/DD, including 51% ownership by developmental disability entities and including providers that specialize in serving individuals with I/DD. Please describe how this structure supports capacity to serve at least 5,000 enrollees. Limit 3,000 characters.

A.2. Provide a general description of the current experience your CCO/HH (including your lead partners) or your organization (if you are not currently a designated CCO/HH) has in providing integrated services to individuals with I/DD in a person-centered model. Limit 3,000 characters.

A.3. CCO/HH providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements. Acknowledge your understanding of this requirement or provide your existing Provider Identifier. Limit 300 characters.

A.4. Provide description of the CCO/HH individual and family advisory body and how it will interact with CCO/HH leadership. Limit 3,000 characters.

II. Regional Coverage and Capacity to Serve Minimum Number of Individuals

CCO/HH Service Regions

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 within 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 CCO/HH care management and deliver the CCO/HH 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 must provide a financial plan for review and consideration.

Proposed CCO/HH Service Region:

A.5. Please indicate below which Regions your organization will be able to serve, either in their entirety by checking "All" or in part, by checking the applicable counties.

Area: Region 1 – ☐ ALL

☐ Allegany	☐ Cattaraugus	☐ Chautauqua	☐ Chemung	☐ Erie	☐ Genesee	☐ Livingston
☐ Monroe	☐ Niagara	☐ Ontario	☐ Orleans	☐ Schuyler	☐ Seneca	☐ Steuben
☐ Wayne	☐ Wyoming	☐ Yates				

Region 2 – ☐ ALL

☐ Broome	☐ Cayuga	☐ Chenango	☐ Clinton	☐ Cortland	☐ Delaware	☐ Essex
☐ Franklin	☐ Hamilton	☐ Herkimer	☐ Jefferson	☐ Lewis	☐ Madison	☐ Oneida
☐ Onondaga	☐ Oswego	☐ Otsego	☐ St. Lawrence	☐ Tioga	☐ Tompkins	

Region 3 ☐ ALL

☐ Albany	☐ Columbia	☐ Dutchess	☐ Fulton	☐ Greene	☐ Montgomery	☐ Orange
☐ Putnam	☐ Rensselaer	☐ Rockland	☐ Saratoga	☐ Schenectady	☐ Schoharie	☐ Sullivan
☐ Ulster	☐ Warren	☐ Washington	☐ Westchester			

Region 4 – ☐ ALL

☐ Bronx	☐ Kings	☐ New York	☐ Queens	☐ Richmond

Region 5 – ☐ ALL

☐ Nassau	☐ Suffolk

A.6. Please complete Attachment D indicating MSC/CMA provider affiliates as instructed.

A.7. Please identify the health care professionals and other members of your current interdisciplinary CCO/HH team that will provide care management and coordination of integrated services to individuals with I/DD in your current CCO/HH network (as of the date of the release the Application) or your organization (if you are not currently a designated CCO/HH) with expertise in serving individuals with I/DD. Describe the nature of their current expertise in serving individuals with I/DD in a person-centered model. Limit 3,000 characters

Section B – Other General Qualifications

As described in more detail below, CCO/HH Applicants will be required to meet the infrastructure standards and qualifications, address the CCO/HH functional components (see below), deliver the core CCO/HH services described in this Application and meet any other standards and requirements for the CCO/HH. In addition, Applicants will be required to demonstrate their ability to tailor the State Plan requirements to serve the unique needs of individuals with I/DD.

Other general qualifications include the following:

I. CCO/HH provider is responsible for all CCO/HH program requirements, including services performed by the subcontractor(s). CCO/HH providers can either directly provide, and/or subcontract for the provision of CCO/HH care management services. After one year of operation, all Care Managers, including former MSCs, providing care management services must be directly employed by the CCO/HH.

II. Care coordination and integration of heath care services will be provided to all CCO/HH enrollees by an interdisciplinary team of providers, where each individual's care is under the direction of a dedicated care manager who is accountable for assuring access to developmental disability, medical and behavioral health care services and community social supports as defined in the enrollee's Life Plan.

III. CCO/HH providers must have procedures in place for accepting Hospital referrals for any eligible individual with chronic conditions who seeks or needs treatment in a hospital emergency department.

IV. CCO/HH providers must demonstrate their ability to perform each of the CCO/HH Provider Functional Requirements outlined by CMS and in Section K.

V. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Other General Qualifications (Questions)

B.1. Please acknowledge you have read and understand the general qualifications listed above and provide any information or identify existing procedures or actions you will take to demonstrate you meet these qualifications. Limit 3,000 characters.

Section C - Core Services

Providing and Tailoring the Provision of Core CCO/HH Requirements to Meet the Needs of Individuals with I/DD

The State Plan and Section 1945 (h) (4) of the Social Security Act defines CCO/HH services as "comprehensive and timely, high quality services" and includes the following CCO/HH services that must be provided by designated CCO/HH providers:

a) Comprehensive care management;
b) Care coordination and health promotion;
c) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
d) Individual and family support, which includes authorized representatives;
e) Referral to community and social support services, if relevant; and
f) The use of HIT to link services, as feasible and appropriate.

In addition, CCO/HHs will be expected to provide OPWDD's Valued Outcomes listed below:

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

The State Plan will specify and require CCO/HHs to meet the following core CCO/HH requirements. As indicated below, please describe how the provision of each of the following core CCO/HH requirements will be delivered and tailored to meet the complex needs of individuals with I/DD eligible for CCO/HHs. Responses should clearly demonstrate the level of competency and skill that will be provided in delivering the core requirements.

Core Services: Comprehensive Care Management

CCO/HHs will be required to have policies and procedures in place to develop, document, execute and update individualized, person centered Life Plans for each individual.

The CCO/HH requirements for providing comprehensive care management services include the following activities and must be reflected and documented in each Life Plan:

a) Develop a comprehensive health assessment that identifies medical, mental health, chemical dependency, developmental disability and social service needs is developed.

b) The individual's Life Plan integrates the continuum of medical, behavioral health services, rehabilitative, long term care, developmental disability and social service needs and 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.

c) 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 execution of their Life Plan should agree with the goals, interventions and time frames contained in the plan.

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

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

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

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

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

Examples of activities that constitute providing comprehensive care management under the CCO/HH model include:

- Completing a comprehensive assessment used to identify the individual's physical, mental health, substance use, long term supports and services, developmental disability, and social service needs.
- Completing and revising, as needed, the person-centered Life Plan with the individual and their family and/or representative to identify the individual's needs and goals, and include family members and/or representatives and other social supports as appropriate.
- Consulting with the interdisciplinary team, primary care physician, and specialists on the individual's needs and goals.
- Consulting with the primary care physician and/or other specialists involved in the treatment plan.
- Conducting clinic outreach and engagement activities to assess on-going and emerging needs and to promote continuity of care and improved health outcomes.
- Preparing crisis intervention plans.

Comprehensive Care Management (Questions)

C.1. Describe how your CCO/HH plans to deliver and tailor the comprehensive care management services and activities listed above to serve individuals with I/DD. Limit 3,000 characters.

C.2. Describe your approach to collaborating with an interdisciplinary team to develop the Life Plan and how the individual will be involved in the development of the Life Plan. Limit 3,000 characters.

C.3. Describe how the CCO/HH will develop a person-centered Life Plan for each individual that coordinates and integrates all clinical and non-clinical health-care related needs and services? Limit 3,000 characters.

C.4. Describe how the CCO/HH will provide the required care management services that are appropriate for the individual's acuity, as outlined in the tiers below, including how the CCO/HH will document and review these services. Limit 3,000 Characters.

Tiers 1-4 - must have a monthly core billable service, and in addition:
Tiers 1 – 3 - Care Manager must have at least one face-to-face meeting with CCO/HH enrollee each quarter (January - March; April – May; June - August; and September – December.
Tier 4 - Care Manager must have a monthly face-to-face meeting with the CCO/HH enrollee.
Willowbrook Class Members must have a case load level of no greater than 20 members per Care Manager.

Core Services: Care Coordination and Health Promotion

This CCO/HH 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.

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

- Providing individuals with education on their chronic condition
- Teaching self-management skills
- Conducting medication reviews and regimen compliance

Promoting wellness and prevention programs by assisting CCO/HH 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 member needs and preferences. The CCO/HH requirements for providing care coordination and health promotion include the following:

a) The CCO/HH provider is accountable for engaging and retaining CCO/HH enrollees in care, 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, developmental disability services, long term supports and services, and social and community services where appropriate through the creation of an individual Life Plan.

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

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

d) The CCO/HH provider must define how the enrollee's care will be directed when conflicting treatment is being provided.

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

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

g) The CCO/HH provider 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 enrollee and the CCO/HH provider. 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).

h) The CCO/HH provider ensures 24 hour/seven day a week access to a Care Manager to provide information and if needed, emergency consultation services.

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

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

k) The CCO/HH provider 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.

Examples of activities that constitute providing care coordination and health promotion under the CCO/HH model include:

- Coordinate with service providers and health plans to secure necessary care, share crisis intervention and emergency information.
- Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.
- Conduct case reviews with the individual and their family and/or representative and interdisciplinary team to monitor/evaluate the enrollee's status/service needs.
- Crisis intervention – revise Life Plan/goals as required.
- Advocate for services and assist with scheduling of services.
- Monitor, support, and accompany the enrollee to scheduled medical appointments.

Care Coordination and Health Promotion (Questions)

C.5. Describe how your CCO/HH plans to deliver and tailor the care coordination and health promotion services and activities listed above to serve individuals with I/DD. Please include in your response a description of how your organization will address the long term care, mental health and substance use, and physical needs of the person. Limit 3,000 characters.

C.6. How will your CCO/HH educate and engage enrollees in making decisions that promote 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. Limit 3,000 characters.

C.7. Describe your processes for ensuring there is 24-hour/7 day a week access to the Care Manager and if needed, emergency consultation services. Limit 3,000 characters.

C.8. Describe how the CCO/HH will track information and care needs for each enrollee across providers, monitor member outcomes, initiate changes in care and address the needs of the enrollee. Limit 3,000 characters.

C.9. How will the CCO/HH provide, culturally appropriate, and person- and family-centered HH services? Limit 3,000 characters

C.10. How will the CCO/HH coordinate and provide access to chronic disease management, including self-management support to enrollees and their families? Limit 3,000 characters.

Core Services: Comprehensive Transitional Care

This CCO/HH core service includes the facilitation of services for the individual and their family and/representative when the individual is transitioning between levels of care (including, but not limited to, hospital, nursing facility, Intermediate Care Facility (ICF), Individualized Residential Alternative (IRA), rehabilitation facility, community based group home, family or self-care), experiences transitions 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 to a new Care Manager within the same CCO/HH. The CCO/HH requirements for providing comprehensive transitional care services include the following:

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

b) The CCO/HH provider has policies and procedures in place to support individuals experiencing transitions 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 to a new Care Manager within the same CCO/HH.

c) The CCO/HH provider 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 enrollees who require transfers in the site of care.

d) The CCO/HH provider utilizes HIT as feasible to facilitate interdisciplinary collaboration among all providers, the individual and their family and/or representative and local supports.

e) The CCO/HH provider 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 re-engage the enrollee in care if the appointment was missed.

Examples of activities that constitute providing Comprehensive Transitional Care include:

- Follow up with hospitals/ER upon notification of a enrollee's admission and/or discharge to/from an ER, hospital/ residential/rehabilitative setting.
- Facilitate discharge planning and follow up with hospitals/ER upon notification of a enrollee's admission and/or discharge to/from ER/ hospital/residential/rehabilitative setting.
- Link enrollees and their family and/or representative with community supports to ensure that needed services are provided.
- Follow up post discharge with enrollees and their family and/or representative to ensure needed services are provided.
- Notify and consult with treating clinicians, including the enrollee's primary care physician and/or developmental disability service provider(s), schedule timely follow up appointments, and assure that all ordered medications are in the home and at other administering sites (e.g., day program, sheltered workshop, schools etc.) and assist with medication reconciliation.
- Facilitate a smooth transition if an enrollee transitions from one CCO/HH to another or from one Care Manager to another within the same CCO/HH.

Comprehensive Transitional Care (Questions)

C.11. Describe how your CCO/HH plans to deliver and tailor the comprehensive transitional care services and activities listed above to serve individuals with I/DD. Limit 3,000 characters.

C.12. Describe your approach for facilitating services for the enrollee when the enrollee is experiencing life transitions from school to adult services or life changes such as employment, retirement, or other life events. Limit 3,000 characters.

C.13. Describe your approach to facilitating services for the enrollee and their family and/or representative when the enrollee is transitioning between levels of care (including but not limited to transition from hospital, Intermediate Care Facility (ICF), Individualized Residential Alternative (IRA), rehabilitation facility etc.) or when the enrollee is electing to transition to a new CCO/HH provider. Describe your approach and procedures for incorporating comprehensive discharge planning (e.g., from the hospital or other treatment facilities) in the Life Plan, including the approach to involving the family and/or representative in the discharge and Life Plan process. Limit 3,000 characters.

C.14. In instances where it is requested by the enrollee or necessary and in the best interest of the enrollee, describe your approach and procedures for transitioning an enrollee from one CCO/HH Care Manager to another. Limit 3,000 characters.

C.15. Describe the process that will be used to ensure the Care Manager and CCO/HH prompt notification of emergency room and inpatient facility admissions/discharges. Limit 3,000 characters.

C.16. How will the CCO/HH coordinate transitional care across settings, specifically with regard to transitioning enrollees under 21 years of age to an adult system of DD and LTSS care. Describe your approach to tailoring and transitioning care management for individuals with I/DD that become adults and remain eligible for CCO/HH. Limit 3,000 characters.

Core Services: Individual and Family Support

This CCO/HH core service includes coordinating of information and services to support individuals and their family and/or representative to maintain and promote quality of life, with a focus on community living options. The CCO/HH requirements for providing individual and family support services including the following:

a) The enrollee's person-centered Life Plan reflects their preferences, education and support for self-management: self-help recovery, and other resources as appropriate.

b) The Life Plan is accessible to the enrollee and their family and/or representative based on the enrollee's preference.

c) The CCO/HH provider utilizes peer supports, support groups and self-care programs to increase the enrollee's knowledge about their disease, engagement and self-management capabilities, and to improve adherence to prescribed treatment.

d) The CCO/HH provider discusses advance directives with the enrollee and their family and/or representative.

e) The CCO/HH provider communicates and shares information with the enrollee and their family and/or representative with appropriate consideration for language, literacy and cultural preferences.

f) The CCO/HH provider gives the enrollee access to their Life Plans and options for accessing clinical information.

Examples of activities that constitute providing individual and family support services under the CCO/HH model include:

- Develop, review and revise the enrollee's Life Plan with the enrollee and their family and/or representative to ensure the plan reflects the enrollee and their family and/or representative's preferences, education, and support for self-management.
- Consult with the enrollee and their family and/or representative on advanced directives and educate on the enrollee's rights and health care issues as needed.
- Meet with enrollee and their family and/or representative inviting any other providers to facilitate needed interpretation services.
- Refer enrollee and their family and/or representative to peer supports, support groups, social services, entitlement programs as needed.

Individual and Family Support (Questions)

C.17. Describe how your CCO/HH plans to tailor the individual and family support services and activities listed above to serve individuals with I/DD. How will your organization coordinate and provide access to individual and family support, including referral to community, social support and recovery services? Limit 3,000 characters.

C.18. Describe your approach to ensuring the Life Plan is built around the strengths of the enrollee and reflects the enrollee and their family and/or representative preferences. Limit 3,000 characters.

C.19. Describe your approach to encouraging involvement of the enrollee and their family and/or representative in identifying the needs of both the enrollee as well as their family/representative. Limit 3,000 characters.

C.20. Explain the CCO/HH's approach for communicating and sharing information with the enrollee and their family and/or representative that is considerate of language, literacy and cultural preferences. Limit 3,000 characters.

C.21. Describe the CCO/HH's approach to providing each enrollee and their family and/or representative access to the Life Plan and other clinical information. Limit 3,000 characters.

Core Services: Referral to Community and Social Support Services

This CCO/HH core service includes providing information and assistance to engage and refer enrollee's and their family and/or representative to community based resources, (regardless of funding source) that can help meet the needs identified in the enrollee's person-centered Life Plan. This core service is intended to include activities that connect and monitor the enrollee's community activities and opportunities, develop relationships with others, and foster independence and integration, including employment.

The CCO/HH requirements for providing referrals to community and social support services include the following:

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

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

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

Examples of activities that constitute making referrals to community and social support services include:

- Identify resources that link the enrollee and their family and/or representative to community supports as needed.
- Collaborate and coordinate with community based providers to support effective utilization of services based on enrollee and family/representative need.

Referral to Community and Social Support Services (Questions)

C.22. Describe how your CCO/HH plans to deliver and tailor referrals to community and social support services and activities listed above to serve individuals with I/DD. Limit 3,000 characters

C.23. Describe how your CCO/HH will identify and provide linkages to community-based resources for individuals with I/DD and their families and/or representatives, including peer supports and youth development services. Limit 3,000 characters.

C.24. Describe how you will actively manage referrals, access, engagement, follow-up and coordination of services. Limit 3,000 characters.

C.25. Describe the CCO/HH's policies, procedures and accountability structure supporting effective collaborations with community based resources and clearly define the roles and responsibilities. Limit 3,000 characters.

Core Services: Use of Health Information Technology (HIT) to Link Services

The CCO/HH must adhere to all State and Federal legal, statutory, and regulatory requirements. CCO/HH providers will make use of available information systems and access data through the Regional Health Information Organization/Qualified Entities (RHIO/QE) to conduct these processes as feasible, to comply with the initial standards cited in items 6a – 6d for implementation of CCOs. In order to be approved, Applicants must provide a plan to achieve the final standards cited in items 6e-6i within six (6) months of program initiation. The CCO/HH requirements for Use of HIT to Link Services includes the following initial and final standards:

Initial Standards:

a) CCO/HH has structured information systems, policies, procedures and practices to electronically create, document, execute, and update a Life Plan for every enrollee.
b) CCO/HH has a systematic process to follow-up on tests, treatments, services and referrals, which is incorporated into the enrollee's Life Plan.
c) CCO/HH has an electronic record system which allows the enrollee's 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.
d) CCO/HH makes use of available HIT and accesses data through the RHIO/QEs to conduct these processes, as feasible.

Final Standards:

e) 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.
f) 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.
g) CCO/HH will be required to comply with the current and future version of the SHIN-NY Guidance (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.
h) 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/QEs provide policy and technical services required for health information exchange through the Statewide Health Information Network of New York (SHIN-NY).
i) 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 enrollee's personal life goals and valued outcomes.

In addition, the CCO/HH must 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.

As you work to achieve these nine (9) HIT Standards, please note:

CCO/HHs applying for individuals with I/DD's CCO/HH status will have 6 months from the date of CCO/HH designation to meet compliance with HIT standards. The Department of Health will provide informational webinars and trainings on HIT adoption and usage as well as technical assistance in meeting the CCO/HH HIT standards.

Use of Health Information Technology (HIT) to Link Services (Questions)

C.26. If you are an organization seeking CCO/HH designation, please provide information regarding your capability to meet the initial and final health IT standards described above. In addition, please provide your organization's plan for achieving final health IT standards within six (6) months of your CCO/HH designation. Limit 3,000 characters.

C.27. Please provide information on how you plan to work with network partners and Care Managers to ensure these HIT standards are implemented and how you intend to accommodate the rights of minors to consent to certain types of health care without the permission of their parent/ guardian, and whether parents/guardians or others can access their health information. Limit 3,000 characters.

C.28. How will the CCO/HH use HIT to link services, facilitate communication with enrollees and their family/ representative and among the health team, and provide feedback to service providers, as feasible and appropriate? In addition, how will the CCO/HH provide access for enrollees and their family and/or representative to the Life Plan and other related documentation via a secure portal that includes digital signature and two-way communication for the approval and management of the Life Plan between the enrollee and the CCO/HH? Limit 3,000 characters.

C.29. Please describe if your HIT systems now recognizes and accommodates the rights of enrollees to consent to certain types of health care information sharing and whether parents/guardians or others can access their health information. If your HIT systems do not accommodate the ability to segregate health care information in this manner, please described how your organization accommodates the consent rights of enrollees, including minors.
Limit 3,000 characters.

C.30. Please describe the capacity of your HIT system to provide enrollees, families, representatives, providers and the State access, via a secure web-based portal, to 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. Please specify the HIT vendor that you have selected to develop this capability. Limit 3,000 characters.

Section D – System Standards

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) 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 CCO/HH standards and quality measures. The CCO/HH must use systems provided by the State to verify OPWDD and CCO/HH eligibility, enroll and track enrollees in the CCO/HH, capture the enrollee'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 under development and the Final Application will include that information. The State is now assessing the feasibility of modifying the Medicaid Analytics Performance Portal (MAPP) CCO/HH 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			
System	**System Description**	**Day 1 Use**	**Future Use**
CHOICES	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	• Record individual's choice of CCO/HH • Process CCO/HH Enrollments and Dis-enrollments • Review DDP2 assessment outputs including CCO/HH rate tiers • Verify HCBS services authorized by OPWDD • Confirm CCO/HH consent • Access CAS assessment summaries • Verify pertinent enrollee information included in their demographic profile • Download enrollee roster • Complete LOC	• Verify HCBS services authorized by OPWDD • Verify pertinent individual information
Tracking And Billing Systems (TABS)	TABS is the State system of record storing information on individuals receiving OPWDD HCBS services	• Calculates the CCO/HH rate tier based on data from DDP2 assessment and other enrollee characteristics • CCO/HH rate tiers will be included on enrollee roster that the CCO/HH will download from CHOICES • CCOs will not have direct access to the TABS, but will have access to pertinent TABS data through CHOICES.	*Phased out*
CCO/HH HIT Systems Capability (e.g., EHR Life Plan, Billing systems etc.)	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	• Upload/Record enrollee roster from CHOICES • Develop and maintain an individual's Life Plan as defined by the State and Health Home standards and requirements • Process and track enrollments for • downstream providers • Timely bill for services and remit payments to Care Managers in accordance with NYS Medicaid processes • Generate quality measures reports	• Continue all Day 1 Uses and further enhancements as may be required

MAPP/HHTS	Performance management system that provides tools to Health Homes to support providing care management	*Not available on Day 1*	• Process CCO/HH Enrollments and Dis-enrollments • CCO consent verification and management • Quality Analytics
Uniform Assessment System-New York (UAS-NY)	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	• CAS implemented Statewide • CCO/HHs will have access to view the initial CAS for purposes of aiding in service planning • CCO/HHs will be conducting CAS re-assessments through UAS

In addition, CCO/HHs must ensure the following system functionalities will be available as of the initial date of operation.

a) Provide the capability for enrollees, family/representatives, 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.

b) 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.

c) 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.

d) CCO/HH IT capability must maintain interoperability with other defined State systems using NYS ITS approved protocols.

e) CCO/HH IT capability must provide access for enrollees and family/representatives 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.

f) CCO/HH IT capability must capture the enrollee's consent, electronically share changes to demographics and service adds, edits, and deletions-as prescribed by OPWDD.

Systems Standards (Questions)

D.1. Upon implementation, how will the CCO/HH demonstrate that there is adequate capability to access all State systems detailed in Part I of the Application (CHOICES, TABS) to be able to perform all functions of a CCO/HH?
Limit 3,000 Characters.

D.2. The State plans to eventually migrate CCO/HHs to MAPP/HHTS and UAS-NY. Please acknowledge that you understand that this may be a future system requirement. Limit 3,000 characters.

Section E – Billing

The CCO/HH is required to have a billing system that allows for timely claims submission to the State's Medicaid Management Information System and payment to care management agencies. As part of the readiness reviews, the State will verify that the systems in place are able to process payments within 15 days of receiving payment from the State or Managed Care Plan as will be required in the future and as described in Section 10 Part I of the CCO/HH Application. The CCO/HH will need to be prepared to demonstrate an operational system that has been tested.

E.1 Please describe the system your organization has in place and how will your organization be able to adhere to the requirement of processing payments within 15 days of receiving payment from the State or Managed Care plan. Limit 3,000 Characters.

E.2. Identify the billing vendor that will be used for CCO/HH services. Limit 3,000 Characters.

Section F - CCO/HH Care Manager Qualifications and Requirements

Care Managers with Expertise in Serving Individuals with I/DD

Persons and entities that have experience in providing care management for individuals with I/DD, including developmental disability provider agencies that have or now serve I/DD and Medicaid Service Coordinators. Please refer to Part I of the Application for information on the standards and requirements for Care Managers, including background checks.

CCO/HH Care Manager Qualifications and Requirements (Questions)

F.1. How will the HH develop and maintain a CCO/HH network of partners that includes current Medicaid Service Coordination agencies that will transition to HH Care Management agencies (CMAs)? Explain how you will directly employ Care Managers who are qualified to provide care management to individuals with I/DD? Limit 3,000 characters.

F.2 Please describe how the CCO/HH will ensure sufficient capacity to deliver quality care management services to members upon implementation and how the CCO/HH will monitor case load and capacity as the CCO/HH expands its membership. Limit 3,000 characters.

F.3. Explain how the CCO/HH will ensure Care Managers are knowledgeable and qualified to serve individuals with I/DD. Limit 3,000 characters.

F.4. Describe how the CCO/HH will implement training and education for CCO/HH Care Managers. Limit 3,000 characters.

F.5. Provide a description of the proposed Care Manager position for individuals with I/DD, including professional discipline/qualifications, and relevant education, training and experience. Please note the "Standards for Care Managers" described in Part I of the Application. Limit 3,000 characters.

F.6. Define how the CCO/HH will address the transition from MSC to CCO/HH service coordination functions that creates a career path and builds to the OPWDD enhanced comprehensive care coordination standards, ensuring the smooth integration of individuals into the CCO/HH program with no break in services and ensuring continuity of care.
Limit 3,000 characters.

Section G - Willowbrook

Services provided to Willowbrook class members comport with the requirements of the Willowbrook Permanent Injunction, the CCO/HH must adhere to the following provisions:

a) CCO/HH will identify members status as a Willowbrook class member in its electronic care planning data system.
b) A class member's Active Representation (appendix H of the Permanent Injunction) status will be reflected and updated as needed. The Care Manager will ensure that active representation is being reviewed on an ongoing basis, referrals will be made to the Community Advisory Board (CAB) as mandated when necessary.
c) A copy of the Willowbrook Class Member's Notice of Rights will be retained in the members record in the electronic care planning data system. This will be provided to all service providers that deliver services to the Willowbrook class member.
d) The names and contact information for Willowbrook parties, comprised of the New York Lawyers for Public Interest, New York Civil Liberties Union and the CAB who represent the member will be identified in the electronic data system. These representatives will receive copies of all notices or other communications as dictated by the Willowbrook Permanent Injunction.
e) CCO/HH will report to the Willowbrook parties, Willowbrook class members' placement in a Skilled Nursing Facility or other residential placement in accordance with the Permanent Injunction.
f) All CCO/HH staff engaged in care planning with 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 or to others in the class member's immediate environment.

Willowbrook (Questions)

G.1. Please describe how the CCO/HH's will ensure their electronic care planning data system will include the required provisions identified in Section G. a, c & d above. Limit 3,000 characters.

G.2. Please describe how the CCO/HH will ensure active representation is reviewed on an ongoing basis. Describe your referral and notification process to the CAB and other parties identified in d above. Limit 3,000 characters.

G.3. Describe your reporting process to the Willowbrook parties for members who are placed in a Skilled Nursing Facility (SNF) or other residential placements in accordance with the Permanent Injunction. Limit 3,000 characters.

G.4. Describe how you will ensure that CCO/HH staff engaged in care planning for Willowbrook class members are trained in and knowledgeable of the requirements of the Permanent Injunction for Willowbrook class members. Limit 3,000 characters.

Section H - Network Requirements

Applicants will need to ensure their proposed CCO/HH networks have the breadth of partners required to serve individuals with I/DD as indicated by the Applicant in Attachment D of this Application. In addition to the network requirements described below for serving individuals with I/DD, the proposed networks of Applicants should include managed care plans, medical providers (e.g., hospitals, substance use disorder providers, primary care practitioners, clinics, ambulatory care, preventive and wellness care, patient centered medical homes, pharmacies/medication management services, and Federally Qualified Health Centers (FQHC), specialists, psychiatrists and psychologists, and home care services); behavioral health care providers (e.g. acute and outpatient mental health, substance use disorder treatment services and rehabilitation providers, etc.); and community based organizations and social services providers (e.g., public assistance support services, housing services, foster care agencies).

Applicants must demonstrate they have Care Managers that now or have served I/DD population.

As part of the requirements of this Application, currently designated CCO/HHs must affirm that the current network partners as filed with the Department of Health is accurate and complete as of the due date of this Application. Please note it is not necessary that the network partners on file as of the due date of this Application include the additional partners that are identified by you in this Application to serve individuals with I/DD. Note that as part of the Application review process, the State will collectively consider your network on file and the additional network partners submitted with this Application.

It is expected that Applicants which are currently designated CCO/HHs will expand their network of partners, as described in more detail below, to ensure access to Care Managers and services, including an interdisciplinary team, that can meet the complex needs of individuals with I/DD.

Network Requirements (Questions)

H.1. **All Applicants must use the form provided herein to provide a comprehensive list of its CCO/HH provider network.** The CCO/HH Network Partner List, Attachment D (http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/idd/docs/part_1_attachment_d.xlsx) requires the following network partner information: CCO/HH Name and CCO/HH Provider ID in cells C2 and C3. Below these fields, please add each partner name in a separate row with their NPI, the date the partner joined the HH network, and indicate the network partner service type with "Y" for yes or "N" for no. Each network partner service type must have either a "Y" or "N" for each field. Please include both entities (i.e. hospitals, clinics, community organizations) and individual providers (i.e. physicians, psychologist). Please do not add any additional columns to the Excel worksheet.

Partner List

The following is a list of types of service providers developed in consultation with stakeholders. Applicants should consider developing a comprehensive network to serve the unique and complex needs of individuals with I/DD eligible for CCO/HHs. The breadth and comprehensiveness of the network (along with the proposed region of service and access to providers) will be a focus of evaluation on each Application.

a) Developmental Disability Service Providers, including Residential Habilitation, Day Services, Employment Services, Self-Direction, Intensive Behavioral Services, Family Education and Training, Adaptive Technology and Environmental Modification Providers. (complete I/DD Service Providers Tab)
b) Behavioral Health Rehabilitation Services, including Assertive Community Treatment (ACT), OMH Licensed Residential Programs and Personalized Recovery Oriented Services (PROS)
c) Free Standing Clinics, including FQHC's, Article 16, Article 28, Article 31 and Article 32 clinics
d) Home Health Care Services
e) Inpatient Hospital Services, including Substance Abuse and Behavioral Health Services
f) Long Term Supports and Services, including Personal Care and Adult Day Health Care
g) Medical Care and Specialty Providers, including, Primary Care, Ambulatory Care, Preventive and Wellness Care, Psychiatry, Podiatry, Audiology, Optometry, HIV/AIDS and Dental
h) Nursing
i) Outpatient Hospital Services, including Behavioral Health and Rehabilitation Therapy
j) Regional START Teams
k) Skilled Nursing Facility Services
l) Supportive Health Services, including school-based and early intervention
m) Providers with Expertise in Serving Individuals with I/DD
n) Miscellaneous, including Durable Medical Equipment and Personal Emergency Response Services (PERS)

To assist Applicants, the State has prepared the attached draft list of providers (see Attachment E) with expertise in providing care management and other services to individuals with I/DD. Please note the State worked collectively across agencies to attempt to prepare a comprehensive list of providers. However, if we have inadvertently missed a provider that should be added to the list please inform the state via email at hhidd@health.ny.gov.

Section I - Connectivity with Systems of Care that Impact Individuals with I/DD

As part of building or expanding a CCO/HH network to serve individuals with I/DD, CCO/HHs must demonstrate connectivity to the systems of care that serve individuals with I/DD

Connectivity with Systems of Care that Impact Individuals with I/DD (Questions)

I.1. Please describe how your CCO/HH will establish and maintain connectivity with the systems of care to serve individuals with I/DD. Limit 3,000 characters

I.2. Describe the nature of any current relationships your CCO/HH or your organization has established with Regional START Teams, Developmental Disability Regional Offices (DDRO), and local government units. Limit 3,000 characters.

Section J - Quality Measures

Please refer to Part I of the Application for more information and guidance on Quality Measures.

Quality Measures(Questions)

J.1. Identify the routine data reports and other data sources that will be used to identify quality assurance successes and problems. Limit 3,000 characters.

J.2. Describe the processes the I/DD CCO/HH will put in place to report on quality measures identified in Part I with the Data Source listed as “CCO Reporting.” Limit 3,000 characters.

J.3. How will the CCO/HH establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level? Limit 3,000 characters.

Section K - CMS CCO/HH Provider Functional Requirements

As described in the CMS State Medicaid Director's Letter, 10-024 (https://www.cms.gov/smdl/downloads/SMD10024.pdf) designated providers of CCO/HH are expected to address the functions listed below.
Applicants will be required to attest in Section G of this Application that they will address the issues below.

a) Provide quality-driven, cost-effective, culturally appropriate, and person -centered CCO/HH services.
b) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
c) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
d) Coordinate and provide access to mental health and substance abuse services.
e) Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
f) Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
g) Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
h) Coordinate and provide access to long-term care supports and services.
i) Develop a person-centered Life Plan for each enrollee that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
j) Use of HIT to link services, facilitate communication among team members and between the health team and the enrollee and their familyrepresentative, and provide feedback to practices, as feasible and appropriate.
k) Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Attestation

☐ As an authorized representative of this Organization, I attest and certify to the conditions stated above and do so on behalf of this Organization.

CMS CCO/HH Provider Functional Requirements (Questions)

K.1. Please provide any additional information that is not otherwise addressed in this Application to demonstrate how you will provide these functions in the person-centered CCO/HH model for individuals with I/DD.
Limit 3,000 characters.

Section L - Other Federal and State Requirements

Attestation

Please indicate that as the CCO/HH Applicant, you attest to providing or meeting the following requirements:

a) The CCO/HHCCO/HH will provide the core CCO/HH requirements, tailored to meet the needs of individuals with I/DD, as described in this Application.

b) The CCO/HH will provide the following services:

i. Coordination of care and services post critical events, such as emergency department use, hospital inpatient admission and discharge;
ii. Language access (written translation and spoken interpretation) capability, including language adaptations for non-verbal members;
iii. 24 hour 7 days a week telephone access to a care manager;
iv. Crisis intervention;
v. Links to acute and outpatient medical, mental health and substance abuse services;
vi. Links to community based social support services-including housing;
vii. Beneficiary consent for program enrollment and for sharing of patient information and treatment; and
viii. CCO/HHs serving individuals with I/DD must attest that all notices and informational materials to members will be in a manner and format that can be easily understood, and the CCO/HH has in place a mechanism to help enrollees understand the requirements and benefits of the Life Plan.

c) The CCO/HH will, to the extent required, collect data and report on specific quality measures required by the State and/or CMS, including those defined under Part I of this Application under "Quality Measures" and "Data Collections and Tracking Requirements."

d) The CCO/HH has approached the providers listed in this Application and has obtained the providers' commitment to be part of the CCO/HH network. Formal evidence of this commitment will be required prior to designation. Contractual agreements must be in place with all organizations for which there is a financial arrangement prior to the first request for reimbursement when partnerships involve a financial arrangement.

e) Payments which are subject to State mandated rates and other transitional provisions and rates implemented by the State will be made at rates which are not less than those mandated rates. The CCO/HH will have billing systems in place that can submit timely billable information to eMedNY via the 837EDI, and when or where applicable be prepared to modify 837i submission to Medicaid Managed Care Plans. The CCO/HH must have both an MMIS and National Provider Identification number to ensure timely remittance and payment.

f) CCO/HH Provider Applicants must submit a written attestation that the services specified above will be provided in accordance with the CCO/HH functional components referenced in the CMS State Medicaid Director's Letter, 10-024 (https://www.cms.gov/smdl/downloads/SMD10024.pdf) and described earlier in Part II of this Application.

By checking the box below, the CCO/HH Applicant attests and certifies that the information submitted in this CCO/HH Provider Application and any attached pages is true, accurate, and complete. In addition, the CCO/HH Applicant agrees to comply with all current and future CCO/HH Program rules, payment structures and operational policies, regulations and directives of the NYS Department of Health (DOH) and Centers for Medicare and Medicaid Services (CMS). The CCO/HH Applicant also agrees to immediately notify the Department of Health of any changes that may occur either as a CCO/HH provider or with any changes of providers/subcontractors within the CCO/HH network.

☐ As an authorized representative of this Organization, I attest and certify to the conditions stated above and do so on behalf of this Organization.

Section M – Rights of the State

The rights of the State provided below are unchanged from the rights included in the CCO/HHs Application governing the initial designation of all CCO/HHs.

a) The State reserves the right to enroll individuals in a specific CCO/HH, subject to the individual's right to opt-out of CCO/HH care management.

b) The State reserves the right to cancel a CCO/HH provider's approved status based on upon failure of the provider to provide CCO/HH services in accordance with the NYS CCO/HH Provider Qualification Standards, provide quality CCO/HH services to its enrollees, or upon other significant findings determined by the State.

c) The State reserves the right to cancel the program at any time for lack of funding, and/or if, after evaluation of the program, desired results in quality, efficiency and decreased costs are not shown, or any other reason determined by the State.

Thank you for your interest in CCO/HHs serving individuals with I/DD. This concludes Part II of the Application. In order to ensure the application is completed in its entirety, please use the application submission checklist on page 1.