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

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Introduction

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

OPWDD is committed to helping individuals with I/DD live richer lives and creating stronger, person-centered services. OPWDD's goal is to meet the needs of individuals and families in the most comprehensive way possible and promote the achievement of quality outcomes and improvement across the service delivery system. Any net savings achieved due to more efficient service utilization will be invested back into the OPWDD system.

This document contains the New York State MMCO I/DD system transformation requirements and standards for operating a SIP-PL. It is written for organizations that have first applied to obtain Article 44 licensure as an MMCO. The SIP-PL must demonstrate that it is under majority control by not-for-profit entities that have extensive experience providing and/or coordinating health and long-term care (LTC) services for individuals with I/DD. The State interprets control as defined in 10 NYCRR Part 98-1.2(j).

This document also includes a description of the multi-phase system transformation, including enrollment into SIPs-PL and the phasing in of specialized I/DD services within the SIP-PL network. The sequencing of enrollment and network development is described in Section 1.2. The final design for SIPs-PL and the transition of OPWDD Home and Community Based Services (HCBS) and its service population to Managed Care will be described in amendments to the Comprehensive HCBS Waiver and other Waiver authorities. Waiver actions are subject to approval by the federal Centers for Medicare and Medicaid Services (CMS).

SIP-PL Application and Readiness

Interested, qualified entities will be required to complete an application which includes the submission of Attachment J: Pro-forma Template and Instructions and describes the operational strategies for maintaining and improving the quality of services provided to individuals with I/DD while achieving the efficiencies necessary for financial sustainability. The comprehensive application and supporting documentation will undergo a joint review by NYSDOH and OPWDD, herein referred to as the State. The State will perform a desk review of the application and supporting documents, followed by on-site reviews which are expected to begin within three (3) months of a complete application submission.

The State will also conduct pre-implementation readiness reviews to assess each Applicant's capacity to serve individuals with I/DD. The readiness review process will ensure that SIP-PL Applicants are prepared to comply with all program and contract requirements and are ready to

deliver services to individuals with I/DD prior to enrollment. Readiness reviews will assess the SIPs-PL ability and capacity to perform satisfactorily in all major operational areas prior to enrollment. Reviews will include, but not be limited to, individual and provider communications, provider network management, program integrity and compliance, the provision of Care Management, utilization review, quality and performance improvement, financial management, claims processing, reporting, and encounter data.

SIP-PL Legal Authority

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

Reserved Rights

The State reserves the right to amend or modify the requirements and standards contained within this document and conduct additional readiness review activities if needed.

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

1.0 Vision

New York State established the MRT in 2011 to improve health outcomes, control Medicaid costs in a sustainable way, and provide Care Management for all Medicaid enrollees by aligning incentives for the provision of high-quality, integrated, and coordinated services. A key feature of the MRT initiative is to transform the healthcare delivery system from a fee-for-service model to a value-based Managed Care model. Value-Based Payment (VBP) is a strategy used by New York State's Medicaid program and other payers to incentivize quality outcomes and a higher performing system of services and healthcare. As OPWDD transitions to Managed Care, MMCOs contracting with New York State will be encouraged to incorporate VBP arrangements with providers.

In 2015, OPWDD's Commissioner convened a panel, comprised of stakeholders including providers, family members, advocacy groups, and State and local government representatives, to discuss and provide recommendations to the Agency on transforming the way healthcare is delivered to individuals with I/DD. The panel was asked to shape clear and actionable recommendations to guide OPWDD's path moving forward. OPWDD's Commissioner's Transformation Panel offered a set of sixty-one (61) recommendations designed to improve access to services and assist in ensuring a smooth transition to a Managed Care service delivery model for the I/DD population.

New York State's experience in the implementation of MMC has shown that provider availability under Managed Care, including access to specialists, is improved over availability in fee-for-service. OPWDD is confident this will be the case with SIPs-PL. SIP-PL Applicants will be given

information about the providers that most frequently serve the I/DD population and will be encouraged to contract with them.

1.1 Overview of Current OPWDD Service Systems

OPWDD serves almost one-hundred and twenty thousand (120,000) Medicaid enrolled individuals with I/DD. Although most Medicaid specialized I/DD services are paid through fee-for-service, over twenty-thousand (20,000) individuals with I/DD are already enrolled in other types of MMCOs for non-OPWDD services. The transition to Managed Care will support and arrange for the delivery of all services for individuals with I/DD, including medical, behavioral health, I/DD and LTSS, while improving access and promoting better health outcomes. Person-centered service planning and principles will not change in Managed Care, and continuity of care provisions will ensure that current levels of support remain in place for individuals during the transition.

The current oversight, incident reporting requirements and quality standards for OPWDD HCBS Waiver and State Plan services will not change significantly during the transition to Managed Care. The current regulatory framework continues to apply to services under the jurisdiction of OPWDD and includes the following New York Codes Rules and Regulations (NYCRR):

- 14 NYCRR 701 – Justice Center Criminal History Information Checks
- 14 NYCRR 633 – Protection of Individuals Receiving Services
- 14 NYCRR 635 – General Quality Control and Administrative Requirements
- 14 NYCRR 624 – Reportable Incidents and Notable Occurrences
- 14 NYCRR 625 – Events and Situations
- 14 NYCRR 681 – Intermediate Care Facilities for Individuals with Intellectual and/or Developmental Disabilities (ICF/IID)
- 14 NYCRR 636 – Person-Centered Planning (for matters related to Habilitation services)

The OPWDD Division of Quality Improvement (DQI) will continue its surveillance and survey of programs and services subject to the oversight of OPWDD. Any future changes to this regulatory framework will be subject to advance public notice and engagement and training for provider agency staff.

The SIP-PL is responsible for ensuring certain entitlements under the Willowbrook Permanent Injunction, including protection from harm, high-quality and appropriate services, and community-based integrated services provided in the least restrictive setting. The SIP-PL must ensure these entitlements regardless of any Willowbrook Class Member's inability or failure to pay a fee or ineligibility for Medicaid. Information on the Willowbrook class action litigation, filed in 1972, including New York State's expectations for delivery of services to Willowbrook Class Members can be found at the following web site:

https://opwdd.ny.gov/opwdd_resources/Willowbrook_class/.

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

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

1. I/DD Health Home (I/DD HH) Care Management for individuals with I/DD
2. Transition of the OPWDD population and non-residential services into Managed Care on a voluntary basis
3. OPWDD transition to mandatory enrollment and inclusion of residential services over time

I/DD HH Care Management for Individuals with I/DD

The State received approval from CMS in April 2018 to expand the NYSDOH Health Home model to serve individuals with I/DD enrolled in Medicaid. Effective July 1, 2018, Care Coordination Organizations (CCOs) began delivering I/DD HH services to individuals who chose to receive this comprehensive model of Care Management. This enhanced model of Care Management is an important step in the transition to Managed Care and it is a critical component of OPWDD's MRT Redesign Plan and Commissioner's Transformation Panel. I/DD HH Care Managers have been working with individuals and their families/caregivers to develop integrated, comprehensive Life Plans which outline the individual's supports, services and outcomes. They are providing comprehensive, individual and family-focused Care Management and addressing the individual's need for I/DD, medical and behavioral healthcare, transitional Care Management, and access to community and social supports.

The provision of I/DD HH services ensures an efficient and effective transition of individuals with I/DD to Managed Care. To ensure continuity of care for individuals with I/DD and the availability of qualified Care Managers, the SIP-PL must be prepared to provide Care Management directly or delegate to an entity delivering I/DD HH services or to another qualified entity with the State's approval. It is expected that existing I/DD providers and CCOs will develop the capacity to transition the provision of Care Management services to the SIP-PL.

Transition of the OPWDD Population and Non-Residential Services into Managed Care

Development of SIPs-PL

The State's primary goal is to ensure robust, cross-system service coordination by entities that have experience with I/DD service provision and delivery and who meet the requirements described in this document for operating as a SIP-PL.

The State's intent is to qualify an adequate number of SIPs-PL to serve the target population and meet federal requirements for Plan choice. If there is insufficient SIP-PL participation and/or capacity to begin enrolling the I/DD population mandatorily, the State will develop criteria that will be used to qualify non-provider-led Mainstream Managed Care Plans (MMCPs) choosing to operate a Specialized I/DD Plan – Mainstream (SIP-M) as a separate line of business to provide coverage of I/DD services. In all cases, whether an individual is now enrolled in a MMCP, chooses to enroll in an existing MMCP, or enrolls in a newly established SIP-PL, the provision of Care Management services will be by experienced Care Managers who are either directly

employed by the SIP-PL through delegated arrangements with CCOs, or with another qualified entity¹ with the State's approval.

Enrollment and Choice

SIP-PL enrollment will be based on the timing of SIP-PL readiness and qualifications. Enrollment will occur in the following order:

1. SIPs-PL begin to voluntarily enroll individuals with I/DD - Statewide
2. Mandatory enrollment for individuals with I/DD will begin no less than one year after voluntary enrollment begins and will be based on SIP-PL readiness

Individuals eligible to enroll in SIPs-PL include individuals enrolled in the OPWDD Comprehensive HCBS Waiver, individuals living in ICF/IIDs, and other Medicaid-enrolled individuals who are also eligible for OPWDD services.² MMC eligible non-I/DD family members of SIP-PL enrollees may enroll in a comprehensive MMC program also operated by the SIP-PL. This includes individuals already enrolled in a comprehensive MMC program. Prior to the time when SIP-PL enrollment becomes mandatory for OPWDD services, individuals who are enrolled in an MMCP will have the option of retaining their MMCP and receiving OPWDD services via Medicaid fee-for-service or opting to enroll in a SIP-PL. At the time when SIP-PL enrollment becomes mandatory, OPWDD benefits may only be accessed through a SIP-PL.

Initially, the SIP-PL will provide coverage of comprehensive MMC benefits, I/DD HH Care Management, and OPWDD non-residential HCBS services. SIP-PL enrollment will be rolled out Statewide and begin with the voluntary enrollment of individuals with Medicaid only. Thereafter, enrollment will be expanded to include individuals with both Medicaid and Medicare coverage and individuals with Medicaid and comprehensive Third-Party Health Insurance (TPHI). Expansion timing will be based on system readiness. Individuals who have both Medicaid and Medicare coverage will have the following options:

1. Remain in fee-for-service for Medicare and enroll in a SIP-PL for Medicaid services, including HCBS, with Medicaid coverage of co-insurance deductible and coordination of benefits
2. Receive Medicare acute health benefits through a Medicare Advantage Product and enroll in a SIP-PL for wraparound coverage of those services that are only covered by Medicaid, including HCBS
3. Alternatively, these individuals may enroll in a Dual Advantage product that offers all Medicare and Medicaid benefits in one (1) Plan (i.e., Fully Integrated Duals Advantage Plan for individuals with I/DD (FIDA I/DD))

The following individuals with I/DD are not eligible for SIP-PL enrollment:

- Individuals enrolled in a Developmental Center (DC) / Small Residential Unit (SRU)

¹ This provision recognizes that certain, existing Article 44 license holders (FIDA I/DD Plan) already have a Care Management function in place that meets the specialized, comprehensive service expectations of the I/DD HH service model.

² Individuals with I/DD who are eligible for Medicaid through a "spend down" may enroll in a SIP-PL.

- Individuals in residential schools and specialty hospitals
- Individuals who are residents of a residential healthcare facility at the time of enrollment
- Individuals who are eligible for and/or enrolled in a Health and Recovery Plan (HARP)
- Individuals excluded from enrollment in a comprehensive MMCO, except where specifically identified as eligible for SIP-PL enrollment in this document

In addition to the OPWDD non-residential HCBS Waiver services identified below, individuals will continue to access OPWDD-specialized State Plan services, including ICF/IID services, Day Treatment, Article 16 Clinic Services³, and Independent Practitioner Services for Individuals with I/DD (IPSIDD).

OPWDD Non-Residential HCBS Waiver Services

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

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

New York State has contracted with an enrollment broker to assist in implementation of the MMC and Managed Long-Term Care (MLTC) programs. The broker, New York Medicaid

³ The SIP-PL will be required to contract with all Article 16 Clinic providers at the established APG Government Rate unless payment is through a shared savings arrangement approved by the State.

Choice, is responsible for educating individuals and families on their Managed Care options, covered benefits, how Managed Care works, their rights and responsibilities, and assisting them with enrolling into a health plan of their choice. The enrollment process for SIPs-PL will also be through New York Medicaid Choice. The State will provide New York Medicaid Choice with complete provider network information for all SIPs-PL, as well as detailed information on all SIP-PL benefits and services, including I/DD, medical, behavioral health and LTSS.

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

OPWDD Transition to Mandatory Enrollment and Inclusion of Residential Services in the SIP-PL Benefit Package

The transition to mandatory enrollment is expected to begin Statewide no less than one (1) year after voluntary enrollment begins in a given region. The State may elect to roll out regionally based on Applicant readiness. The shift to mandatory enrollment will be subject to CMS approval and may only begin if there are sufficient Plans available to ensure choice, per CMS requirements. The transition will also be contingent upon the SIPs-PL capacity to achieve performance measures established by the State. Performance measures will be developed as part of the State's quality strategy and with the input of OPWDD's I/DD Clinical Advisory Group (CAG). Recommendations from the CAG will be provided to OPWDD's Joint Advisory Council (JAC) for Managed Care on an annual basis. The recommendations are anticipated to include the review of measures and benchmarks and their effectiveness at measuring SIP-PL performance.

The OPWDD residential benefit is expected to be carved into the SIP-PL benefit package no less than two years after voluntary enrollment begins. The inclusion of the residential benefit in capitation is subject to the State's assurance that Plans are capable of managing the benefit and will be based on the SIPs-PL ability to achieve State-defined clinical, quality and fiscal benchmarks including fiscal neutrality. Savings achieved through the management of residential services must be sufficient to offset any costs associated with the management of this benefit. Attachment I summarizes the impacted populations and proposed benefits, which are contingent on federal approvals and State financing.

2.0 Definitions

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

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

Behavioral Health Medical Director: The individual designated by the SIP-PL to have overall accountability for behavioral health services for SIP-PL enrollees. This position is required when SIP-PL enrollment exceeds 10,000 enrollees. This individual must be a licensed New York State

physician with a minimum of five (5) years of experience working in a Managed Care or clinical setting (at least two (2) years must be in a clinical setting). The behavioral health Medical Director shall have appropriate training and expertise in general psychiatry and/or addiction disorders (i.e., board certification in general psychiatry and/or certification in addiction medicine or certification in the subspecialty of addiction psychiatry). This individual must be in New York State.

Care Coordination Organization (CCO): A CCO is an entity delivering both I/DD HH Care Management and Basic HCBS Plan Support services to eligible individuals with I/DD.

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

Concurrent Review: The process of evaluating the medical necessity of a request for continued services that are being provided. Concurrent reviews are performed on both inpatient and outpatient services.

Coordinated Assessment System (CAS): An assessment tool specifically tailored to capture the unique health and support needs of individuals with I/DD in New York State. The CAS is being implemented in phases, and the Developmental Disability Profile (DDP-2) will continue to be the assessment tool used until the CAS is implemented statewide.

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

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

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

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

Developmental Disability Profile (DDP-2): A form used to evaluate an individual's areas of need including medical, behavioral, activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

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

Dual-Eligible: A term used to identify individuals who qualify for and are in receipt of medical coverage from both Medicare and Medicaid benefits.

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

Family Member: A family member is defined as:

- A parent of an individual with I/DD: 633.99(bm) Parent. A biological or legally adoptive mother or father.
- A sibling of an individual with I/DD: 633.99(cn) Sibling. One (1) of two (2) or more parties having at least one (1) common parent.
- An immediate family member: 635-99.1(ax) Immediate family. Brother, sister, grandparent, grandchild, first cousin, aunt, uncle, spouse, parent or child of an individual, whether such relationship arises by reason of birth, marriage or adoption.

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

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

Federally Qualified Health Center (FQHC): Community-based healthcare providers that receive funds from the Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. FQHCs may be community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing.

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

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

Home and Community-Based Services (HCBS): Services received or delivered in an individual’s own home or community rather than in institutions or in other isolated settings. These services include HCBS contained within the MMC benefit package, as well as the OPWDD HCBS Waiver services defined in Attachment G.

Home Setting or Community Setting: The setting in which an individual primarily resides or spends time, that is not a hospital, nursing facility, ICF/IID, or psychiatric facility.

I/DD Clinical Director: The individual designated by the SIP-PL who is responsible for clinical and behavioral health services appropriate to individuals with I/DD. This individual shall hold a New York State clinical license in a behavioral health field, have at least seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) and five (5) years working with individuals with I/DD, providing clinical services. Knowledge of New York State systems serving individuals with I/DD is required. This position must be located in New York State. Once the SIP-PL reaches certain enrollment thresholds, the SIP-PL may elect to hire additional clinicians in other disciplines.

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

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

As defined and implemented by the Medicaid State Plan, I/DD HH Care Management services include the following six (6) core functions and the provision of an integrated and electronic person-centered Life Plan:

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

I/DD HH SIP-PL Liaison: The CCO staff person designated to be a point of contact between the provider of I/DD HH services and the SIP-PL to ensure the authorization of services necessary to support individuals with I/DD in community-based settings.

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

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

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

Level of Care (LOC): Used as part of a collaborative process with an individual and their family to obtain necessary information and documentation to determine HCBS eligibility. See Attachment A for a description of HCBS eligibility criteria for LOC population.

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

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

Long-Term Supports and Services (LTSS): Healthcare and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS are comprised of community-based services such as home health services, private duty nursing, consumer directed personal assistance services (CDPAS), adult day health care program, AIDS adult day health care program, personal care services, and institutional services including long-term placement in residential healthcare facilities.

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

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

Medicaid Managed Care Organization (MMCO): An HMO, Prepaid Health Services Plan (PHSP), MLTC, HIV Special Needs Plan (HIV SNP), FIDA-IDD Plan, HARP, SIP-PL and SIP-M certified under Article 44 of the PHL.

Medicaid Managed Care Plan (MMCP): An HMO or PHSP certified under Article 44 of the PHL to provide comprehensive health services to an enrolled population eligible for Medicaid.

Medical Director: The individual designated by the SIP-PL who has overall accountability for all services delivered to SIP-PL enrollees. The Medical Director must be a Licensed New York State board-certified physician with a minimum of five (5) years of experience working with individuals with I/DD in Managed Care or clinical settings (at least two (2) years must be in a clinical setting). If the SIP-PL Medical Director does NOT have the stated I/DD knowledge and experience, the SIP-PL must also identify an additional Medical Director who meets the I/DD experience requirements. Allocation for this additional position, if necessary, must be at a minimum of 0.5 Full Time Equivalent (FTE). The SIP-PL may submit a request to waive the

minimum allocation of time with appropriate documentation for review and approval by the State.

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

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

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

Office for People With Developmental Disabilities (OPWDD): The New York State agency responsible for coordinating services for almost one-hundred and twenty thousand (120,000) New Yorkers with I/DD, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. OPWDD provides services directly and through a network of approximately six-hundred and fifty (650) not-for-profit service agencies. Supports and services, including Medicaid funded LTC 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 (FSS) <https://www.opwdd.ny.gov>.

OPWDD Certified Provider: A provider who applies and is approved by OPWDD to provide OPWDD funded services. OPWDD verifies the agency’s readiness to provide the services requested. Readiness is based on programmatic, fiscal, and incident management compliance. OPWDD certified providers are issued operating certificates in accordance with Mental Health Law (MHL) § 16.05. Each funded service requires its own authorization (i.e., operating certificate) through an agreement or contract with OPWDD. OPWDD certified providers must ensure and document compliance with OPWDD’s statutory and regulatory requirements, including incident reporting (Part 624), protection of individuals receiving services, criminal background checks (Part 633), general quality control and administrative requirements (Part 635), and corporate compliance.

Personal Outcome Measures (POMs): A tool developed by the Council on Quality and Leadership (CQL) used to ensure supports and services are truly person-centered. POMs are a list of twenty-one (21) personal outcome indicators designed to measure if an individual is supported in a way that achieves the outcomes that are most important to him/her.

Person-Centered Planning: An individualized approach to service planning structured to focus on the unique values, strengths, preferences, capacities, interests, desired outcomes, and needs of the individual. This process empowers individuals with I/DD to have an active voice in the development of their Life Plan.

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

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

Prior Authorization: An approval for services that must be obtained through the utilization review process to determine the medical necessity of services proposed to be provided.

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

Quality Assurance Reporting Requirements (QARR): MMCOs are required to submit quality performance data each year. Demographic information analyzed in this report includes an individual’s sex, age, race/ethnicity, Medicaid aid category, cash assistance status, language preferences, behavioral health conditions, including serious mental illness and SUD, and region of residence. The QARR are largely based on measures of quality developed and published by the NCQA such as HEDIS®.

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

Quality Management: A system that documents processes, procedures, and responsibilities for achieving quality practices and objectives. Quality management generally encompasses two (2) approaches: quality assurance, including compliance and reporting on performance and quality standards, timelines and access to services; and quality improvement, a systematic, formal approach to the analysis of practice performance and efforts to improve performance. It is a proactive approach rather than reactive, identifying and resolving issues before they occur. An effective Quality Management Program (QMP) not only evaluates the ability of the SIP-PL to provide quality services to individuals with I/DD, but also the impact of the services on the individual’s health outcomes.

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

Retrospective Review: The process of evaluating the medical necessity of services that have already been provided. Retrospective reviews are performed on both inpatient and outpatient services.

Single Case Agreement (SCA): An agreement between an out-of-network (non-contracted) provider and an MMCP which allows the provider to be reimbursed for services delivered to an individual enrolled in the MMCP.

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

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

Spend Down: The spend-down program (also called excess or surplus income) is a way for certain applicants to get Medicaid even though their income or assets are over the allowable limit, by offsetting excess income with medical expenses. If an individual's monthly income is over the Medicaid limit, they may still be able to get help with their medical bills. The amount of income over the Medicaid limit is called "excess income". It is like a deductible. If an individual is eligible for Medicaid except for having excess income and they can show that they have medical bills equal to their excess income in a given month, Medicaid will pay the additional medical bills beyond that for the rest of that month.

Start-up date: The date the SIP-PL will begin providing the benefits and services described in this document.

Third-Party Health Insurance (TPHI): Comprehensive healthcare coverage or insurance (including Medicare and/or private insurance coverage) that does not fall under one (1) of the following categories:

- Accident-only coverage or disability income insurance
- Coverage issued as a supplement to liability insurance
- Liability insurance, including auto-insurance
- Workers compensation or similar insurance
- Automobile medical payment insurance
- Credit-only insurance
- Coverage for on-site medical clinics
- Dental-only, vision-only, or long-term care insurance
- Specified disease coverage
- Hospital indemnity or other fixed dollar indemnity coverage
- Prescription-only coverage

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

Valued Outcomes (Habilitation Goals): The result that an individual wants to pursue or achieve, and which will inform the organization and delivery of authorized and available services. It can be long-term desires or simple day-to-day choices. They are individualized, clearly stated, and not vague. The Valued Outcomes must be listed in the individual's Life Plan in the Valued Outcomes section. They are linked to other services that the individual receives, and there must be at least one (1) Valued Outcome for each Waiver habilitation service that the individual receives.

Wraparound Benefit: A wraparound benefit is a Medicaid benefit that supplements another coverage source such as Medicare or private insurance. It is often referred to as wrap-around coverage. For example, where Medicare and Medicaid coverage overlap, Medicare will pay first, and Medicaid may then cover co-insurance and deductibles. Medicaid coverage is also

available for services in the Medicaid benefit package that are not included in the Medicare benefit package.

3.0 Performance Standards

1. SIP-PL Applicants must meet the requirements, standards and qualifying criteria contained within this document to manage the delivery of Medicaid-covered services for all enrollees, in addition to the benefits and services for individuals with I/DD. The State's transition to mandatory enrollment and the inclusion of OPWDD residential HCBS services in the SIP-PL benefit package, will be dependent upon the SIPs-PL ability to successfully meet performance standards established by the State.
2. The State expects that upon transition of the OPWDD benefits and services, SIPs-PL will continue to operate under contracts with the State, meeting all requirements in the MMC Model Contract unless otherwise stated in this document.
3. The SIP-PL is required to develop a governance model that addresses the needs of the I/DD population and the I/DD benefits and services.

3.1 Organization Capacity

The SIP-PL must meet the following minimum requirements:

1. The SIP-PL must demonstrate that it is under majority control by not-for-profit entities that have extensive experience in providing and/or coordinating health and LTC services for individuals with I/DD. The State interprets control as defined in 10 NYCRR Part 98-1.2(j). Experience coordinating care for individuals with I/DD will be evaluated based on the experience of the organization's leadership in overseeing and operating entities that deliver Care Management, ICF/IID and/or HCBS Waiver services.
2. SIP-PL Applicants must be in good standing with OPWDD.
3. The SIP-PL or its business associates must not have current, unsatisfied charges or orders related to administration of services against it by any state or the federal government.
4. The SIP-PL or its business associates must not have had a contract to manage services discontinued, cancelled or non-renewed by any State or the federal government for lack of performance or non-performance within the prior three (3) years.
5. The SIP-PL or its business associates must not have any members who are on the Medicaid Exclusion List.
6. The SIP-PL may contract with a delegated manager through a Management Services Agreement (MSA) to oversee and/or administer benefit package services, including the I/DD and/or HCBS benefits. The delegated manager must meet all requirements and standards in this document applicable to functions contractually delegated to the manager. The delegated manager can be an Independent Practice Association (IPA) that provides management services or another management contractor. Any contract

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

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

- h. Per federal guidelines, the SIP-PL must have sufficient staff available to respond to prior authorization requests for post stabilization services within one (1) hour (twenty-four (24) hours a day). This service may be provided out-of-state, but staff must have knowledge of:
 - i. Covered Services
 - ii. New York State Managed Care Rules
 - iii. Approved Utilization Management Criteria
 - iv. Provider Networks
 - i. The SIP-PL must provide I/DD, clinical and medical management as specified in this document
 - j. The SIP-PL must provide education and training on the topics described in this document
 - k. The SIP-PL must have sufficient resources to assist with quality management initiatives, financial oversight, reporting and monitoring, and oversight of any subcontracted or delegated functions related to the I/DD population
10. The SIP-PL must have a reasonable strategy and sufficient internal resources, including staff and infrastructure, to review functional assessments, OPWDD HCBS eligibility determinations, and Life Plans, including those developed by I/DD HHs.
11. The SIP-PL is responsible for the provision of Care Management for all enrollees. Care Management provided by the SIP-PL must comport with the person-centered planning requirements in the MMC Model Contract. The Care Management must also comport with the I/DD HH service model and with the person-centered planning regulation found in 14 NYCRR § 636, subpart 636-1. The requirements for the Care Management provided to individuals with I/DD will be described in a forthcoming policy document.
12. The SIP-PL shall establish mechanisms to monitor service quality, develop quality improvement initiatives, and solicit feedback/recommendations from key stakeholders to improve quality of care and individual outcomes through the involvement of consumer and other stakeholder advisory boards.
13. The SIP-PL shall establish an Advisory Committee that reports to the governing board to advise and assist the SIP-PL in identifying and resolving issues related to the management of I/DD, physical and behavioral health benefits for individuals with I/DD. The committee shall include:
- a. Individuals with I/DD who are served in the OPWDD system and their family/caregivers
 - b. I/DD service providers
 - c. Other stakeholders as appropriate
14. Representatives of the Advisory Committee shall have expertise in I/DD service delivery and familiarity with the service needs of adults and children with I/DD, and individuals with behavioral health needs. The committee representatives should be chosen to reflect the entire geographic service area of the SIP-PL.

15. The SIP-PL must have an established information technology (IT) platform that provides electronic support to comply with requirements in this document including but not limited to IT specifications for delegated Care Management.

3.2 Personnel

1. The SIP-PL must have the required I/DD, physical health, behavioral health, pharmacy, utilization management, quality management, and Care Management experience to meet the needs of individuals with I/DD, including any special needs they may have.
2. The SIP-PL retains governing responsibility per 10 NYCRR Part 98. If the SIP-PL delegates certain management functions, the SIP-PL and its delegated managers must work as an integrated team with involved state agencies, I/DD HHs, providers, and Regional Planning Consortia (RPCs) regardless of the SIPs-PL organizational structure.
3. The SIP-PL shall establish and maintain an organizational culture, leadership approach, and administrative structure that supports a partnership amongst Plans, providers, LGUs, I/DD service systems, individuals, family members and advocates, and embraces the State's vision for the OPWDD service delivery system as described in this document.
4. The SIP-PL shall ensure key personnel, managerial staff, and operational staff are able to accommodate the administration of benefits and services for the I/DD population.
 - a. Key staff have the overall accountability for ensuring access to high quality and timely care and are required to participate in the RPC. At a minimum, the SIP-PL Medical Director and I/DD Clinical Director shall participate directly or through a delegate who has knowledge of the OPWDD service delivery system and possesses the authority to make decisions on behalf of the SIP-PL
 - b. Managerial staff have day-to-day responsibility for the management of I/DD services within the SIP-PL
5. The SIP-PL shall have I/DD, physical, and behavioral health resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the training, education, experience, orientation, and credentials, as applicable, to perform assigned job duties.
6. The SIP-PL must meet the needs of all SIP-PL enrollees including service delivery and staffing requirements for children as defined in the [MMC Organization Children's System Transformation Requirements and Standards](#). Full implementation of these requirements will be based on enrollment thresholds being met.
7. SIP-PL applications must contain specific details on how functions will be assigned to responsible parties and how the SIP-PL will ensure these functions are achieved in ways that ensure effective services are provided to individuals with I/DD and/or chronic medical, and/or behavioral health needs.
8. The SIP-PL shall orient and train all staff, including delegated managers as appropriate, to the job functions, requirements, and standards articulated in this document, including training on the requirements of the OPWDD service delivery system.

- a. The SIP-PL shall develop and implement a training plan which at a minimum incorporates the topics listed in Attachment D. This plan is subject to the State's review and approval
 - b. All SIP-PL staff must be trained prior to performing work under the standards articulated in this document
 - c. SIPs-PL are strongly encouraged to consider including individuals and/or family members/caregivers in the development and delivery of training and education
 - d. Knowledge checks and competency testing must be incorporated into training plans, and periodic staff reassessments (annually at minimum) are required
9. Unless specified in Attachment C, positions are not required to be full-time or located in New York State. Staff allocation and qualifications must be sufficient to meet the requirements in this document.
10. The SIP-PL shall maintain current organizational charts and written job descriptions that are consistent in format and style for each functional area.
- a. Organizational charts shall clearly demonstrate how required functions will be assigned
 - b. If applicable, the organizational chart should also clearly show how the SIP-PL will oversee delegated managers
 - c. Organizational charts and job descriptions for key personnel and managerial staff must be submitted for review and approval by the State
 - d. The SIP-PL must develop and maintain a staffing plan that describes how staff training will be completed and staffing levels will be maintained to ensure the successful accomplishment of all duties outlined in this document
11. Key Personnel Requirements: The SIP-PL must fill the following key personnel functions to oversee the delivery of services to individuals with I/DD. These roles are mandatory positions and must be filled by separate individuals. See Attachment C.
- a. Required positions for all SIPs-PL
 - i. Medical Director: The SIP-PL shall identify a Medical Director to have overall accountability for all services delivered to SIP-PL enrollees. This position must be reflected in the SIP-PL organizational chart. The Medical Director must be a Licensed New York State board-certified physician with a minimum of five (5) years of experience working with individuals with I/DD in Managed Care or clinical settings (at least two (2) years must be in a clinical setting). This person must meet the experience requirements reflected in Attachment C. If the Medical Director does NOT have the stated I/DD knowledge and experience, the SIP-PL must also identify an additional Medical Director who meets the I/DD experience requirements. Allocation for this additional position, if necessary, must be at a minimum of 0.5 FTE. The SIP-PL may submit a request to waive the

minimum allocation of time with appropriate documentation for the State's review and approval. This position must be located in New York State

- ii. I/DD Clinical Director: The SIP-PL must designate an I/DD Clinical Director to have the overall responsibility for clinical and behavioral health services appropriate to individuals with I/DD. This person shall hold a New York State clinical license in a behavioral health field, have at least seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) and five (5) years working with individuals with I/DD providing clinical services. This position must be reflected in the SIP-PL organizational chart and the identified individual must have appropriate managerial experience. Knowledge of New York State systems serving individuals with I/DD is required. This position must be located in New York State. Changes will be subject to the requirements in #12 below
- iii. I/DD Dental Director: The SIP-PL must designate an I/DD Dental Director who is responsible for dental services provided to individuals with I/DD. This person must be licensed to practice dentistry in New York State and shall have a minimum of five (5) years of experience providing dental services to individuals with I/DD. This position may be filled on a consultant or part time basis

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

- i. Behavioral Health Medical Director: If SIP-PL enrollment exceeds 10,000 enrollees, the SIP-PL must identify a Behavioral Health Medical Director to have overall accountability for behavioral health services for SIP-PL enrollees. The Behavioral Health Medical Director must be a licensed New York State physician and shall have a minimum of five (5) years of experience working in a Managed Care or clinical setting (at least two (2) years must be in a clinical setting). This person shall have appropriate training and expertise in general psychiatry and/or addiction disorders (i.e., board certification in general psychiatry and/or certification in addiction medicine or certification in the subspecialty of addiction psychiatry) and must be located in New York State. The Behavioral Health Medical Director is not required for SIPs-PL with less than 10,000 enrollees

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

review the character and competency of all individuals serving in key staff positions and maintains the right to review and approve individuals filling these positions.

13. Required Functions of Key Personnel: The Medical Director, I/DD Clinical Director, I/DD Dental Director and when applicable, the Behavioral Health Medical Director, shall be involved in the following functions as they relate to the provision of services for individuals with I/DD enrolled in the SIP-PL:

- a. Provision of clinical oversight and leadership to utilization management and Care Management staff working with the I/DD population
- b. Development, implementation, and interpretation of clinical-medical policies and procedures that are specific to the I/DD benefits and services or can be expected to impact the overall health and wellbeing of individuals with I/DD
- c. Ensuring strong collaboration and coordination between I/DD, physical and/or behavioral healthcare across the utilization management and Care Management staff
- d. Clinical peer review recruitment and supervision of SIP-PL staff
- e. Collaboration with Provider Relations staff to ensure an adequate provider network via required provider credentialing guidelines
- f. I/DD and behavioral health provider quality profile design and data interpretation
- g. Development and implementation of the I/DD and behavioral health sections of the QMP and utilization management plans
- h. Participation on the I/DD and behavioral health committees for quality management and utilization management
- i. Administration of I/DD and behavioral health quality management, utilization management, and performance improvement activities, including grievances and appeals
- j. Attendance at regular (at least quarterly) SIP-PL leadership and other I/DD and/or Behavioral Health Medical Director meetings
- k. Ensuring strong collaboration and coordination between other I/DD and behavioral health serving systems, including the I/DD HHs, I/DD healthcare providers and the education system
- l. Attendance at RPC meetings

14. Managerial Staff: The SIP-PL shall develop and maintain overall management and staffing to achieve the goals listed throughout this document in an economic and efficient manner. The SIP-PL shall employ managerial personnel to oversee and provide the functions listed below.

- a. All managerial staff must demonstrate knowledge of the needs, services and benefits for individuals with I/DD
 - b. Managerial staff must have knowledge of or experience related to working with individuals with I/DD and their families/caregivers using the person-centered planning process and collaborating with I/DD and other service systems, including but not limited to the behavioral health service system, local, state and federally-funded non-Medicaid service providers (i.e., community resources and the education system)
 - c. Ideally, the SIP-PL should employ managers who have experience working with individuals with I/DD in behavioral health settings and when possible, experience working with individuals with I/DD and other chronic medical, and/or behavioral health needs
 - d. Managers should have knowledge of service delivery consistent with evidence-based and promising practices for individuals with I/DD
 - e. Managerial staff must also have knowledge of HCBS and related regulatory requirements including:
 - i. Timeframes for completion of the comprehensive assessment and the Life Plan
 - ii. Procedures and state guidelines for approving HCBS recommended in a Life Plan
 - iii. Effective and efficient monitoring of the individual's progress, frequency of HCBS, including identification of any deviations from approved Life Plans
 - iv. Coordination across departments responsible for compliance with HCBS requirements, including but not limited to, reporting related to HCBS assurances and sub-assurances
 - v. Coordination in engaging their entire organization by encouraging individuals, board members, management and staff to work together in a person-centered environment with the goal of promoting and achieving Valued Outcomes for the individuals served
15. The SIP-PL is required to create the following Managerial Staff Positions:
- a. I/DD HH SIP-PL Liaison: SIPs-PL are responsible for ensuring there is a coordinated approach and effective communication between I/DD HHs and individuals and their families/caregivers. The I/DD HH SIP-PL Liaison must support the staffing and functions outlined in this document and in the [MMC Model Contract](#) and act as a liaison between I/DD HHs and families seeking authorization of services necessary to support individuals with I/DD in community-based settings. This position may not be delegated
16. For each department and position listed below, the SIP-PL shall ensure a sufficient staffing plan that includes adequate and experienced managerial resources with the expertise to meet the needs of individuals with I/DD who have chronic medical and/or behavioral health needs, including each HCBS-eligible population. Positions and functions may be combined to the extent that the staff allocation and qualifications are sufficient to meet the requirements in this document, subject to the State's approval.

- a. Comprehensive Care Management
 - b. Utilization Management
 - c. Network Development
 - d. Member Services
 - e. Provider Relations
 - f. Training
 - g. Quality Management
 - h. Information Systems
 - i. Governmental/Community Liaison
17. In addition to the key and managerial staff, the SIP-PL shall have adequate qualified operational staff to meet the responsibilities contained within this document. For each department, the SIP-PL shall ensure staff have the expertise to meet the needs of individuals with I/DD as appropriate to their job function, as described within this document.
- a. Member services staff, claims staff, utilization management staff, and I/DD clinical peer reviewers may work at sites within the United States but outside of New York State. Other operational staff must work at sites located within New York State. Refer to Attachment C for a summary of personnel requirements
18. The SIP-PL is required to create the following position when enrollment of children under the age of twenty-one (21) exceeds 2,500:
- a. Foster Care Liaison: SIPs-PL are expected to have an interagency Foster Care Liaison able to meet the criteria/requirements outlined in the MMCO Children's System Transformation Requirements and Standards document and in Attachment C of this document. The responsibilities for this position may be included within another position
19. The SIP-PL shall have staffing and structure necessary to support individuals with chronic medical, I/DD, and/or behavioral health needs who also need assistance with performing daily activities, including the individuals receiving OPWDD HCBS who have met the level of care eligibility determination (LCED) criteria. The SIP-PL shall have clinical leadership, peer review, and utilization management staff with appropriate clinical expertise to support the needs of the LCED population.

3.3 Member Services

1. The SIP-PL shall provide and/or manage the Member Services call center operations listed below and according to the requirements found in Section 12 of the MMC Model Contract. Unless otherwise noted, functions shall be available during business hours (8:00 am to 6:00 pm) in the New York State service center location.
 - b. The SIP-PL must provide a live Member Services toll-free phone line to respond to inquiries, conduct triage, make referrals and follow-up on questions or concerns related to I/DD benefits and services for seven (7) days per week, three-hundred and sixty-five (365) days per year. This function may be operated out of state with the approval of New York State

- c. A live toll-free line to provide crisis triage, referral, and follow-up twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year
 - d. The SIP-PL shall staff the Member Services call center with a sufficient number of trained representatives to meet call responsiveness expectations reflected in the SIP-PL Member Services policies and procedures and to competently respond to Member Services calls
 - e. The SIP-PL must demonstrate that the Member Services call center staff have knowledge of the benefits and program requirements for the I/DD population
2. The SIP-PL must have Member Services policies and procedures to reflect the following:
 - a. Authorization requirements for I/DD benefits and services
 - b. Requirements for responding promptly to individuals and family members/caregivers and for supporting linkages to other I/DD-serving systems, including but not limited to the LDSS, DDROs, providers of Health Home services, state or federally funded non-Medicaid services (i.e., community supports and the education system), and the New York State Justice Center. Member Services staff shall not be required to make direct linkages by phone to such systems
 - c. Protocols for assisting and triaging individuals who may be in crisis by accessing a clinician qualified to assess the individual's needs. The transfer to the clinician must take place without placing the caller on hold. (The qualified clinician will assess the crisis and provide a warm transfer to the crisis provider, call 911, refer the individual for services or to his or her provider, and/or resolve the crisis over the telephone as appropriate). The SIP-PL must demonstrate the efficacy of linkages between the Member Services call center and local crisis responders, including I/DD service providers for crisis intervention State Plan services
3. As directed by the State, the SIP-PL shall submit Member Handbooks for review and approval. The SIP-PL Member Handbook must meet all requirements outlined in the MMC Model Contract and include information on the I/DD benefits and services, including where and how to access them and related authorization requirements.

3.4 Service Delivery Network Requirements/Access to Care

1. The SIP-PL service areas shall consist of the county or counties listed in the Plan's MMC Contract with the State.
2. The SIP-PL shall contract with enough providers to meet minimum network standards to ensure access to the covered benefits and services described in Attachment F.
3. In addition to the provider network requirements in the MMC Model Contract, the SIP-PL is required to accommodate the service delivery needs of individuals with I/DD as defined in the Life Plan and informed by the person-centered comprehensive assessment process.

4. The SIP-PL is required to offer contracts with all OPWDD certified providers within the SIP-PL service area. The State will provide SIPs-PL with a list of OPWDD certified providers in each region. The State will assess provider capacity during the designation process and may require SIPs-PL to contract with additional providers certified to provide HCBS/SPA services.
5. The SIP-PL must develop and expand their networks based on the anticipated needs of individuals with I/DD and as the benefit package is implemented. SIPs-PL are required to contract with OPWDD certified providers who have expertise in supporting individuals with I/DD to ensure that these individuals receive services from appropriate providers. Network providers shall refer to appropriate network community and facility providers to meet the needs of individuals with I/DD or seek authorization from the Plan for out-of-network providers when participating providers cannot meet an individual's needs.
6. SIPs-PL that contract with clinics holding a state integrated license shall contract for the full range of services available pursuant to that license and subject to the agreement of the clinic. In the event that a contracted clinic refuses to contract with the SIP-PL for all services provided pursuant to the clinic's license, the SIP-PL must notify the State and must demonstrate a good faith effort to negotiate a contractual arrangement with the clinic for the full range of services available.
7. The SIP-PL must authorize services in accordance with established timeframes in the MMC Model Contract.
8. The SIP-PL must ensure access to all benefits and services in the SIP-PL benefit package. This includes coverage of, and payment for, covered services for which the SIP-PL does not have an available provider and emergency services, including emergency services provided within the United States or its territories.
9. The SIP-PL shall execute Single Case Agreements with non-participating providers to meet clinical needs of individuals with I/DD when in-network services are not available. The SIP-PL shall monitor the use of Single Case Agreements to identify high-volume, non-participating providers for contracting opportunities and identify network gaps and development needs. The SIP-PL must pay at least the fee-for-service fee schedule for twenty-four (24) months following enrollment for all Single Case Agreements.
10. The SIP-PL must ensure access to all behavioral health services in the MMC benefit package. However, network adequacy standards will initially recognize the existing provider capacity and current behavioral health service providers for individuals with I/DD. If SIP-PL enrollment reaches 10,000, the existing MMC behavioral health network capacity requirements must be met.
11. The SIP-PL must demonstrate prioritization of opportunities for self-direction by supporting individuals and helping them to understand their options and make choices in their lives whenever possible. The SIP-PL will be responsible for the oversight of the self-direction program included in the SIP-PL benefit package. However, the self-direction program rules will not change and will continue to operate in Managed Care as it does in the fee-for-service program. OPWDD is committed to continuing Transformation goals related to self-direction.

12. The SIP-PL must meet the minimum appointment availability and network standards for each service type identified in Tables 2 and 3 below. If contracting with required providers does not meet the minimum network standards, the SIP-PL must attempt to secure contracts with additional providers to meet the applicable standard. If a provider is unwilling to contract with the SIP-PL, the SIP-PL must offer Single Case Agreements.
13. The SIP-PL shall comply with the appointment availability standards and definitions in the MMC Model Contract. These are general standards and are not intended to supersede sound clinical judgment as to the necessity for care and services on a more expedient basis, when judged clinically necessary and appropriate.

Table 2. Minimum Network Standards by Service Type

Service	Urban Counties	Rural Counties ⁴
Habilitation <ul style="list-style-type: none"> • Day • Community • Prevocational <ul style="list-style-type: none"> ○ Site Based ○ Community • Supported Employment • Pathway to Employment 	At least 2 in county	At least 2 in region
Respite	At least 2 in county	At least 2 in region
Intensive Behavioral Services	All in county	All in county (or region)
OPWDD Certified Clinics	All in county	All in county (or region)

Table 3. Appointment Availability⁵ Standard by Service Type

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge
OPWDD Certified Clinics		Within 24 hours	Within 1 week	Within 5 business days of request
Intensive Behavioral Services		Within 72 hours of request	2–4 weeks	Within 24 hours
Vehicle Modifications			Within 2 weeks of request	Within 5 business days of request

⁴ New York State Public Health Law defines a rural county as any county having a population of less than 200,000 (see Attachment E).

⁵ Timeframes for the availability of HCBS services begins at the point in time when the network provider contacts the individual to begin the habilitation planning process.

Service Type	Emergency	Urgent	Non-urgent	Follow-up to emergency or hospital discharge
Community Transition Services			Within 2 weeks of request	Within 5 business days of request
Family Education and Training			Within 5 business days of request	Within 5 business days of request
Pathway to Employment			Within 2 weeks of request	
Prevocational Services			Within 2 weeks of request	
Supported Employment			Within 2 weeks of request	
Services to Support Self-direction		Within 72 hours of request	Within 5 business days of request	
Habilitation: Day, Community	Within 24 hours	Within 72 hours of request	Within 2 weeks of request	
Assistive Technology/Adaptive Devices		Within 72 hours of request	Within 2 weeks of request	Within 24 hours of request
Environmental Modifications		Within 72 hours of request	Within 2 weeks of request	Within 24 hours of request
Respite		Within 24 hours of request	Within 1 weeks of request	Within 24 hours of request

Note: Table 3 illustrates how appointment availability standards apply to each specialized service type. In addition to the required core provider types (as listed on the Health Commerce System (HCS)), SIPs-PL are obligated to have a sufficient network of designated HCBS providers qualified to meet the needs of individuals with I/DD enrolling in MMC under this transition. In many areas, the minimum standards above may not be adequate to meet the individual’s need for access. Where minimum network standards in Table 2 are not adequate to meet the individual’s need for access and/or to meet the appointment access standards in Table 3, the SIP-PL will be required to exceed the minimum network standards in Table 2 to ensure access to care. The State reserves the right to modify the minimum network standards in accordance with the MMC Model Contract. Regions are aligned with DDRO regions. Refer to Attachment E for additional information.

3.5 Continuity of Care

1. In addition to the continuity of care provisions required for comprehensive MMCOs, SIPs-PL must meet continuity of care for services that are subject to the oversight of OPWDD. Continuity of care provisions ensure that an individual’s current Life Plan

remains in place during their transition and enrollment into a SIP-PL for a minimum of ninety (90) days. The individual will always have a choice of provider with the SIP-PL network and, hence, none of the provider protections and continuity of care provisions described below diminish an individual's right to request a change in the services described in his or her Life Plan and/or a change in service provider.

2. To ensure continuity of care for individuals receiving non-residential HCBS services operated, certified, funded, authorized or approved by OPWDD, the SIP-PL must pay the current provider of non-residential services at the rates established by the State for a period of ninety (90) days from the date of enrollment.
3. The SIP-PL must allow individuals to continue with their care providers, including medical and behavioral health, for a continuous episode of care. This requirement will be in place for the first twenty-four (24) months following enrollment. It applies only to episodes of care that were ongoing during the transition period from fee-for-service to Managed Care.

3.6 Network Monitoring

1. The SIP-PL must have a process for regularly monitoring network adequacy. The SIP-PL shall develop strategies to ensure uninterrupted services to individuals and ensure that major components of their current network delivery system are not adversely affected by the transition to Managed Care.
2. The SIP-PL must develop a detailed network plan for review and approval that must be updated annually and submitted to the State upon request. The network plan shall include, but not be limited to the following components:
 - a. An analysis of network adequacy derived from data on enrollment, utilization, prevalent diagnoses, individual demographics, access and availability survey results for the covered benefits, out-of-network utilization (i.e., Single Case Agreements), outcomes (when available), grievances, appeals, individual and family satisfaction, and provider issues that were significant or required corrective action during the prior year
 - b. An explanation of how the network meets the needs of the I/DD population and provides access to the covered benefits and services
 - c. Identification of any current material gaps in the I/DD network and specialty service providers needed to provide access to covered benefits, priorities for network development for the coming year and a work plan with goals, action steps, timelines, and measurement methodologies for addressing the gaps and priorities
3. OPWDD certification of providers will suffice for the SIP-PL credentialing process. When contracting with OPWDD certified providers, the SIP-PL may not separately credential individual staff members in their capacity as employees of these programs. The SIP-PL must conduct program integrity reviews to ensure that provider staff are not disbarred or excluded from Medicaid or any other federal healthcare programs or excluded from Medicaid reimbursement in any other way. The SIP-PL shall still collect and accept program integrity related information from these providers, as required in the MMC

Model Contract, and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

4. When credentialing OPWDD-certified, OMH-licensed, OMH-operated and OASAS-certified providers, the SIP-PL shall accept the OPWDD, OMH and OASAS licenses, operation and certifications in place of, and not in addition to, any Plan credentialing process for individual employees, subcontractors or agents of such providers. The SIP-PL shall still collect and accept program integrity related information from these providers, as required in the [MMC Model Contract](#), and shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid programs.
5. The SIP-PL shall submit the SIP-PL Provider Manual to the State for review and approval. The Provider Manual must include policies and procedures that address all relevant information on I/DD services including HCBS and the specific provider requirements described throughout this document, state guidance, and the federal CMS Waiver Special Terms and Conditions.
6. The SIP-PL shall develop a provider profiling system for providers of Health Home services, that includes outcomes and compliance with HCBS assurances and sub-assurances. At minimum, HCBS assurances are anticipated to include the assurances and sub-assurances listed in Attachment B. These assurances and sub-assurances may be modified by the State to more appropriately reflect the needs of individuals with I/DD.

3.7 Network Training

1. The SIP-PL shall expand its current provider training curriculum to reflect the I/DD service population and benefits. To the extent practical, provider training should be coordinated with providers of Health Home services and the SIP-PL annual training plan should be updated to address any gaps that are identified by the SIP-PL or providers of Health Home services related to the treatment of individuals with I/DD.
 - a. An initial orientation and training shall be offered to all providers in the SIP-PL network.
 - b. Training and technical assistance shall be provided to the expanded array of providers on billing, coding, data interface, documentation requirements, provider profiling programs, and utilization management requirements
 - c. Training shall include processes for functional assessments for OPWDD HCBS eligibility determinations (i.e., targeting criteria, risk factors, functional limitations) and Life Plan development and review, including Habilitation and/or Staff Action Plans and Valued Outcomes
2. The State will collaborate with SIPs-PL to develop a uniform provider training curriculum that addresses clinical components necessary to meet the needs of individuals with I/DD transitioning to Managed Care. Examples of clinical topics include:

- a. Unique needs of the I/DD population;
- b. Person-centered treatment planning and service provision.

3.8 Utilization Management

1. SIPs-PL will use Medical Necessity Criteria (MNC) as defined in New York Social Services Law, § 365-a to determine appropriateness of new and ongoing services. For HCBS, the concept of necessity is derived from a person-centered planning process, which for OPWDD services is described in 14 NYCRR § 636, subpart 636-1(b) Person-Centered Planning. Necessity of HCBS is based on the evaluation of an individual's goals and Valued Outcomes in the Life Plan, the availability of natural supports and other services to support the individual meet these goals, and the extent to which the service promotes independence and community engagement. While MNC is required to justify the provision of services, the State supports a person-centered approach to care in which the individual's needs, preferences, and strengths are considered in the development of the Life Plan. SIPs-PL must make every effort to implement the goals contained in the individual's Life Plan by providing alternatives where the desired service does not meet MNC guidelines.
2. The SIP-PL should view each request for authorization for a specific service level within the larger context of the individual's needs. When an individual no longer meets MNC for a specific service, the SIP-PL should work with the individual's provider to ensure that an appropriate new service is identified (if needed), necessary referrals are made, and the individual successfully transitions without disruption in care. The SIP-PL shall have processes for reviewing claims and authorization requests to determine if an individual with I/DD, who is not currently enrolled in an I/DD HH or in a 1915(c) Waiver, should be referred for I/DD HH or HCBS Waiver services.
3. SIPs-PL shall establish utilization review protocols that comport with the State's Medicaid medical necessity standards, federal and state parity requirements, the MMC Model Contract, and other related standards that may be developed by the State for the I/DD services described in this document.
4. SIPs-PL that choose not to conduct prior authorization or concurrent review for specific ambulatory levels of care must provide the State with their data-driven plan to identify and work with providers who are outliers. The SIP-PL must do the same for services for which prior authorization is not permitted.
5. SIPs-PL shall develop and implement utilization management protocols for I/DD, medical, behavioral health, long term supports and services (LTSS), pharmacy and HCBS benefits, including policies, procedures and guidelines that comply with the following requirements:
 - a. Utilization management protocols, MNC guidelines, and admission criteria and service authorization criteria must be consistent with state guidance
 - b. Utilization management protocols and guidelines, as well as any subsequent modifications to the protocols and guidelines, shall be submitted to the State for review and approval prior to adopting

- c. Utilization management protocols for I/DD services shall include a process to accelerate access to necessary services commensurate with an individual's need. Necessary services authorized under these guidelines will be provided in accordance with a set threshold amount that will be established by the State. Utilization management protocols for self-direction will follow state guidelines and budgeting standards
 - d. The SIP-PL review process for HCBS shall include review and approval of Life Plans inclusive of HCBS Waiver services.
 - i. HCBS Waiver services must be managed in compliance with the CMS HCBS Final Rule (CMS 2249-F and CMS 2296-F), according to the person-centered planning process as described in 14 NYCRR § 636, subpart 636-1 and any other applicable state guidance
 - ii. The SIP-PL must ensure that Life Plans are developed in a person-centered manner, are compliant with the Final Rule, 14 NYCRR § 636, subpart 636-1, and other state guidance, meets the individual's needs, and includes their goals and outcomes
 - iii. The SIP-PL must ensure that all HCBS services the individual receives are included in the Life Plan and authorized pursuant to that Life Plan
 - iv. The SIP-PL shall develop a data driven approach to identify service utilization patterns that deviate from any approved Life Plan, conduct outreach to review such deviations, and require appropriate adjustments to either service delivery or the Life Plan
 - e. To begin authorization of new services beginning with the effective date of enrollment, the SIP-PL must be ready to accept Life Plans from providers of Health Home services as of that date. Providers of Health Home services and SIP-PLs will execute a Business Associate Agreement (BAA) thereby allowing the SIP-PL to receive Life Plans from providers of Health Home services
6. The SIP-PL shall educate utilization management staff in the application of utilization management protocols, clearly articulating the criteria to be used in making utilization management decisions and describing specific Care Management functions. This includes the requirements in the MMC Model Contract regarding individuals with I/DD. The SIP-PL shall ensure that all utilization management staff who are making service authorization decisions and/or conducting Care Management have been trained and are competent in working with the specific area of service they are authorizing.
 7. The SIP-PL shall ensure consistent application of review criteria regarding requests for initial and continuing stay authorizations. At minimum, on an annual basis, all staff performing initial and continuing stay authorizations and denial reviews shall participate in inter-rater reliability testing to assess consistency in the application of utilization management guidelines. Staff performing below acceptable thresholds for inter-rater reliability shall not be allowed to make independent authorization decisions until such time that they can be retrained, monitored and are able to demonstrate performance that exceeds the acceptable threshold. The inter-rater reliability testing, including test scenarios and processes, shall be customized to address all medical, I/DD, behavioral

health, and HCBS services subject to prior authorization or concurrent review, as defined throughout this section.

8. The SIP-PL shall establish criteria to identify quality issues, other than medical necessity, that result in referral to a clinical peer reviewer. The SIP-PL must develop a reasonable method and have systems in place including appropriate utilization management documentation audits.
9. The SIP-PL shall establish protocols to ensure that discharge planning is comprehensive. Protocols shall include, but are not limited to:
 - a. Identifying comprehensive discharge plans that address not only treatment availability, but also community supports necessary for achievement of milestones and community integration including but not limited to, education (inclusive of special education), family and social interactions, stable housing, financial support, medical care, transportation, employment/vocational training and a crisis intervention/prevention plan
 - b. Identifying and reducing barriers to access and/or engagement with post-discharge ambulatory appointments, medication, and other treatment(s)
 - c. Confirming post-discharge appointment availability and adherence. In the absence of adherence, the SIP-PL must offer appointment options
 - d. Procedures for concurrent review for enrollees requiring extended care in inpatient classified settings due to insufficient response to treatment and/or placement limitations, to ensure services are authorized at the appropriate care level so that services are not inappropriately denied
10. The SIP-PL shall comply with state Medicaid guidance including Managed Care policy documents, relevant performance improvement specification documents or manuals, and policies governing prior authorization, concurrent or retrospective review.
11. The SIP-PL shall utilize information acquired through quality management and utilization management activities to make annual recommendations to the State on the continuation or adoption of different practice guidelines and protocols, including measures of compliance, fidelity, and outcomes. The identification of evidence-based or promising practices shall consider cultural and developmental appropriateness. The SIP-PL shall comply with the MMC Model Contract in implementing practice guidelines.
12. In general, denials, grievances, and appeals of health and behavioral health services must be peer-to-peer. A peer is defined in Public Health Law Section 4900(2)(a) (i-iii). Further, the following standards shall apply to SIP-PL staff conducting utilization management reviews for the SIP-PL:
 - a. A physician with five (5) years' experience serving the I/DD population must review all denials for individuals with I/DD and such determinations must take into consideration the needs of the family/caregiver
 - b. A physician board certified in child psychiatry should review all inpatient denials for psychiatric treatment for children under the age of twenty-one (21)

- c. A physician certified in addiction treatment must review all inpatient LOC/continuing stay denials for SUD treatment
- d. Denials of Habilitative Services must be reviewed by a licensed professional who is also qualified as a Qualified Intellectual Disability Professional (QIDP). Information on QIDP qualifications can be found in 42 CFR 483.430

3.9 Clinical Management

1. Over the next several years, the State will work with the Plan Associations and MMCPs to ensure that individuals with I/DD and their families have appropriate access to primary care, specialty healthcare, behavioral health, and habilitative services provided by knowledgeable and informed providers including, medical professionals, clinicians, and program staff to achieve integration in primary care and other settings. Key areas of consideration shall include:
 - a. Compliance with federal mandates for conducting and reporting I/DD Screening: The American Academy of Pediatrics Practice Guidelines and the federal and state Early and Periodic Screening, Diagnostic and Treatment (EPSDT) schedules indicate routine developmental surveillance should be conducted during each well-child visit. Developmental surveillance and screening for specific disorders starting during infancy is critical to early identification and intervention with developmental disorders. Information should be obtained using standardized instruments, parental and professional observations, and clinical judgment. Concerns raised by developmental surveillance should result in screening or referral for diagnostic evaluation
 - b. Improving access to services to promote maternal and child health in order to identify disabilities earlier, especially for non-English speaking individuals. OPWDD serves individuals and families from many ethnic and cultural backgrounds., It is critical to ensure that individuals and families have a greater understanding of the importance of doctor/hospital visits and can communicate about their disabilities
 - c. Promoting integration through activities such as:
 - i. Reducing barriers to primary and specialty healthcare services among individuals with I/DD caused by social and economic disparities, geographic isolation, transportation challenges, limitations in communication skills, and cultural differences among others. Transportation, communication, and other problems commonly experienced by individuals with I/DD only increase the challenges faced by providers. Individuals with I/DD may need assistance in filling out medical forms, making medical care decisions, securing transportation to and from appointments, and finding a qualified medical professional with the training to work effectively with them
 - ii. Providing opportunities to promote healthy lifestyle practices and prevent diseases by increasing providers' knowledge regarding the distinctive needs of individuals with I/DD. Individuals with I/DD have been found to experience more serious health problems than the general population

including but not limited to seizures, diabetes, sensory problems (i.e., visual and auditory impairments), serious dental problems, cardiac problems, obesity and gastrointestinal problems. Some syndromes are associated with increased risk for physical problems. For example, Down syndrome is associated with auditory impairment, cataracts, impaired cardiac functioning, early onset dementia symptoms, and thyroid disorders that can result in psychiatric symptoms. Physical illnesses can often be overlooked in individuals with I/DD due to difficulties in reporting symptoms. Individuals with severe communication difficulties may find it difficult to articulate their health needs and without adequate support and education, may not recognize ill health. Ensuring that providers are well-versed in understanding the challenges that individuals with I/DD may have with advocating for and understanding their medical/behavioral healthcare needs is critical to health promotion and disease prevention

- iii. Promoting wellness and prevention programs by assisting and providing individuals with resources that address topics which include but are not limited to exercise, nutrition and smoking cessation
 - iv. Trauma informed care strategies and models
 - v. Monitoring the use of psychotropic and other medications with individuals with I/DD. This is critical as care for individuals with I/DD who have multiple conditions is often fragmented (i.e., different specialists may be managing seizures, a gastrointestinal disorder, and self-injurious behaviors), resulting in potential for adverse drug interactions or chronic drug toxicity which has a detrimental impact on overall health
 - vi. Screening for depression, dementia, and SUD
2. The SIP-PL shall develop their I/DD, physical and behavioral health integration requirements to include the following:
- a. Orientation, ongoing training and education for clinical, medical, and program staff about co-occurring I/DD, medical, and/or behavioral health disorders and integrated clinical management principles. This staff training is critical as individuals with I/DD are at risk to receive fewer routine health examinations, immunizations, behavioral health assessments, prophylaxis and treatment, and have fewer opportunities for physical exercise. Individuals with I/DD may also not receive appropriate screening for dietary and nutritional status, exercise habits, oral diseases, substance use/abuse, depression, other mental illnesses, cancer, abuse, neglect, domestic violence, or occupational hazards. Routine preventive services including periodic oral prophylaxis and restoration, cancer screening, immunizations, and early intervention in emerging psychiatric symptoms, may not be recommended or provided. Nutrition and weight control, exercise, oral health, family planning, safe sex, strategies for protection from rape, domestic violence, and sexual abuse, maintaining treatment regimens, avoiding medication errors, recognizing and seeking care for emerging disorders, and age-related changes in and risks to health status and other educational and self-care skills may also be neglected as a focus of treatment. The SIP-PL shall ensure their requirements adequately address these at-risk areas

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

6. The SIP-PL shall develop and implement a defined pharmacy management program for drug classification to include the following areas for individuals with I/DD:
 - a. Specialized pharmacy management policies for I/DD, primary care, and other specialty provider types shall include, but not be limited to:
 - i. Drug use evaluation
 - ii. Drug therapy guidelines
 - iii. Drug utilization review
 - iv. Diagnosis-related drug use evaluation
 - v. Polypharmacy
 - vi. Metabolic and cardiovascular side effects of psychotropic medications for children and adults with I/DD
 - b. Use of data to identify opportunities for intervention that address safety, gaps in care, utilization, and cost stratified by age and diagnoses
 - c. Monitoring of pharmacological classes of medications with emphasis on psychotropic, anti-infective, anticonvulsant, and opioid pharmaceuticals
 - d. Protocols to monitor the use of psychotropic medications for individuals meeting any of the following criteria:
 - i. Individuals with I/DD under the age of six (6) taking any psychotropic medications
 - ii. Individuals with I/DD who are on more than one (1) medication from the same class (antidepressants, antipsychotics, attention-deficit/hyperactivity disorder medications, anxiolytics/hypnotics, mood stabilizers), or
 - iii. Individuals with I/DD who are on three (3) or more psychotropic medications
 - e. Therapeutic equivalents for medications requiring prior authorization or formulary exceptions
7. The SIP-PL shall develop clear guidance to promote physical and behavioral health integration for individuals with I/DD. Considerations include:
 - a. Provider access to rapid consultation from psychiatrists who are knowledgeable about treating individuals with I/DD and co-morbid behavioral health conditions
 - b. Provider access to education and training, and
 - c. Provider access to referral and linkage support for child, adolescent, and adult at-risk patients
8. The SIP-PL must meet the following additional requirements for individuals with I/DD accessing HCBS:
 - a. Ensure the provision of I/DD HH Care Management services either directly or through other entities approved by the State

- b. Ensure that I/DD HH Care Managers assist individuals with accessing benefits, provide individuals and family/caregivers with education and coaching to facilitate adherence to recommended treatment, develop Life Plans in accordance with applicable state and federal regulations and guidance, and monitor individual outcomes
- c. When an individual is institutionalized or otherwise in a non-HCBS setting, the individual may not receive HCBS. However, the SIP-PL shall coordinate with the Care Manager and providers on the discharge plan which includes any HCBS services that are needed
- d. Track and promote the use of state-selected and nationally recognized clinical practice guidelines for individuals with I/DD, examples of which are listed below. The SIP-PL shall define expectations for provider utilization of evidence-based practices where appropriate and provide or enable continuing education activities to promote integration of these practices. The State will provide additional guidelines pertaining to Evidence Based Practices (EBPs)
 - i. Clinical Practice Guidelines for Children with I/DD
 - ii. Guidelines on Management of Dental Patients with Special Health Care Needs
 - iii. Guidelines for Dementia-related Health Advocacy for Adults with I/DD and Dementia
 - iv. Positive Behavior Intervention and Supports
 - v. Comprehensive Behavioral Treatment for Young Children
 - vi. Antecedent-based Interventions (ABI) with Functional Behavioral Assessment (FBA)
 - vii. Behavioral Interventions/ Applied Behavior Analysis (including Differential Reinforcement, Extinction, Functional Communication Training, Reinforcement, Task Analysis and Chaining and Response Interruption/Redirection)
 - viii. Cognitive Behavioral Therapy
 - ix. Dialectical Behavior Therapy
 - x. Functional Communication Training
 - xi. Story-based Intervention
 - xii. Parent Training / Parent Implemented Interventions
 - xiii. Peer Training Package / Peer Mediated Interventions
 - xiv. Social Skills Package
 - xv. Trauma Informed Care
 - xvi. Good Lives Model (for use with Sex Offenders with I/DD)

3.10 Cross System Collaboration

1. The SIP-PL shall meet with the State on I/DD and Managed Care issues at a frequency determined by the State. At the State's discretion, the DDRO, and/or LDSS may be involved in meetings that address services. SIPs-PL shall participate in meetings with the State on specific issues as determined by the State, including but not limited to, issues related to individuals with I/DD or other identified special populations.

2. The SIP-PL shall meet quarterly with the DDRO in their respective regions. The DDROs will work closely with the state agencies to inform I/DD and Managed Care policy and problem solve regional service delivery challenges.

3.11 Quality Management

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

the quality management committee agenda and in the quality management committee minutes

3. The SIP-PL shall provide for utilization management committee and utilization management sub-committee functions to meet the utilization management requirements and standards for individuals with I/DD and the I/DD benefits and services described in this document. The committees must be chaired by the I/DD and/or Behavioral Health Medical Director and are charged with implementing processes to collect, monitor, analyze, evaluate, and report utilization data consistent with the reporting requirements defined in this document. The Medical Director(s) with I/DD knowledge and experience must participate on the I/DD utilization management subcommittee.
 - a. The utilization management committee looking at physical health services must include examination of service utilization and outcomes for individuals with I/DD. The utilization management committee shall review and analyze data and other metrics as determined by the State.
 - b. The utilization management subcommittee shall review and analyze data in the following areas, interpret the variances, review outcomes, and develop and/or approve interventions based on the findings
 - i. Under and over utilization of I/DD services and cost data
 - ii. Admission and readmission rates, trends, and the average length of stay for all inpatient classified LOC
 - iii. Emergency Department (ED) utilization and crisis services use
 - iv. I/DD prior authorization/denial and notices of action
 - v. Transitional issues for youth ages 18 to 23 years, focusing on continuity of care and service utilization
 - vi. Other metrics determined by the State
 - c. For individuals with I/DD eligible for HCBS, the utilization management subcommittee shall separately report, monitor findings and recommend appropriate action on the following additional metrics:
 - i. Prior authorization/denial and notices of action
 - ii. HCBS utilization
 - iii. HCBS Quality Assurance performance measures as determined by the state and pending CMS requirements
4. The SIP-PL shall ensure intervention strategies have measurable outcomes and are recorded in the utilization management /clinical management committee meeting minutes. Analyses shall be conducted separately for individuals with I/DD.
5. The SIP-PL must include in the Quality Management Program a method for monitoring on a provider level that policies and expectations outlined in Sections 3.5 and 3.6 are being met.
6. The SIP-PL must actively work toward ensuring that the foundation of the State's quality strategy is centered around the following goals for individuals receiving services:
 - a. Improving health outcomes for individuals with I/DD

- b. Reducing the number of individuals with I/DD being referred and diverted to institutional levels of care when they can be supported in the community (consistent with supporting living in the most integrated setting)
 - c. Improving the coordination of care for individuals with I/DD
 - d. Increasing access to available services
7. The SIP-PL must have a process in place to facilitate individual choice, improve coordination of services, and emphasize health and wellness through a process that is conflict free.
8. The SIP-PL process must have data collection capabilities that focus/report on outcomes and be able to submit data to the State as required.

3.12 Reporting and Performance Measurement

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

- a. The SIP-PL is required to use CQL certified interviewers to conduct CQL interviews using the CQL interview methodology based upon the 21 CQL Personal Outcome Measures (POMs) on a representative sample of enrolled individuals annually.
 - i. The SIP-PL may contract with other entities approved by OPWDD to obtain CQL certified interviewers or may obtain certification for its own staff or network provider staff. In the latter case, the SIP-PL must ensure that certification is retained and that there is an adequate number of certified interviewers to conduct the required certified interviews at least annually
 - ii. The SIP-PL will adhere to OPWDD CQL Practice Guidelines for SIPs-PL to be published on OPWDD's website including the sampling parameters

3.13 Claims Processing

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

3.14 Information Systems and Website Capabilities

1. The SIP-PL shall have information systems that enable the paperless submission and processing of notification, prior authorization and other utilization management related requests. The paperless submission must include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic 278 authorization format and a web-based authorization submission system for providers to directly enter authorizations to the SIP-PL and review status. These systems shall also provide status information on the processing of said requests.
2. The SIP-PL shall maintain content on a website that meets the following minimum requirements:
 - a. Secure access to provider and member portals

- b. Web-based training
 - c. Standard reporting
 - d. Data access as needed for the effective management and evaluation of the performance of the SIP-PL
 - e. The SIP-PL website shall be organized in a manner that allows information to be easily accessible by individuals with I/DD, family members/caregivers, network providers, stakeholders, and the general public in compliance with the ADA. The SIP-PL website must include at a minimum, the following information or links:
 - i. Detailed processes for obtaining crisis intervention services, crisis contact information, including toll-free crisis telephone numbers
 - ii. How to identify and access services, including I/DD, physical health, behavioral health, and HCBS by specific program/service types
 - iii. Telecommunications device for the deaf/text telephone numbers
 - iv. Information on the right to choose a qualified I/DD, physical health, behavioral health, or HCBS provider. This should include descriptions of the I/DD HCBS and the process to apply for and access these services
 - v. A Provider Directory that includes I/DD, physical health, behavioral health, and HCBS provider names, locations, telephone numbers, service types, non-English languages spoken for current network providers in the individual's service area, providers that are NOT accepting new patients and, at a minimum, information on specialists and hospitals. All provider information must be available at the time of the SIP-PL on-site review. The online directory must be searchable by specific service/program types and populations served (i.e., dentists experienced in serving individuals with I/DD)
 - vi. The SIP-PL Member Handbook and Provider Manual
 - vii. Information regarding community forums, volunteer activities, and workgroups/committees that provide involvement opportunities for individuals' receiving services, family members/caregivers, providers, and stakeholders
 - viii. Information regarding advocacy organizations, including how individuals and family members/caregivers may access advocacy services.
 - ix. Hyperlinks to the NYSDOH and OPWDD websites and other websites determined by the State
 - x. Opportunities, including surveys, for individuals with I/DD in receipt of I/DD and/or HCBS benefits, family members/caregivers, network providers and other stakeholders to provide feedback (i.e., satisfaction and complaints)
 - xi. Information on processes for filing grievances, prior authorization requests, service denial appeals and reporting incidents
 - xii. Other documents as required by the State
3. The SIP-PL shall develop a plan to implement information systems that support data-driven approaches to monitor compliance with requirements in this document, including network adequacy and I/DD-specific reporting requirements, including the ability to produce routine and ad hoc reports that are required by the State for I/DD specific

services. This includes, but is not limited to, functionality to produce required and/or ad hoc reports by population, age group and/or system affiliation (i.e., LCED, DD eligibility).

4. The SIP-PL shall have information systems that interface with the HIT systems of providers of Health Home services, to collect data elements for reporting on HCBS assurances and sub assurances, such as assessment and Life Plan elements, and amount, duration, and scope of services authorized and reimbursed.
5. The SIP-PL information systems shall include functionality for all required HCBS reporting including, I/DD LCED designation, Life Plan, qualified provider, health and welfare, and fiscal accountability monitoring for individuals with I/DD receiving HCBS including:
 - a. The analytical capability to calculate performance indicators, detect data redundancy, measure data quality, and document compliance with state and federal regulations
 - b. The flexibility to accommodate the requirements as stated in the CMS Special Terms and Conditions and accommodate changes that are identified through the quality improvement process
 - c. The capability to access and store assessment data and electronic versions of the Life Plan to serve as notification or authorization for any HCBS service in the SIPs-PL claims management system
 - d. The ability to create reports on any data and have a timely completion indicator, etc. for quality of care monitoring related to HCBS quality assurance measures
 - e. The capability to send and receive individual data, including all clinical and non-clinical electronic records, in a secure and compatible platform
 - f. File and information sharing capabilities with networks and/or providers including, OPWDD certified providers, providers of Health Home services and other entities providing services to SIP-PL enrollees
 - g. Mechanisms to provide oversight entities (state agencies) with swift access to view individuals' electronic records, Life Plans, documentation of services and supporting documents

3.15 Financial Management

1. The SIP-PL shall submit fiscal reporting for I/DD and I/DD HCBS, including medical and administrative expenditures, in a format and frequency defined by the State.
2. Capitation payments made to the SIP-PL for I/DD services will be monitored by the State and compared to the I/DD expenditure target.
3. SIPs-PL and providers wishing to negotiate alternative payment methodologies to the provider following implementation may do so pending state approval and subject to compliance with state and federal law.

3.16 Reserve Requirements for SIPs-PL

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

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

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

The enabling statute for specialized Managed Care for the I/DD population⁶ does not specify reserve requirements. The Commissioners of NYSDOH and OPWDD have established the following reserve requirements for SIPs-PL:

1. New York State Contingent Reserve requirements for services other than OPWDD services or health care should be set at five percent (5%) of net premium revenue consistent with the standard for MLTC
2. New York State Escrow fund requirements for OPWDD services should be set initially at three percent (3%) of estimated expenditures, and possibly increased to four percent (4%) then five percent (5%) over three (3) years
3. HCBS residential and non-residential services and ICF/IID will not be subject to contingent reserve requirements until these services are at risk
4. The cost of residential services (HCBS and ICF/IID) will not be included in the calculation of contingent reserve requirements and escrow fund due to OPWDD's control on certifying and authorizing these residential services through the OPWDD DDROs, including the number, types and distribution of approved services, and
5. Escrow fund and contingent reserve requirements for the healthcare benefit portion of the SIP-PL (estimated at fifteen percent (15%) of total Medicaid costs for individuals with

⁶ Public Health Law § 4403-g.

I/DD) should be set at the same percent required of MMCOs, as the risk related to healthcare services is similar across service sectors

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

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

The criteria appearing in the LOC instrument are:

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

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

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

1. A twelve (12) month delay in one or more functional areas, or
2. A thirty-three percent (33%) delay in one (1) functional area, or a twenty-five (25%) delay in each of two (2) functional areas, or
3. If appropriate, standardized instruments are administered yielding a score of two (2.0) standard deviations below mean in one functional area or a score of one and a half (1.5) standard deviations below the mean in each of two (2) functional areas. Additional information and future changes to these processes is contained within OPWDD policy guidance.

Attachment B: CMS Standard Reporting and Monitoring Requirements

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

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

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

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

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

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
3	The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of Life Plans for HCBS Waiver-enrolled individuals.	Life Plan addresses all assessed needs (including health and safety risk factors) and personal goals, either by the provision of Waiver services or through other means.	<p>Percent of individuals reviewed with a Life Plan that was adequate and appropriate to their needs and goals (including health goals) as indicated in assessment(s).</p> <p>Percent of individuals reviewed with a Life Plan that had adequate and appropriate strategies to address their health and safety risks as indicated in the assessment(s).</p> <p>Percent of individuals reviewed with a Life Plan that addressed goals/needs as indicated in the assessment(s).</p>	<p>Data source: record reviews, onsite or through utilization review unit</p> <p>Data collection responsible parties: SIP-PL and OPWDD</p> <p>Frequency of data collection: continuously and ongoing</p> <p>Sampling: representative sample, 95% CI</p> <p>Data aggregation responsible parties: SIP-PL, NYSDOH and OPWDD</p> <p>Frequency of data aggregation and analysis: monthly</p>

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
		<p>Life Plans are updated/revise at least annually or when warranted by changes in the individual’s needs</p>	<p>Percent of individuals whose Life Plan was updated within 365 days of the last evaluation. Percent of individuals whose Life Plan was updated as warranted by changes in the individual’s needs.</p>	<p>Data source: SIP-PL database Data collection responsible parties: SIP-PL Frequency of data collection: ongoing Sampling: 100% review Data aggregation responsible parties: SIP-PL and providers of Health Home services Frequency of data aggregation and analysis: quarterly</p>
		<p>Services are delivered in accordance with the Life Plan, including the type, scope, amount, duration, and frequency specified in the Life Plan.</p>	<p>Percent of new individuals receiving services according to their Life Plan within 45 days of approval of their Life Plan. Percent of individuals who received services in the type, number, duration, and frequency specified in the Life Plan.</p>	<p>Data source: Life Plan, record reviews, financial records Data collection responsible party: SIP-PL Frequency of data collection: quarterly Sampling: representative sample, 95% CI Data aggregation responsible party: SIP-PL Frequency of data aggregation and analysis: semi-annually</p>

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
		<p>Individuals are afforded choice between/among Waiver services and providers.</p>	<p>Percent of individual records reviewed with a completed, signed freedom of choice form that specifies choice was offered among Waiver services and providers.</p> <p>Percent of individuals reviewed with a Life Plan that includes the individual and/or family/caregiver's signature as consistent with state and federal guidelines.</p>	<p>Data source: record reviews, on-site Data collection responsible party: SIP-PL Frequency of data collection: continuously and ongoing Sampling: representative sample, 95% CI Data aggregation responsible parties: SIP-PL and NYSDOH Frequency of data aggregation and analysis: semi-annually</p>
4	<p>The State demonstrates that it has designed and implemented an adequate system for assuring that all Waiver services are provided by qualified providers</p>	<p>The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing Waiver services</p>	<p>Percent of Waiver providers providing Waiver services that meet licensure and certification requirements prior to furnishing Waiver services – initially</p> <p>Percent of Waiver providers providing Waiver services that meet licensure and certification requirements prior to furnishing Waiver</p>	<p>Data source: SIP-PL credentialing files Data collection responsible party: SIP-PL Frequency of data collection: continuously and ongoing Sampling: 100% review Data aggregation responsible party: SIP-PL Frequency of data aggregation and analysis: quarterly Note: The SIP-PL must be able to stratify the data by licensed, certified, and atypical in order to pinpoint deficiencies in SIP-PL credentialing.</p>

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
			services – continuously Percent of Waiver providers providing Waiver services that have an active agreement with the SIP-PL.	
		The State monitors non-licensed/non-certified providers to assure adherence to Waiver requirements.	Percent of providers of Waiver services that meet training requirements —non-licensed/noncertified provider, training requirements.	Data source: training verification records Data collection responsible party: SIP-PL Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible parties: NYSDOH and OPWDD Frequency of data aggregation and analysis: quarterly Note: New York may combine Performance Metrics in this sub- assurance and the next sub- assurance. However, the SIP-PL must be able to stratify the data by licensed, certified and atypical in order to pinpoint deficiencies in SIP-PL training.
		The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and Waiver authorities.	Percent of providers of Waiver services that meet training requirements — all providers, ongoing training requirements.	Data source: training verification records Data collection responsible party: SIP-PL Frequency of data collection: monthly Sampling: 100% review Data aggregation responsible parties: NYSDOH and OPWDD Frequency of data aggregation and analysis: quarterly

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

#	CMS Assurance	CMS Sub-Assurance	Metric – based on CMS requirements approved in other states	Formula – based on CMS requirements approved in other states
	<p>like participants by qualified providers. The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the Waiver program.</p>			<p>Frequency of data aggregation and analysis: continuously and ongoing</p>
			<p>Percent of claims verified through the SIPs-PL compliance audit to have paid in accordance with the individual’s Life Plan.</p>	<p>Data source: SIPs-PL compliance report Data collection responsible party: SIP-PL Frequency of data collection: quarterly, continuously and ongoing Sampling: 95% CI Data aggregation responsible parties: SIP-PL and NYSDOH Frequency of data aggregation and analysis: quarterly</p>
		<p>The State provides evidence that rates remain consistent with the approved rate methodology throughout the five (5) year Waiver cycle.</p>	<p>The State pays the SIP-PL actuarially sound rates.</p>	<p>N/A to SIP-PL reporting</p>

Attachment C: Plan Staffing Requirements for SIPs-PL

Position/ Title	NYS Location Required (Yes/No)	SIP-PL Requirements
Key Personnel		
Medical Director	Yes	<ul style="list-style-type: none"> • Licensed New York State Board-certified Physician • Minimum of five (5) years of experience working with individuals with I/DD in Managed Care or clinical settings (at least two (2) years must be in a clinical setting) • If the Plan’s Medical Director does NOT have the stated I/DD experience, the SIP-PL must also identify an additional Medical Director who meets the I/DD experience requirements. Allocation for this additional position, if necessary, must be at a minimum of 0.5 FTE. The SIP-PL may submit a request to waive the minimum allocation of time with appropriate documentation for the State’s review and approval
I/DD Clinical Director	Yes	<ul style="list-style-type: none"> • New York State Clinical License in a Behavioral Health Field • At least seven (7) years of experience in a Managed Care or I/DD clinical setting, including at least two (2) years of Managed Care experience (preferably MMC) • Five (5) years working with individuals with I/DD, providing clinical services • Knowledge of New York State systems serving individuals with I/DD
I/DD Dental Director	No	<ul style="list-style-type: none"> • Licensed to practice dentistry in New York State • Minimum of five (5) years of experience providing dental services to individuals with I/DD • May be filled on a consultant or part-time basis
Behavioral Health Medical Director <i>(This position is required when SIP-PL enrollment exceeds 10,000 enrollees)</i>	Yes	<ul style="list-style-type: none"> • Licensed New York State Physician • Minimum of five (5) years of experience working in a Managed Care or clinical setting (at least two (2) years must be in a clinical setting) • Appropriate training and expertise in general psychiatry and addiction disorders (i.e., board certification in general psychiatry and certification in addiction medicine or certification in the subspecialty of addiction psychiatry)

Position/ Title	NYS Location Required (Yes/No)	SIP-PL Requirements
Managerial Staff		
I/DD HH SIP-PL Liaison	Yes	<ul style="list-style-type: none"> • Experience, expertise and knowledge of the unique and complex needs of the I/DD population • Knowledge of State and local systems serving individuals with I/DD, Health Homes, and specialty providers responsible for addressing the healthcare needs of serving individuals with I/DD, including the medically needy LOC population
I/DD Care Management Director	Yes	<ul style="list-style-type: none"> • Licensed Masters Level Clinician • I/DD Managed Care or I/DD clinical experience • Experience working with Health Homes recommended • Experience working with community and family-based services and experience working across I/DD-serving systems recommended • Knowledge of systems serving individuals with I/DD
I/DD Utilization Management Director	No	<ul style="list-style-type: none"> • Non-Physician Licensed Behavioral Health Professional (NP-LBHP) • I/DD Managed Care or I/DD clinical experience • Experience working with community and family-based services recommended • Knowledge of systems serving individuals with I/DD
Member Services Director	No	<ul style="list-style-type: none"> • Experience in Managed Care or clinical setting • Experience managing member service call center operations. • Knowledge of the provider system serving individuals with I/DD • Knowledge of the new benefits and program requirements for individuals with I/DD
Network Development Director	Yes	<ul style="list-style-type: none"> • I/DD Managed Care or I/DD clinical experience • Demonstrated experience in I/DD network development • Knowledge of and experience with principles of I/DD integration • Knowledge of family-centered, individual-guided principles and development of Evidenced Based Practices • Knowledge of service needs of individuals with I/DD
Provider Relations Director	Yes	<ul style="list-style-type: none"> • Experience in I/DD Managed Care or I/DD clinical setting • Experience managing I/DD provider issues including, resolving grievances, coordinating site visits, and maintaining quality of care • Knowledge of the provider system serving individuals with I/DD

Position/ Title	NYS Location Required (Yes/No)	SIP-PL Requirements
Training Director	Yes	<ul style="list-style-type: none"> • Significant experience and expertise in developing, tracking, and executing I/DD training to SIP-PL and network provider staff • Significant experience and expertise in developing training programs related to I/DD systems for individuals and families
Quality Management Director	No	<ul style="list-style-type: none"> • Experience and expertise in quality improvement for I/DD services and programs, ideally in publicly-operated or publicly funded programs • Experience with Managed Care service delivery systems • Familiarity with person-centered and guided service delivery • Familiarity with family-centered service delivery for individuals and families with I/DD needs • Knowledge of appropriate performance measures (including HEDIS and QARR) for individuals with I/DD
Information Systems Director	No	<ul style="list-style-type: none"> • I/DD experience and expertise in Medicaid data analytics and I/DD data systems • Knowledge of all federal and State laws governing the confidentiality and security of PHI, including confidential mental health information
Governmental/Community Liaison Director	Yes	<ul style="list-style-type: none"> • Must be an individual with significant Plan leadership responsibilities • The SIP-PL must designate representative(s) to attend relevant stakeholder, planning, and advocacy meetings to ensure that the SIP-PL is aligned with the State’s vision for Managed Care I/DD service delivery and is aware of new state or local I/DD initiatives
Operational Staff		
Utilization Management/ Care Management	UM – No CM - Yes	<ul style="list-style-type: none"> • Non-Physician Licensed Behavioral Health Practitioner (NP-LBHP) for utilization management • Masters Level Clinician for Care Management • Experience in managing care for individuals with I/DD, including individuals in high risk groups, individuals with co-occurring I/DD and behavioral health needs, and who may be involved in multiple services systems (education, justice, medical, and welfare); or individuals with medical fragility/complex medical conditions requiring significant medical or technological health supports • For utilization management, authorization decisions must be made by a NP-LBHP with a minimum of three (3) years of experience treating individuals with I/DD in an I/DD setting • Knowledge and experience in health and services for individuals with I/DD, HCBS, and social service programs

Position/ Title	NYS Location Required (Yes/No)	SIP-PL Requirements
Clinical Peer Reviewers	No	<ul style="list-style-type: none"> • Board-certified Physician • Five (5) years of experience serving individuals with I/DD • For BH services, peer reviewers may include: Licensed Doctoral Level Psychologists with experience serving individuals with I/DD, in addition to above
Quality Management Specialists	No	<ul style="list-style-type: none"> • Experience and expertise in quality improvement for services and programs for individuals with I/DD, ideally in publicly-operated or publicly-funded programs • Familiarity with person-centered and guided service delivery • Knowledge of family-centered, individual guided service delivery for individuals and families with I/DD needs • Knowledge of appropriate performance measures (including HEDIS and QARR) for individuals with I/DD
Provider Relations	Yes (some staff must be in New York State)	<ul style="list-style-type: none"> • Experience in I/DD Managed Care or I/DD clinical setting. • Experience managing I/DD provider issues including resolving grievances, coordinating site visits, and maintaining quality of care • Knowledge of the provider system serving individuals with I/DD
Additional SIP-PL Staff		
Foster Care Liaison <i>(This position is required when SIP-PL enrollment of children under the age of twenty-one (21) exceeds 2,500)</i>	Yes	<ul style="list-style-type: none"> • Experience, expertise and knowledge of the child welfare system, foster care healthcare requirements and the unique needs of children with I/DD • Knowledge of the New York State child-serving systems required to effectively be responsible for coordination of care for children with I/DD in foster care • The responsibilities for this position may be included within another position

Attachment D: SIP-PL Staff Training Requirements

Training Topics to be completed 30 days prior to SIP-PL Implementation	Clinical Staff	Member Services	Provider Relations
New York State's vision, mission, goals, operating principles for the service and population expansion including I/DD services for individuals with I/DD	Required (R)	R	R
Understanding existing I/DD services, new SPA services and HCBS for individuals with I/DD	R	R	R
Cultural competence outlining the impact of culture, ethnicity, race, gender, sexual orientation, and social class within the service delivery process	R	R	R
HCBS eligibility requirements and protocols	R	R	R
HCBS operational requirements (i.e., needs assessment (CAS), Life Plans)	R	R	R
I/DD services/medical integration; co-occurring I/DD and medical disorders, and integrated Care Management principles	R	R	R
Medical Necessity Criteria and service authorization requirements for expanded benefits and HCBS	R	R	
Network access standards for new services and HCBS	R	R	R
New information systems, data collection tools (if applicable)	R		R
Reporting and monitoring requirements (i.e., critical incident reporting, HCBS assurances and sub-assurances)	R	R	R
Complaints, grievance, appeals	R	R	R
After-hours and crisis triage protocols	R	R	R
Linkage requirements (i.e., with OMH, OASAS, OCFS, LDSS, OPWDD, DDROs and other non-Medicaid agencies serving individuals with I/DD)	R	R	R
Network participation requirements (i.e., provider qualification validation)			R
Provider training and site visits			R
Provider profiling and performance management			R
Primary Care and I/DD service integration, including but not limited to appropriate screening and early identification tools for use in medical settings	R		R
The Health Home Model & Practice — Roles and Responsibilities	R	R	R
Understanding the interaction of systems serving individuals with I/DD and navigating and coordinating systems of care	R	R	R
Trauma Informed Practices	R		
Importance of Families and understanding how to assist families/caregivers to access services	R	R	R
Family Psychoeducation	R	R	R

Care Management Staff:

All Care Management units/staff must adhere to the I/DD HH training and competency standards described in the *I/DD HH Training Guide for Care Managers*.

Skills-Building Areas:

The SIP-PL must ensure the provision of training for all Care Managers in the following 10 skill-building areas. This learning is intended to result in outcome measures informed by the person-centered planning process.

1. Values Person-Centeredness and Communication
2. Builds Relationships and Establishes Communication within Care Coordination Team and Among Providers
3. Promotes Community Orientations
4. Demonstrates Cultural Competence
5. Demonstrates Knowledge of I/DD, Chronic Diseases, and Social Determinants of Health
6. Demonstrates Knowledge of Community Supports and Services, New Models of Care, and Health Care Trends
7. Understands Ethics and Professional Boundaries
8. Promotes Quality Improvement
9. Understands Health Information Technology
10. Demonstrates Proficiency in Documentation and Confidentiality

Attachment E: Network Development in Rural Counties

Rural County Definition

For the purpose of network development, a rural county is defined as one with a population of fewer than 200,000 inhabitants.

The following are defined as rural counties:

Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Ontario, Orleans, Oswego, Otsego, Putnam, Rensselaer, Schenectady, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Wyoming, and Yates are rural counties.

Region Definition

For the purpose of determining network adequacy (including I/DD providers) in rural counties a region is defined as the catchment area beyond the border of a county, which includes the other counties of the state-designated DDRO region.

Regional Office-Region 1	Counties
Finger Lakes DDRO 620 Westfall Rd., Suite 108 Rochester, NY 14620	Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates
Western NY DDRO 1200 East and West Rd. West Seneca, NY 14224	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans
Regional Office-Region 2	Counties
Broome DDRO 229-231 State St., 1st Floor Binghamton, NY 13901	Broome, Chenango, Delaware, Otsego, Tioga, Tompkins
Central NY DDRO Eligibility Department 187 Northern Concourse North Syracuse, NY 13212	Cayuga, Cortland, Herkimer, Lewis, Madison, Oneida, Onondaga, Oswego
Sunmount DDRO 2445 State Route 30 Tupper Lake, NY 12986	Clinton, Essex, Franklin, Hamilton, Jefferson, St. Lawrence
Regional Office-Region 3	Counties
Capital District DDRO 500 Balltown Rd. Bldg. 10-C, 3 rd Floor Schenectady, NY 12304	Albany, Fulton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Hudson Valley DDRO 9 Wilbur Road Theills, NY 10984	Rockland, Orange, Sullivan, Westchester
Taconic DDRO 38 Fireman's Way	Columbia, Dutchess, Greene, Putnam, Ulster

Poughkeepsie, NY 12603	
Regional Office-Region 4	Counties
Metro NY DDRO/Bronx 2400 Halsey St. Bronx, NY 10461	Bronx
Brooklyn DDRO 888 Fountain Ave. Bldg. 1, 2nd Floor Brooklyn, NY 11239	Kings
Metro NY DDRO/Manhattan 25 Beaver St., 4th Floor New York, NY 10004	New York
Staten Island DDRO 1150 Forest Hill Rd. Bldg. 12, Suite A Staten Island, NY 10314-6316	Richmond
Regional Office-Region 5	Counties
Long Island DDRO 415-A Oser Ave. Hauppauge, NY 11788	Nassau, Suffolk

Meeting Network Requirements in the Case of Insufficient County Providers

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

Reimbursement of Non-Participating Providers in the Case of Inadequate Network

SIPs-PL whose networks are inadequate, whether due to an insufficient number of contracts or an insufficient number of available appointments, will be required upon an individual’s request, to permit an individual to receive services at a non-participating provider and reimburse those providers at no less than the Medicaid fee-for-service rate. The SIP-PL must utilize Single Case Agreements when necessary.

Attachment F: SIP-PL Benefit Package / Covered Services for Individuals with I/DD

Service	Covered by SIP-PL for Individuals with I/DD
Medical / Health Services	
Inpatient Hospital Services	Yes
Inpatient Stay Pending Alternate Level of Medical Care	Yes
Physician Services	Yes
Nurse Practitioner Services	Yes
Midwifery Services	Yes
Preventive Health Services	Yes
Second Medical/Surgical Opinion	Yes
Laboratory Services	Yes
Radiology Services	Yes
Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Yes
Smoking Cessation Products	Yes
Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))	Yes
EPSDT Services/Child Teen	Yes
Health Program (C/THP)	Yes
Emergency Services	Yes
Post-Stabilization Care Services	Yes
Foot Care Services	Yes
Eye Care and Low Vision Services	Yes
Dental and Orthodontic Services	Yes
Family Planning and Reproductive Health Services	Yes
Renal Dialysis	Yes
Experimental and/or Investigational Treatment	Yes
Observation Services	Yes
Medical Social Services	Yes
Tuberculosis Directly Observed Therapy	Yes
Therapy Services (OT/PT/Speech, Clinic, and Independent Practitioner)	Yes
Long / Short Term Support	
Home Health Services	Yes
Private Duty Nursing Services	Yes
Hospice	Yes
Personal Care Services	Yes
Personal Emergency Response System (PERS)	Yes

Service	Covered by SIP-PL for Individuals with I/DD
Consumer Directed Personal Assistance Services	Yes
Home Delivered Meals	Yes
Live-In-Caregiver	Yes
Residential Health Care Facility (Nursing Home) Services (RHCF) Short term	Yes
Transportation	
Non-Emergency Transportation	Provided fee-for-service
Emergency Transportation	Provided fee-for-service
Durable Medical Equipment / Products / Supplies	
Durable Medical Equipment (DME)	Yes
Audiology, Hearing Aids Services & Products	Yes
Prosthetic/Orthotic Services/Orthopedic Footwear	Yes
Behavioral Health / Substance Use Disorder Treatment	
Court-Ordered Services	Yes
LDSS Mandated SUD Services	Yes
Mental Health Services	Yes
SUD Inpatient Detoxification Services	Yes
SUD Inpatient Rehabilitation and Treatment Services	Yes
SUD Residential Addiction Treatment Services	Yes
SUD Outpatient (Includes outpatient clinic; outpatient rehabilitation; and opioid treatment)	Yes
SUD Medically Supervised Outpatient Withdrawal	Yes
Buprenorphine Prescribers	Yes
Crisis Intervention Services	Yes
Long Term Residential Placement	
Residential Health Care Facility (Nursing Home) Services (RHCF)	Yes
Developmental Centers / Small Residential Units	Yes - Covered up to ninety (90) days from placement or until individual is disenrolled, whichever is earlier
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	Yes
Care Management	
Adult Health Home	No
Children's Health Home	No
I/DD Health Home or Basic HCBS Plan Support	Yes
SIP-PL Comprehensive Care Management	Yes

Service	Covered by SIP-PL for Individuals with I/DD
Day Health Programs	
Adult Day Health Care	Yes
AIDS Adult Day Health Care	Yes
OPWDD Day Treatment	Yes
ICF/IID Day Services	Yes
OPWDD Waiver Services	
OPWDD Fiscal Intermediary	Yes
Support Brokerage	Yes
Day Habilitation	Yes
Residential Habilitation	No
Pathway to Employment, Prevocational Services and Supported Employment	Yes
Family Education and Training	Yes
Individual Directed Goods and Services	Yes
Intensive Behavioral Services	Yes
Respite	Yes
Community Habilitation	Yes
Adaptive Technology/Assistive Devices	Yes
Community Transition Services	Yes
Live-in Caregiver	Yes
Children’s HCBS Waiver Services pending federal approval for individuals participating in Children’s HCBS Waiver(s)⁷	
Palliative Care (Expressive Therapy, Pain and Symptom Management, Bereavement Services, and Massage Therapy)	Yes
Non-Medical Transportation	Provided fee-for-service
Community Habilitation	Yes
Day Habilitation	Yes
Adaptive and Assistive Equipment	Yes
Accessibility Modifications	Yes

⁷ Children’s HCBS Waiver Services are included in the SIP-PL Benefit Package effective on the date that the State includes these services in the comprehensive MCO Benefit Package. Children with ICF Level of Care participating in 1915(c) Waivers are eligible for these services from fee-for-service until the services are included in the Benefit Package.

Service	Covered by SIP-PL for Individuals with I/DD
Caregiver/Family Supports and Services	Yes
State Plan Behavioral Health Services and Demonstration Benefits for Children and Youth under 21⁸	
Assertive Community Treatment (ACT)	Yes
Children's Crisis Intervention	Yes
Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed	Yes
Continuing Day Treatment (minimum age 18 for medical necessity for this adult oriented service)	Yes
Community Psychiatric Support and Treatment (CPST)	Yes
Crisis Intervention Demonstration Service	Yes
Family Peer Support Services	Yes
Youth Peer Support and Training (YPST)	Yes
Psychosocial Rehabilitation Supports (PSR)	Yes
Licensed Behavioral Health Practitioner (LBHP) Service	Yes

⁸ State Plan Behavioral Health Services for Children and Youth Under 21 are included in the SIP-PL Benefit Package effective on the date that the State includes these services in the comprehensive MMCO Benefit Package.

Attachment G: OPWDD HCBS Waiver Service Definitions

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
Habilitation	Individuals with I/DD meeting HCBS eligibility criteria	<p>Day Assistance with acquisition, retention or improvement in self-help, socialization and adaptive skills including communication, travel and adult education that regularly takes place in a non-residential setting, separate from the individual’s private residence or other residential arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, community inclusion, relationship building, self-advocacy and informed choice. Day habilitation services may also be used to provide supportive retirement activities, including: altering schedules to allow for more rest time throughout the day, support to participate in hobbies, clubs and/or other senior-related activities in their communities.</p> <p>Community Services occurring largely in community (non-certified) settings to facilitate and promote independence and community integration. Community habilitation is defined as a face-to-face service and therefore, in order for a service to be billed, the staff must be with the individual.</p> <p>Prevocational (Site-Based and Community) Services that provide learning and work experiences, including volunteering, where individual’s can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time based on the person-centered planning process.</p> <p>Supported Employment Ongoing supports to individuals who, because of their disabilities, need continuous support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the state minimum wage. The outcome of this service is paid employment at or above the state minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals; as such, career planning is also an allowable service activity.</p> <p>Pathway to Employment A person-centered, comprehensive career planning and support service that provides assistance for individuals to obtain, maintain or advance in competitive employment or self-employment. It is a</p>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
		<p>focused, time-limited service that engages an individual in identifying a career direction, provides instruction and training in pre-employment skills, and develops a plan for achieving competitive, integrated employment at or above the state minimum wage. Within twelve (12) months, the outcome of this service is documentation of the individual’s stated career objective; a detailed career plan used to guide individual employment supports; and preparation for supported employment services that assist an individual in obtaining, maintaining or advancing in competitive employment or self-employment.</p>
Respite	Individuals with I/DD meeting HCBS eligibility criteria	<p>Services provided to individuals who are unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual. Respite care is not furnished or provided for the purpose of compensating relief or substitute staff in certified community residences.</p>
Assistive Technology – Adaptive Devices	Individuals with I/DD meeting HCBS eligibility criteria	<p>An item, piece of equipment or product system; whether acquired commercially, modified or customized; that is used to increase, maintain or improve functional capabilities of individuals. These services directly assist an individual in the selection, acquisition or use of an assistive technology device. The devices and services must be documented in the individual’s Life Plan as being essential to their habilitation, ability to function or safety, and essential to avoid or delay institutionalization.</p>
Environmental Modifications	Individuals with I/DD meeting HCBS eligibility criteria	<p>Physical adaptations to the individual’s home, required by the individual’s Life Plan, that are necessary to ensure their health, welfare and safety, or that enable them to function with greater independence in the home, and without which the individual would require institutionalization and/or a more restrictive and expensive living arrangement.</p>
Family Education and Training	Individuals with I/DD meeting HCBS eligibility criteria	<p>Training given to families of individuals enrolled in the HCBS Waiver, intended to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of a disability on the individual and their family, including behavioral management practices, and educating the family about service alternatives. The purpose is to support the family unit in understanding and coping with the individual’s disability and create a supportive environment at home to decrease premature residential placement outside the home.</p>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
<p>Services to Support Self Direction</p>	<p>Individuals with I/DD meeting HCBS eligibility criteria</p>	<p>Any individual eligible for HCBS Waiver services may self-direct some or all of their services. They receive and direct an individualized portable budget that is pursuant to an approved Life Plan.</p> <p>Fiscal Intermediary If an individual chooses to self-hire their own staff, the employer of record must be either the fiscal intermediary or, once the “common law employer” status is implemented, the individual or family may act in this capacity. In addition to using a fiscal intermediary to pay staff that the individual “self-hires,” an individual must choose a fiscal intermediary agency if the following services are included in their budget in order to provide for appropriate billing and claiming: individual directed goods and services, live-in caregiver, support brokerage or community transition services. The fiscal intermediary supports the individual self-directing with billing and payment of approved goods and services, fiscal accounting and reporting, ensuring Medicaid and corporate compliance and general administrative supports.</p> <p>Support Brokerage Assist Waiver participants (or the participant's family or representative as appropriate) to self-direct and manage some or all of their Waiver services. Support brokerage does not duplicate or replace the Care Management services and differs from Care Management in terms of intensity, frequency and scope. The support broker assists the participant in the day-to-day management of services and provides support and training to individuals and their families regarding the ongoing decisions and tasks associated with participant direction.</p> <p>Individual Directed Goods and Services (IDGS) Services, equipment or supplies not otherwise provided through this Waiver or through the Medicaid State Plan that addresses an identified need in an individual's Life Plan, which includes improving and maintaining the individual's opportunities for full membership in the community. Individuals who choose to self-direct their services with budget authority may receive IDGS as a Waiver service. Individuals may manage their IDGS budget, as described in their Life Plan, to fully purchase or put funds towards their personal fiscal resources to purchase items or services which meet the criteria as described in the 1915(c) OPWDD Comprehensive HCBS Waiver.</p>

Benefit	Eligibility Criteria	Description of Amount, Duration and Scope of Services
Community Transition Services	Individuals with I/DD meeting HCBS eligibility criteria	Non-recurring set-up expenses for individuals who are transitioning from an institutional or other provider-operated living arrangement to a living arrangement in a private residence in the community where the individual is directly responsible for their own living expenses. Allowable expenses are those reasonable and necessary to enable an individual to establish a basic household. Items purchased are the property of the individual receiving the service. The service must be identified in the Life Plan. The service is administered by a fiscal intermediary agency for billing purposes, even if this is the only self-directed service that the individual accesses.
Live-in Caregiver	Individuals with I/DD meeting HCBS eligibility criteria	An unrelated care provider who resides in the same household as the individual and provides supports to address the individual's physical, social or emotional needs in order for them to live safely and successfully in their own home.
Intensive Behavioral Services	Individuals with I/DD meeting HCBS eligibility criteria	Available for individuals who reside in a non-certified residential location, their own home or family home, or a family care home; and the individual, or a party acting on behalf of the individual, certifies through written documentation that the individual is at risk of imminent placement in a more restrictive living environment due to challenging behavioral episodes. Intensive behavioral services are short-term, outcome-oriented and of higher intensity than other behavioral interventions and are focused on developing effective behavioral management strategies to ensure health and safety and/or improve quality of life.
Vehicle Modifications	Individuals with I/DD meeting HCBS eligibility criteria	Physical adaptations to the individual's vehicle, required by the individual's Life Plan, that are necessary to ensure their health, welfare and safety or that enable them to function with greater independence. These physical adaptations include portable electric/hydraulic and manual lifts, ramps and ancillary equipment or modifications necessary to guarantee full access to, and safety in, a motor vehicle.

Attachment H: The Life Plan

I/DD HH Life Plan	Basic HCBS Plan Support Life Plan
<p>The Life Plan is required to be a person-centered service plan that is developed using an Integrated Information Technology or IT (electronic) system for preparing, implementing and monitoring the electronic Life Plan.</p>	<p>The Basic HCBS Plan Support Life Plan does not require the use of an IT (electronic) system.</p>
<p>The integrated IT system will allow for prompt real-time notification(s), regarding any changes to the individual’s Life Plan, to those providers in the individual’s network.</p>	<p>The Basic HCBS Plan Support Life Plan is not required to use an integrated IT system to connect all providers with real-time notifications and updates.</p>
<p>The electronic Life Plan will be required to integrate all preventive and wellness services, medical and behavior healthcare, personal safe-guards and habilitation to support the individual’s personal goals in a state-of-the-art document.</p>	<p>The Basic HCBS Plan Support Life Plan only requires the integration of HCBS services.</p>
<p>The Life Plan is an understandable and personal plan for implementing decisions made during person-centered planning; incorporating all service and habilitation plan(s), Individual Safeguards/Individual Plans of Protective Oversight in one comprehensive document.</p>	<p>The Basic HCBS Plan Support Life Plan is an understandable and personal plan, with its required attachments for implementing decisions made during a person-centered planning process.</p>
<p>The Life Plan identifies the Personal Outcome Measure(s) that best fit with each goal and Valued Outcome as determined by the individual, Care Manager and/or the Interdisciplinary Team (IDT).</p>	<p>The Basic HCBS Plan Support Life Plan is not required to include Personal Outcome Measures.</p>
<p>The Life Plan includes, as applicable, a Special Considerations section to provide specific information in instances where an individual makes an informed choice not to follow specific medical or treatment advice that may still need to be considered when providing supports and services to assist the individual with achieving their Valued Outcome(s).</p>	<p>The Basic HCBS Plan Support Life Plan is not required to include a special considerations section.</p>
<p>The Life Plan is required to be accessible to the individual and their family/representative with appropriate consideration for language and literacy, either electronically and/or via mail, based on the individual’s preference.</p>	<p>The Basic HCBS Plan Support Life Plan is required to be accessible to the individual and their family/representative with appropriate consideration for language and literacy, via mail.</p>

Attachment I: Chart of Populations and Benefits

	Benefits in Capitation	Population
Voluntary Enrollment		
	<ul style="list-style-type: none"> • I/DD Health Home • Comprehensive MMC • OPWDD Non-Residential HCBS Waiver Services 	Phase-in of populations <ul style="list-style-type: none"> • Medicaid only • Duals • TPHI
Mandatory Enrollment		
Beginning no less than one (1) year after voluntary enrollment begins	<ul style="list-style-type: none"> • I/DD Health Home • Comprehensive MMC • OPWDD Non-Residential HCBS Waiver Services 	Phase-in of populations <ul style="list-style-type: none"> • Medicaid only • Duals • TPHI
No less than two (2) years after voluntary enrollment begins	<ul style="list-style-type: none"> • Same as above • OPWDD Residential HCBS Waiver Services 	All populations

Attachment J: Pro-forma Template and Instructions

Instructions for SIP-PL Business Model Projection Template

The attached workbook includes the SIP-PL Business Model Projection Template(s) that must be completed by the Applicant and submitted electronically and in hard copy with the Applicant's response to the Qualification Document. These templates will help to identify the areas in which the Applicant expects to achieve efficiencies through its Business Model.

Each Template has been prefilled by the State with the relevant 2017 fee-for-service spending data, including service utilization, unit price and PMPM cost by category of service. This information should be used to inform the PMPM and Revenue assumptions that the Applicant is making in its Projections.

The workbook includes templates for Medicare and non-Medicare members in specific age bands, and in specific geographic regions of the State. The summary tab within the workbook will automatically roll up to a statewide summary for the Applicant.

The Applicant may propose to serve one (1) or more geographic regions, but must propose to serve all populations (Medicare, non-Medicare and age bands) within the selected geographic region(s).

Applicants must:

1. Complete the Template for each region they are proposing to serve, which will aggregate to the statewide tab.
2. Adhere to the prescribed format (Applicants may not make changes to these formats).

Applicants must complete the SIP-PL Business Model Projection Template based on:

- Program requirements, including benefits and the phase-in schedule outlined in this document, including the carve-in of residential services no less than two years after voluntary enrollment begins.
- Minimum Medical Loss Ratios as defined for MMC federal regulation (42 CFR part 438) of eighty-five percent (85%).

Completion of the SIP-PL Business Model Projection Template does not constitute a bid price, nor does it obligate the State to future reimbursements or levels thereof.