SACHS POLICY GROUP
60 East 42nd Street, Suite 1762
New York, NY 10165
Phone: 212 827 0660
Fax: 212 827 0667

Draft 1115 Waiver Amendment for OPWDD Managed Care

OVERVIEW

On July 24th, the New York State Department of Health (DOH) and Office for People with Developmental Disabilities (OPWDD) posted for public comment a draft amendment to the 1115 Medicaid Redesign Team (MRT) Waiver that would authorize the transition of individuals with intellectual and/or developmental disabilities (I/DD), and of the OPWDD service system, into managed care over the next seven years. Note that all timeframes discussed below are subject to federal approval.

The draft is available here. Comments will be accepted through August 24th at HHIDD@health.ny.gov. Below is a summary of some important provisions.

SERVICES AND POPULATIONS

Under this amendment, current OPWDD services and populations (both Medicaid-only and dual-eligible) will be incorporated into the 1115 MRT Waiver. This includes I/DD residential services, OPWDD Home and Community-Based Services (HCBS) Waiver services (including the developing Health Home for Individuals with I/DD services), and the Community First Choice Option (CFCO).

I/DD residential services are defined as:

- Intermediate Care Facilities (ICFs) for the I/DD population, including developmental centers, small residential units, and "community" or small model ICFs;
- OPWDD Specialty Hospitals; and
- Other OPWDD-approved non-institutional residential settings, including Individualized Residential Alternatives (IRAs) and Family Care Homes.

Institutional residents will be moved into the MRT Waiver, except for residents of developmental centers, small residential units, and OPWDD Specialty Hospitals. These settings will remain in fee-for-service (FFS) until a later date. Any individuals living in institutional settings, including ICFs, will remain ineligible to receive separate HCBS or Health Home services.

TIMELINE AND PROCESS

The proposed amendment would go into effect in January 2018. The initial phase of the amendment would formally move I/DD populations into various eligibility groups, although this would not entail immediate operational changes to services. In total, 108,000 individuals would be transitioned, of whom about 20,000 are presently in a managed care plan for non-I/DD services.

Health Homes Serving Individuals with I/DD

Starting in July 2018, individuals with I/DD will begin to enroll in I/DD-specific Health Homes, also known as Care Coordination Organizations (HH/CCOs). HH/CCOs will be controlled by providers with experience serving the I/DD population, and will take over and expand the current function of Medicaid Service Coordination (MSC), developing person-centered Life Plans that will serve as the plan of care for individuals with I/DD. The State intends for HH/CCOs eventually either to become I/DD managed care plans or to partner with existing plans to provide care management services.

More information on the HH/CCO program can be found in SPG's recent summary of the draft HH/CCO Request for Applications (RFA).

State Independent Entity

For individuals who opt out of HH/CCOs, a State Independent Entity will handle the care planning and service coordination function. This entity will contract with the Health Home delivery system and will provide similar services (included under HCBS in the waiver, but without an enhanced federal match).

The Entity will also handle various functions for individuals not already enrolled in Medicaid and/or populations like Family of One children deemed eligible for Medicaid with a waiver of parental income, such as conducting HCBS eligibility screening, developing the provisional Life Plan, determining preliminary HCBS eligibility, and making referrals to enrollment brokers and HH/CCOs.

Voluntary Enrollment

Starting in 2019 downstate and 2020 in the rest of the State, individuals with I/DD (both Medicaid-only and dual-eligible) will begin to enroll in provider-led managed care plans called Specialized I/DD Plans (SIPs-PL). SIPs-PL will need to demonstrate experience providing or coordinating I/DD services, based on criteria to be determined by the State at a later date. Early adopter SIPs may begin enrollment in late 2018.

Enrollment in SIPs-PL will be voluntary-only during this period. All individuals who do not choose to enroll in a SIP-PL will remain in FFS.

Mandatory Enrollment

Starting no earlier than in 2021 in the downstate area and in 2022 in the rest of the State, enrollment in a managed care plan will become mandatory for individuals with I/DD. The enrollment mandate will be rolled out regionally, after the State determines that there are a sufficient number and quality of plans in each area to support the needs of people with I/DD.

The State intends to allow individuals with I/DD currently enrolled in mainstream Medicaid managed care (MMC) plans for non-I/DD plans to remain in their current plan, if they so choose. As such, starting in the mandatory enrollment period, existing MMC plans may choose either to offer mainstream Specialized I/DD Plans (SIPs-M) or to amend their existing contracts with I/DD-specific provisions (including a requirement to cover the I/DD HCBS package). The waiver indicates that SIPs-M should be established "to the extent necessary to ensure statewide coverage," and it is therefore unclear whether MMC plans will be able to offer SIPs-M even in regions the State deems adequately served by SIPs-PL.

Dual eligibles will not be able to enroll in MMC plans, and instead will need to join a SIP, whether provider-led or mainstream. However, individuals enrolled in the I/DD Fully Integrated Duals Advantage (FIDA) program will be able to remain in their plan. For their dually eligible members, SIP plans will be responsible for coordinating with Medicare and paying Medicare cost-sharing requirements. Dual eligibles will not be restricted to the plan's network to receive Medicare benefits.

Dual eligibles who are also eligible for both managed long-term care (MLTC) and I/DD HCBS services may choose either to enroll in MLTC or to receive I/DD HCBS, but not both.

Non-Risk Period for Residential Services and HCBS

For no more than two years after the beginning of mandatory enrollment, the cost of I/DD residential services and I/DD HCBS will be passed through on a non-risk basis (i.e., paid at the State Plan rates). Afterwards, I/DD residential services will be moved into the capitation rate, while HCBS will be moved

to some form of risk-bearing value-based payment models (such as risk corridors, performance-based incentives, or full risk); public comment is being solicited in particular on this issue. Also, plans must pay at least the FFS rate for essential State Plan services and providers, such as Article 16 clinics and Independent Practitioner Services for I/DD (IPSIDD).

All other State Plan services will be incorporated into the capitation rate, including CFCO services. If implemented as planned, the non-risk period will end in 2023 downstate, and 2024 in the rest of the State.