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Revised Draft Requirements and Standards for Specialized I/DD Plans

OVERVIEW

On February 12th, the New York State Department of Health (DOH) and Office for People with Developmental Disabilities (OPWDD) released a revised draft document that outlines the requirements and standards for specialized Medicaid managed care (MMC) plans to serve people with intellectual and/or developmental disabilities (I/DD). As outlined in the State's I/DD Waiver Transition Plan, individuals with I/DD will be able to voluntarily enroll statewide in provider-led managed care plans called Specialized I/DD Plans – Provider-Led (SIPs-PL). 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. Organizations seeking to establish a SIP-PL will need to demonstrate experience providing or coordinating health and long-term care (LTC) services for I/DD populations, based on the criteria outlined in this document.

Key revisions to the document from the previous draft released in August 2018 include changes to the:

- Proposed transition timeline;
- Care Management requirements;
- Organizational structure;
- Network requirements; and
- Application process.

Below is a summary of major requirements for SIPs-PL. The full revised draft document is available here. Comments are due to peoplefirstwaiver@opwdd.ny.gov by March 27th. Additional feedback on the revised draft document will be used to better inform the State on how to best implement a transition to managed care.

On February 19th, OPWDD hosted a webinar outlining the content of the document and changes since August 2018. The recording and slides can be accessed here.

OPERATIONAL REQUIREMENTS

Eligible Populations

To be eligible to enroll in a SIP-PL, an individual should be:

- Enrolled in the OPWDD 1915(c) Comprehensive Home and Community-Based Services (HCBS) Waiver;
- Living in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs); or
- Another type of Medicaid-enrolled individual also eligible for OPWDD services.

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Individuals with I/DD who are eligible for Medicaid through a "spend-down" program may enroll in a SIP-PL by offsetting excess income with medical expenses. MMC eligible non-I/DD family members of SIP-PL enrollees may enroll in a comprehensive MMC program also operated by the SIP-PL.

In addition to Medicaid-only beneficiaries, those who are dually eligible for Medicaid and Medicare and those with comprehensive Third-Party Health Insurance (TPHI) will be eligible for SIP-PL enrollment. Voluntary enrollment will start with individuals with Medicaid only, and will subsequently be expanded to include dual eligibles and those with TPHI. Dual eligibles will have the choice of (1) remaining in Medicare fee-for-service (FFS) and enrolling in a SIP-PL that will manage the comprehensive Medicaid benefit, including Medicaid coverage of Medicare co-insurance and OPWDD HCBS, (2) enrolling in a Medicare Advantage plan and separately enrolling in a SIP-PL that will manage Medicaid-only services, including OPWDD HCBS, or (3) enrolling in a specialized product for duals, such as the Fully Integrated Duals Advantage for Individuals with I/DD (FIDA-IDD).

The following populations are **not** eligible to enroll in a SIP-PL:

- Individuals in Developmental Centers or Small Residential Units;
- 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); and
- Individuals otherwise excluded from enrollment in a comprehensive MMC plan, except where specifically identified as eligible for SIP-PL enrollment in this document.

The State estimates that, excluding family members, there are approximately 120,000 individuals eligible to enroll in a SIP-PL, including approximately 28,000 already enrolled in a MMC plan.

Enrollment Processes

Enrollment in SIPs-PL will begin on a voluntary basis statewide, with start dates based on the readiness of SIPs-PL in a given region. Mandatory enrollment will begin no less than one year after the start of voluntary enrollment in a given region, subject to approval from the Centers for Medicare and Medicaid Services (CMS) and a sufficient number of SIPs-PL to ensure member choice.

Prior to mandatory enrollment, individuals enrolled in a MMC plan will have the option of retaining their MMC plan and receiving OPWDD services via Medicaid FFS, or opting to enroll in a SIP-PL. When enrollment in SIPs-PL becomes mandatory, OPWDD benefits may only be accessed through a SIP-PL.

As with other Medicaid plans, enrollment in SIPs-PL will be performed through the State's enrollment broker, New York Medicaid Choice. SIPs-PL may not engage in direct outreach or marketing activities. Passive outreach (such as billboards, posters, and brochures) may be performed according to current rules for Medicaid plans.

Benefit Package

The SIP-PL benefit package will initially consist of:

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- All standard State Plan services in the mainstream MMC benefit, including medical services, behavioral health (BH), LTC supports, and other services;
- All OPWDD-specialized State Plan services, including I/DD community-based ICF services, Day Treatment, Article 16 clinic services[1], and Independent Practitioner Services for Individuals with I/DD (IPSIDD);
- I/DD Health Home Care Management (provided by the SIP-PL directly or through a delegated arrangement with a qualified organization); and
- OPWDD non-residential HCBS.

The OPWDD residential benefit is expected to be carved into the SIP-PL capitated benefit package no less than two years after voluntary enrollment begins, subject to the State's determination that plans are capable of managing the benefit. Savings achieved through the management of residential services must be sufficient to offset any costs associated with the management of this benefit.

Organizational Structure

Majority control of a SIP-PL must be held by not-for-profit organizations with a history of providing and/or coordinating health and LTC services for individuals with I/DD. "Control" is defined in 10 NYCRR Part 98-1.2(j). Experience with coordinating care will be evaluated based on the SIP-PL's leadership's experience with providing Care Management, ICF, and/or HCBS Waiver services to people with I/DD. SIPs-PL may subcontract out services, including the management of the I/DD and/or HCBS benefits, as long as the subcontractor meets SIP-PL requirements.

Each SIP-PL will establish an Advisory Committee that includes self-advocates, family members of people with I/DD, DD service providers, and other stakeholders. Committee members should be representative of the full spectrum of services and geographies. This Committee will advise the SIP-PL on issues relating to the management of physical, behavioral, and I/DD services for their enrollees.

If not enough SIPs-PL exist to provide adequate statewide coverage by the time the State begins to roll out mandatory enrollment in I/DD managed care, existing MMC plans that do not meet the provider-led requirement of a SIP-PL may apply to operate a Specialized I/DD Plan – Mainstream (SIP-M). This document does not describe organizational requirements for SIPs-M.

Required Functions

SIPs-PL should have sufficient staff and resources to provide all MMC functions as well as some functions specific to the I/DD population, including but not limited to:

- Network development and provider contracting;
- Network monitoring;
- Provider relations;
- Credentialing and recredentialing;

[1] The SIP-PL will be required to contract with all Article 16 clinics at the established APG Government Rate, unless the payment is through a shared savings arrangement approved by the State.

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- Clinical and medical management (with I/DD expertise);
- Provision of education and training on I/DD benefits and services;
- Review of care planning, assessments, and eligibility determinations;
- Quality management; and
- Financial oversight.

SIPs-PL must also provide the following:

- A toll-free line to provide information and referrals on I/DD benefits and services, available 365 days a year;
- A live toll-free line for crisis triage, referral, and follow-up available 24 hours a day, 365 days a year; and
- The ability to respond to prior authorization requests for post stabilization services within one hour, 24 hours a day.

Required Personnel

Key executive staff requirements include:

- A Medical Director who is a licensed New York State physician with at least five years of experience with individuals with I/DD in managed care or clinical settings (at least two years in a clinical setting)[2];
- An I/DD Clinical Director who has a New York State clinical license in a behavioral health field and at least seven years of experience in a managed care or I/DD clinical setting (at least two years in managed care and at least five in I/DD clinical settings);
- An I/DD Dental Coordinator licensed to practice dentistry in New York State with at least five years of experience providing dental services to individuals with I/DD;
- For SIPs-PL with over 10,000 enrollees, a BH Medical Director who is a licensed New York State physician with at least five years of experience in managed care or clinical settings (at least two years in a clinical setting);
- For SIPs-PL with over 2,500 enrollees under the age of 21, a Foster Care Liaison meeting requirements laid out in the MMC Children's Transformation Requirements and Standards.

Additionally, each SIP-PL must employ a managerial I/DD Health Home SIP-PL Liaison, responsible for ensuring a coordinated approach between CCOs, individuals, families, and the SIP-PL. More details on requirements for these staff and other necessary managerial and operational staff are listed in Attachment C.

SIPs-PL are responsible for ensuring that staff are adequately trained. Training must encompass the topics listed in Attachment D, which are separated out by staff area (clinical, member services, and provider relations).

[2] If the Medical Director does not meet this requirement, the SIP-PL must identify a second Medical Director who does and allocate at least 0.5 FTE to the second Director position.

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Member Services

SIPs-PL must provide a person-staffed Member Services toll-free phone line to respond to inquiries, conduct triage, make referrals, and follow up with enrollees, from 8am to 6pm, year-round. As noted above, crisis responses must be available 24/7. Call centers may be located outside of New York.

Member Services policies should include the implementation of:

- Authorization requirements for I/DD benefits and services;
- Requirements for prompt responses to individuals and family members, including support for linkages to other OPWDD system resources (not necessarily direct phone linkages); and
- Protocols for assisting and triaging individuals in crisis by contacting a qualified clinician.

Network Requirements

SIPs-PL will be required to meet standard MMC Model Contract network requirements and to contract with providers as needed to accommodate the needs of the I/DD population. SIPs-PL will be required to offer contracts to all OPWDD certified providers in their service area. The State will provide a list of certified OPWDD providers in each region. In the future, the State may also require SIPs-PL to contract with additional providers certified to provide HCBS or State Plan Amendment (SPA) services.

In general, SIPs-PL must ensure access to all benefits included in the package (as listed in Attachment F). In recognition of current provider capacity, SIPs-PL will not need to meet BH network requirements until they have at least 10,000 enrollees. However, for most OPWDD HCBS Waiver services, SIPs-PL will need to have at least two providers per county (in urban counties) or per region (in rural counties). Additionally, SIPs-PL must contract with all OPWDD certified clinics and all intensive behavioral service providers in their service areas.

SIPs-PL must also ensure that their networks are adequate to meet appointment availability standards. Depending on urgency, plans may be required to ensure access for certain services within 24 hours, including OPWDD certified clinics, habilitation services, adaptive devices and assistive technology, environmental modifications, and respite. In general, appointments for most non-urgent services may be arranged between five days and two weeks after the request. Full details are available in the table on pp. 29-30.

Network Monitoring, Credentialing, and Training

SIPs-PL will develop a network plan, to be updated annually, which includes: (1) a data-driven analysis of network adequacy, (2) an explanation of how the plan's network meets its enrollees' needs, and (3) identification of any current gaps in the plan's I/DD network and a work plan to address them.

For providers licensed by OPWDD, the Office of Mental Health (OMH), or the Office of Addiction Services and Supports (OASAS), SIPs-PL should accept their certifications or licenses as sufficient for

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credentialing purposes. SIPs-PL should not separately credential individual employees, staff members, or subcontractors.

SIPs-PL will offer network providers a training curriculum on the I/DD population, including an initial orientation and training, technical assistance on claims processes (e.g., billing, coding, and utilization management), and training on functional assessments and Life Plan development processes.

Care Management

SIPs-PL are responsible for the provision of Care Management for all enrollees and the coordination of Care Management services with the I/DD Health Home services model. The requirements for Care Management services provided to individuals with I/DD will be described in a forthcoming policy document.

However, regardless of whether an individual is currently enrolled in a MMC plan, chooses to enroll in an existing MMC plan, or enrolls in a newly established SIP-PL, Care Management services will be provided by experienced Care Managers who are either directly employed by the SIP-PL, or contracted through a delegated arrangement with a CCO or another qualified entity with the State's approval. For example, the FIDA I/DD model already has Care Management functions in place that meet the specialized, comprehensive service expectations of the I/DD Health Home service model.

Continuity of Care

SIPs-PL must meet continuity of care requirements for OPWDD auspice services. For any such non-residential HCBS Waiver services, SIPs-PL must maintain payment to current providers at existing rates for 90 days. Additionally, the individual's current Life Plan remains in place during their transition and enrollment into a SIP-PL for a minimum of 90 days.

For episodes of care that are in progress at the time of transition to managed care, SIPs-PL must allow individuals to continue treatment with their existing providers (including medical and BH providers) until the end of the episode. This requirement is in place for the first 24 months after enrollment.

When in-network services are not available, SIPs-PL should form Single Case Agreements to ensure that members can receive clinically needed services.

Utilization Management and Appeals

SIPs-PL will use medical necessity criteria guidelines to determine whether services are appropriate for members. If an individual no longer meets the criteria, the SIP-PL should work to identify an alternative service that is appropriate (if needed, in keeping with the individual's Life Plan) and must ensure a successful transition out of the service.

SIPs-PL should have a utilization management committee to develop utilization management protocols for I/DD, medical, BH, LTC, pharmacy, and HCBS benefits, with a subcommittee dedicated to I/DD utilization management. For HCBS, this will include review and approval of the Life Plan.

When a discharge is necessary, SIPs-PL must participate in discharge planning. This will include the creation of a comprehensive plan addressing the availability of community supports appropriate for the

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individual, including educational supports, housing, employment, and other areas. It should also include other activities, such as confirming post-discharge appointments availability and adherence. Note that while an individual may not receive HCBS when in an institutional or other non-HCBS setting, the individual's SIP-PL and Care Manager may collaborate on planning for post-discharge HCBS.

In general, denials, grievances, and appeals of health and BH services must be done by peers as defined in State statute. All service denials for individuals with I/DD must be reviewed by a physician with at least five years' experience with I/DD. Certain specific services also have unique requirements:

- Inpatient psychiatric treatment denials for children under 21 must be reviewed by a physician board certified in child psychiatry.
- Inpatient level of care (LOC) or continuing stay denials for substance use disorder (SUD) treatment must be reviewed by a physician certified in addiction treatment.
- Denials of habilitative services must be reviewed by a licensed professional who is a qualified intellectual disability professional (QIDP) under federal regulations.

Clinical Management

SIPs-PL should encourage the integration of medical, BH, and I/DD care through activities including:

- Providing specialized staff training on comorbidities and under-recognized health problems in the I/DD population;
- Putting policies in place to encourage preventive screening; and
- Developing business rules to encourage coordinated care and sharing of clinical information between providers, Health Homes/CCOs, Development Disability Regional Offices (DDROs), and other involved agencies.

SIPs-PL should also implement a pharmacy management program with specialized policies for I/DD populations, including the creation of drug use guidelines and drug utilization review processes and the monitoring of psychotropic, anti-infective, anticonvulsant, and opioid medications.

SIPs-PL shall track and promote the use of evidence-based practices (EBPs) that are State-selected and nationally recognized. Plans should define expectations for provider utilization of EBP models where appropriate. The State intends to provide additional EBP guidelines in the future.

Quality Management

SIPs-PL should have a quality management committee with an I/DD quality management subcommittee. This subcommittee should include individuals, family members, peer support specialists, and I/DD service providers, and will be responsible for carrying out planned quality activities related to I/DD services and HCBS. These activities should include monitoring the quality, efficiency, and effectiveness of I/DD Health Homes in particular. The SIP-PL's quality management program should ensure that all provider standards are being met on the provider level.

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Performance Measurement

SIPs-PL will be expected to submit standard reports that meet the statewide Quality Assurance Reporting Requirements (QARR) in accordance with the MMC Model Contract. Additionally, each SIP-PL will be required to conduct an internal performance improvement project (PIP) in accordance with federal requirements.

SIPs-PL will also track complaints, grievances, appeals, denials, and critical incidents among the I/DD population they serve. If DOH or OPWDD-licensed providers are found to have deficiencies, or if a provider is removed from the network due to quality concerns, SIPs-PL should report to the State.

SIPs-PL are required to use Council on Quality and Leadership (CQL) certified interviewers to conduct measurements of the CQL Personal Outcome Measures (POMs) on a representative sample of enrollees each year. The aggregated results should be used for continuous quality improvement purposes and reported to OPWDD annually.

Claims Processing and Technology

SIPs-PL must support both paper and electronic submission of claims. As requested, remittance advice must be given to providers in the format they request (paper or electronic). SIPs-PL must also have processes in place that allow providers to electronically submit notification, prior authorization, and other utilization management requests, and to receive status updates on claims.

A SIP-PL must have a website that provides certain functions, including but not limited to:

- Secure access to provider and member portals;
- Web-based training;
- A provider directory, searchable by service types and populations served;
- The SIP-PL Member Handbook and Provider Manual;
- Information on ways for individuals and families to be involved in advocacy and other community efforts (e.g., workgroups, volunteer activities, advocacy organizations); and
- Information on processes for filing grievances, prior authorization requests, appeals, and reporting incidents.

The SIP-PL's information systems must support all reporting requirements outlined earlier in this document. In particular, systems must include the capability to access individuals' Life Plans as notification or authorization for HCBS.

RESERVE REQUIREMENTS

In New York, managed care organizations must meet two reserve requirements: (1) a contingent reserve, which consists of the plan's net worth as calculated using Statutory Accounting Principles; and (2) an escrow deposit, which must be in the form of cash. For SIPs-PL, requirements for each will differ by service line.

- For non-OPWDD and non-health care services, the contingent reserve must be at least 5 percent of net premium revenue, consistent with managed long-term care (MLTC) plans.

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- Escrow deposit requirements will be set at 3 percent of estimated expenditures initially, with the possibility of increasing to 4 percent and 5 percent over the next three years.
- For OPWDD non-residential services, there will be no contingent reserve requirement until those services are at risk.
- For OPWDD residential services, including HCBS and ICFs, there will be no contingent reserve or escrow deposit requirement, because the State directly regulates volume and funding of such services.
- For health care services, both requirements will be set consistent with mainstream MMC plans. The contingent reserve would therefore be 7.25 percent of net premium revenue, while the escrow deposit would be 5 percent of estimated expenditures on these services.

SIP-PL APPLICATION AND READINESS

The SIP-PL qualification document is written for entities who already hold, or have already applied for, an Article 44 license as a managed care organization. If such entities are interested in becoming a SIP-PL, they must complete an application (Pro-forma Template and Instructions available in Attachment J) and submit supporting documentation for joint review by DOH and OPWDD. After application review, DOH and OPWDD will complete on-site reviews (approximately three months after application submissions). The State will also conduct pre-implementation readiness reviews to assess each applicant's capacity to serve individuals with I/DD and comply with all SIP-PL program and contract requirements. Readiness reviews will include, but not be limited to:

- Individual and provider communications;
- Provider network management;
- Program integrity and compliance;
- Provision of Care Management;
- Utilization review;
- Quality and performance improvement;
- Financial management;
- Claims processing;
- Reporting; and
- Encounter data.