NHTD/TBI Waiver Transition Subcommittee Meetings
October 6, 2015, 10:00 am – 5:00 pm

Subcommittee #1: Services and Workforce, 10:00 am – 12:00 pm

Opening remarks by Rebecca Corso, Deputy Director, Division of Long Term Care
- Review the purpose of the workgroup and agenda items for subcommittee

Welcome by Patricia Sheppard, Medicaid Managed Care
- Introduction of Department of Health staff

1. Major concerns identified by the workgroup. Concerns were noted and will be discussed in depth at a later date. Issues outstanding include:
    - Expanding waiver services to plan members beyond current waiver participants
    - Care coordination provided by MLTC/MMC plans vs. service coordination as a waiver service
    - Provider qualifications for services provided by waiver service providers vs. provider qualifications for MLTC/MMC plans
    - Accountability for coordination of services
    - Ensuring continuity of care
    - Maintaining cost neutrality
    - Ability of participants to make informed choices

2. Discussion and review of services crosswalk document
    - The subcommittee recommended that the following services do not transition to MLTC or MMC because there are comparable services already available through the plans or the services were not currently utilized within the waiver programs. These services include:
        - Home Delivered/Congregate Meals
        - Home Visits by Medical Personnel
        - Substance Abuse Counseling
        - Moving Assistance
        - Nutrition/Nutritional Counseling
        - Peer Mentoring
        - Respiratory Therapy
        - Respite Care
        - Wellness Counseling

    - The subcommittee recommended that the essential functional elements of the following services transition into the MLTC/MMC environment:
        - Assistive Technology
        - Case/Care Management:
            a. Subcommittee members raised concern that the definitions for care coordination and service coordination are not the same and do not provide the same service to the participant. Workgroup members and service recipients are encouraged to email the transition mailbox (waivertransition@health.ny.gov) with suggestions for the functional elements of service coordination that should be maintained under a managed care environment.

Karen Thayer will draft a crosswalk of care coordination/case management and service coordination functions.

b. Concerns were discussed regarding the caseload ratio of care coordinators to members under managed care plans. Managed care establishes a weighted case load based on a hierarchy of need. This allows for a larger caseload than currently provided through the waiver programs.
c. Discussion regarding potential conflicts under a managed care environment where the care coordinator is employed by the managed care plan. However, it was noted that the same concerns could be raised in the current waiver programs with service coordination.
d. There is concern that care coordinators will not have the personal contact and first-hand knowledge of the individuals on their caseloads.

- Community Integration Counseling (CIC)
    a. NHTD participants utilizing CIC – 227 (2012-2013)
    b. TBI participants utilizing CIC – 1,174 (2012-2013)
    c. There was discussion regarding current waiver provider qualifications for CIC vs. State Education requirements in managed care. The managed care plans require licensed professionals; waiver services do not.
    d. There was a concern presented regarding the impact the transition will have on the workforce. Staff are concerned they will lose their jobs during the transition and it will be difficult to maintain services during the transition process. NYSDOH responded: The State cannot impose a contract between a waiver provider and a managed care plan. The State can make recommendations to plans, but it cannot require a plan to contract with a provider. State could provide a list of the waiver providers to the managed care plans.
    e. There was also discussion surrounding service setting. Are plans willing to provide home based care?
- Community Transitional Services
    a. The provision of this service is directly related to the definition of the service population, and if service population will include new plan members.
    b. This service may be addressed through the Olmstead Housing Subsidy. There is currently $10,000,000 available, through this initiative.
- Environmental Modifications
    a. Home and vehicle modifications are not currently included under MMC plans; only home modifications included in MLTC. How this service will be included warrants further review.
- Home and Community Support Services proposed to be added as a new service under MLTC and MMC.
- Independent Living Skills Training warrants further review.
- Positive Behavioral Interventions and Support Services
    a. Provider qualifications are an issue. A RRDC representative noted that the training, oversight and implementation by the provider is crucial for this service. Currently, Behavioral Specialists develop

the behavioral health plans. DOH questioned why a licensed social worker or counselor could not provide this service while other subcommittee members pointed out that this is not a one-size fits all service. A managed care plan representative noted that without a licensed professional, the plan would not be able to bill for this service.

b. It was emphasized that home visits are a critical component of the service.

- Structured Day Program
  a. New Federal Home and Community Based Services (HCBS) regulations impose new criteria for the co-location of day program services and may impact the service setting.
  b. It was discussed that this is an essential and cost effective service.
- Social Transportation
  a. It was not determined if social transportation should be included in the benefit package. Further discussion with the Medicaid Transportation Unit is required.
  b. A subcommittee member suggested that transportation providers should have travel training and mobility management training. Another member suggested creating a funding source for the managed care plans to provide transportation.

- Additional concerns were presented regarding the availability of waiver-like services to individuals not previously enrolled in the waiver.
  - DOH noted that there are 115,000 people with Alzheimer's disease currently enrolled in MLTC plans. This population is very similar to the NHTD population.
- A subcommittee member asked NYSDOH if it has considered developing a specialized MLTC plan as an option to provide broader services for high-needs individuals.

3. Discussion regarding continuity of care
   - The transition plan will provide that all services in place for a participant at the time of transition will remain in effect for ninety days or until assessments are completed by the managed care plan, whichever is later.
   - A subcommittee member presented the importance of having an efficient tracking system for services received by participants throughout the transition. This is not agreed upon by all members.

4. Additional comments
   - Both the NHTD and TBI waivers are in temporary extension so there is a need to continue to move the transition process along.
   - It is a goal to have a draft of the transition plan for the workgroup by November 18, 2015.
   - Another subcommittee meeting will be planned before the end of October.

Subcommittee #2: Outreach and Education, 1:00 – 2:30 pm
Public Notification Timeline was presented by Rebecca Corso

- The draft Notification dates were discussed -
  - April 1, 2016 – Official public notice sent out

- April 1, 2016 – May 1, 2016 – 30 day comment period on draft transition plan
    a. Comments will be charted and noted whether they were accepted or not with reasons for this decision included.
- June 30, 2016 – Submit transition plan to CMS
    a. Discussion of whether the final transition plan will be viewed by the workgroup after public comment period and prior to CMS submission. The final transition plan that is submitted to CMS is a public document and will be posted to the DOH website.

Opening remarks by Margaret Willard, Managed Long Term Care

- Introduction of participants in the room and on the phone, review subcommittee agenda

1. Participant Education presented by Margaret Willard
    - What has been done so far in managed long term care: The transition from fee-for-service to MLTC in 2012 was facilitated by Maximus to educate consumers in regard to overall benefits, provider networks, complaint assistance, and provider education.
    - Maximus representative discussed the company's role as an enrollment broker through the transition process:
        - Education has evolved to address the extended needs of the population.
        - Outreach includes face-to-face education in field operations at LDSS and phone support through call centers.
        - Outreach includes presentations to various provider groups.
        - Maximus has a limited role in the fair hearings process.
        - Written notices and materials are in compliance with accessibility standards.
        - Maximus runs focus groups to test materials prior to sending out official letters/notices and welcomes feedback on materials.

    - The process for the Maximus Call Centers was discussed:
        - The call center has multiple language lines and contracts with a translation company.
        - When a call comes in to the call center, an automated message asks the caller to enter their CIN or SSN and zip code. Callers can press "0" to skip the message and reach an operator.
        - 3-way calls are an option for the service recipient, Maximus staff, and a third party if necessary.
        - The calls are scripted for this specific population. Scripts are proprietary and owned by Maximus. Scripts are approved by the Department. The company is open to feedback on how to improve call support. Different scripts may be needed for the transition period and after transition is complete.
        - Outreach calls/follow up assistance calls continue throughout the timeline of the transition.
        - All calls are logged and recorded.

    - NYSDOH trains Maximus to effectively work with specific populations and can bring in subject matter experts. Maximus requires its employees to complete training and also provides written training materials.

- Training usually starts 90 days prior to first notices being sent to participants.
- Maximus staff are also trained to work with parents/guardians/other supports.

- Maximus conducts satisfaction surveys on its services, as well as satisfaction surveys with the managed care plans through phone or face-to-face interviews with plan members at set dates after enrollment/contact. Case numbers are linked to the participant so appropriate follow up can be made.

- Suggestions/requests from subcommittee members to Maximus:
  - Make outreach available in convenient locations for consumers, i.e. Structured Day Programs, hold town meetings, build relationship with RRDCs.
  - NHTD population will need more face-to-face outreach.
  - Stagger outreach calls to participants – i.e., not calling at the same time of day every Monday when a participant may not be home.
  - Be sensitive to the fact that some participants will not be able to call back, Maximus should continue outreach efforts in order to contact participants.
  - Send advance notice to the service coordinators.
  - RRDCs need to be involved in the notification process.
  - Stagger notices by last name (A-M then N-Z) to facilitate oversight by RRDCs.
  - Text messages could be another avenue for contact.

2. Review of Enrollee Rights chart
   - Note that the chart does not list all enrollee rights under MLTC and MMC. A full list can be found in the model contracts of MLTC and MMC, which are available on the DOH website.
   - ICAN will be available to waiver participants during the transition to managed care.
   - NY Medicaid Choice (Maximus) is also a resource not currently available to waiver participants.
   - Both MMC and MLTC have Technical Assistance Centers; the phone numbers and websites were given out.
   - Reminder that regulations require that a provider who is terminating a service has to give notice to the participant and provide a safe transition to a new provider. The change cannot be immediate and the participant is entitled to a fair hearing.

3. Brian Watkins, DOH Technical Assistance Center
   - Technical Assistance Center handles MLTC complaints via phone or email.
   - There are two designated intake staff and calls are triaged immediately.
   - On average, the unit is receiving 350 calls a month and is tracking an average resolution time of five days.
   - The phone number and email address is available on DOH websites and notices.

Subcommittee #3: UAS-NY, 2:30 – 3:30 pm

Scott Jill, Uniform Assessment System-New York (UAS-NY)

1. Review of PowerPoint, NHTD & TBI Waiver Transition Subcommittee: UAS-NY Discussion
    - The UAS was developed by interRAI and New York State where specific items were added. It is a research-based validated tool.
    - The goals of the UAS are to:
        - Evaluate individuals' health status and strengths to develop a plan of care
        - Improve care coordination and facilitate delivery of care
        - Improve communication and avoid redundancy
        - Provide the right care at the right time and at the right place
    - The UAS-NY is divided into three sections
        - Community assessment
            a. 13 domains including, but not limited to, cognitive functioning, psycho-social, mental health, day-to-day functioning, etc.
            b. This assessment may trigger supplemental assessments to be completed, but the assessor can decide to do other assessments regardless of Community Assessment determination
        - Mental Health Supplement
            a. Assesses the individual's experience and involvement with mental health system
        - Functional Supplement
        - Information about individual's performance and regular functioning
    - Assessment outcomes include:
        - Clinical Assessment Protocols (CAPs)
            a. 25 protocols may be triggered for a number of reasons, including:
                1) An individual is identified as having greater than average decline in brain health, or
                2) A person has supports that allows them to have a more independent life, among others.
        - Resource Utilization Group (RUGS)
            a. Used to support billing
        - Nursing Facility Level of Care
            a. 22 items addressed
            b. Scores range from 0 to 48
            c. Scores of 5 or higher meet the Level of Care requirements
        - **NOTE**: the UAS-NY does NOT determine eligibility; rather, it shows level of functioning and provides information for assessors to analyze and make decisions based on the outcomes.
    - UAS-NY Training
        - 4 required courses to use Application (2 hours)
        - 2 required courses on Assessment (between 12-15 hours)
            a. These require in depth understanding of assessment
        - 18 additional recommended courses and numerous references and resources
        - Assessor must be an RN
            a. This was not the case for the prior assessment tool
        - Training courses available online 24/7

- An additional training course was created after receiving feedback for the need for more training/information on assessing cognitive functioning

2. Subcommittee discussion
    - A subcommittee member expressed concern that the assessment is too intrusive and time consuming and that reimbursement does not match the time it takes to complete it.
    - The UAS-NY will be required at the time of enrollment in a plan and at a minimum of every 6 months or after a significant change occurs.
    - Clarification that the UAS-NY does not provide a prescription for service nor is it a gatekeeping tool, but it is an assessment used to support a participant's plan of care.
    - The UAS-NY is not needed for enrollment into Mainstream Medicaid; however, if a person requested, for example, a PCA, then MMC would need to conduct a UAS-NY.
    - Discussion regarding the reliability and validity of the UAS-NY. These questions should be directed to interRAI. Noted that the current tool used for assessments (PRI) is outdated and has not been tested in decades.
    - Discussion regarding the UAS-NY's ability to accurately assess individuals with cognitive deficits. When requested by a subcommittee member, interRAI did not have additional TBI-related tools/information to provide. It was stated that the DOH will not change the tool.
        - A subcommittee member pointed out that some TBI waiver participants who were assessed using the UAS-NY did not meet the minimum score to receive services. It is yet to be determined if this is a result of the accuracy of the tool or that these individuals do not actually need the level of services they are receiving in the waiver program.

      Individuals in MLTC do not require nursing home level of care, but must need 120 days of long term care.

        - There was discussion regarding plans using the tool to "cherry-pick" its members. Response: the UAS-NY has been in operation in the MLTC system. MLTC Plans are using the UAS-NY to assess participants, provide plans for services and compete for members. The capitated payments that plans receive are based on the individual need of the plan member.

    - A subcommittee member who is an RN and conducts assessments stated that there are variables that can have an effect on the outcome of the assessment -
        - The time of day the assessment is conducted with a participant;
        - The client's disposition; and
        - The level of consideration taken by the assessor to complete the assessment and make judgments/explanations as necessary that gives weight to the assessment as to the participant's needs.

Subcommittee #4: Finance and Rates, 3:30 – 4:30 pm

1. Review of PowerPoint presentation, Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Waiver Transition: Managed Care Rate Setting Overview
2. Subcommittee discussion

- Rates have not been finalized for the TBI and NHTD populations as related to managed care. Base rates are determined using two years of previous payment information and this is still being accumulated as the transition is not set to take place until 2017.
- Once established, base rates are updated annually, or as necessary due to program changes (i.e., wage parity or discussions with CMS)
    - Rates are determined by looking at trends in the base data (per region). Base data is reviewed in depth with the plans, DOH and Mercer (actuary).
- A subcommittee member raised the issue that this population has a strong need for a high-need rate cell.
- A discussion followed regarding decisions being made based on money in managed care plans, rather than the choice of the plan member.
    - A managed care plan representative stated that it is the principle of managed care to have high, medium, and low need members enrolled in the plan.
- Concern raised over the managed care plan's ability to handle the intensive needs of the waiver population when there is a crisis; the financial incentives do not align; and high intensity services can skew capitated rates.
    - Managed care plan representative stated that the plans already have individuals in the plan who are high need and have been able to manage crises with their existing staff.
- Per Donna Cater, Rate Setting Unit, base data from the waivers will be reviewed and discussed with the plans and Mercer, high risk needs will be accounted for in this discussion, and program changes will also be taken into consideration.
- Cost containment refers to the whole 1115 waiver; the entire 1115 must remain budget neutral.
- Inquiry of whether the excluded Medicaid caps for OT, PT and speech will carry over in the transition. This will have to be looked at.

Wrap up: 4:30 – 5:00 pm

1. Additional concerns addressed:
    - Concern that there will be a loss of safeguards for participants under managed care plans. NYSDOH stated that the Serious Reportable Incident (SRI) process under managed care is parallel to the process under the waiver programs and, in two instances, additional levels of protection are in place under managed care.
    - Concerns about the tracking of the waiver population and decrease in service that occurs after the transition.
    - Concern about the training for new TBI providers. NYSDOH will make training available, not necessarily mandatory.