NHTD/TBI Waiver Transition: UAS Subcommittee
December 14, 2015, 1:00 pm – 2:30 pm

Welcome and Introduction - David Hoffman, Bureau Director, Bureau of Community Integration and Alzheimer's Disease

- Introduction of meeting attendees, both in-person and phone participants.
- Review of meeting agenda:
    1. Uniform Assessment System (UAS) discussion.

History of Nursing Facility Level of Care (NFLOC) and the UAS-NY - Raina Josberger, Director, Bureau of Quality Measurement of Special populations, Office of Quality and Patient Safety

- Managed Long Term Care (MLTC) Plans were utilizing the DMS-1 and the Semi-Annual Assessment of Members (SAAM) to determine level of care for eligibility. In 2006, the Department was charged with combining these tools. These tools based NFLOC heavily on functional status and incontinence.
- The Department was charged with a similar task in the development of the NFLOC using the UAS-NY Community Assessment in 2010. The UAS-NY team met with the different program areas within the Department to determine the necessary elements of the assessment tool. It was determined that the cognitive aspect of the proposed NFLOC algorithm was weak. As a result, the Cognitive Performance Scale (CPS) and questions related to behavioral issues were incorporated into the NFLOC algorithm.
- IPRO conducted an external quality review of the UAS-NY Community Assessment in three different program areas: MLTC, ALP and TBI. The SAAM and the UAS-NY Community Assessment were compared in a sample of ten members from a MLTC plan. IPRO also reviewed the PRI and the UAS-NY Community Assessment with ten ALP and ten TBI waiver participants through the Long Island Regional Resource Development Center (RRDC). IPRO found that the NFLOC for TBI waiver participants yielded a comparable result between the PRI and UAS-NY Community Assessment. The NFLOC generated from the UAS-NY Community Assessment showed a higher care need. These findings suggested that the NFLOC was sensitive to deficits that were not identified in the other tools such as the PRI.
- In MLTC, federal regulations mandate an individual score at least 5 to be eligible for PACE, MAP and FIDA programs. There were no known instances of individuals who score 5 using the SAAM, but scored below 5 using the UAS.
- Examples of the domains included in the UAS-NY Community Assessment are: Functional Status (i.e., dressing, bathing, toileting, locomotion, etc.), Continence, Mood and Behavior, Communication/Vision (i.e., making self-understood), and Nutritional. The cognitive domain includes items related to memory and decision making.

Workgroup discussion regarding the UAS-NY.

- The Department noted that the UAS-NY team did look at the hierarchy of need and could see that the TBI population was scoring higher on the behavioral and cognitive domains of the assessment as compared to the MLTC population in general.
- A Subcommittee member asked if an individual would qualify for NFLOC if he/she scored high on the cognitive and/or behavioral domains, but not other domains, i.e., ADL/IADL skills. A Subcommittee member stated that high scores on the cognitive plus the behavioral domains seems to trigger a NFLOC score of 5.
- A Subcommittee member asked if there was an accommodation/assessment for individuals who have difficulty with receptive and expressive language. The Department responded that there are questions on the UAS-NY Community Assessment for both expressive and receptive language that include: making self-understood and the ability

to understand others. The Department also encourages others involved in an individual's care to be present at the time of the assessment to assist with these issues.

- A Subcommittee member asked at what point the UAS-NY Community Assessment captures a cognitive deficit. The Department responded there are various aspects of the tool that will pick up on a cognitive deficit; for example, the need for supervision/cueing with ADL and IADLs.
- A Subcommittee member expressed frustration with the implementation of the UAS-NY Community Assessment because appropriate training for assessors was not in place before the tool was launched and the tool itself does not capture many of the cognitive deficits present within the TBI population. It was requested that individuals with a cognitive deficit have a different assessment tool than the UAS-NY Community Assessment.
- A Subcommittee member noted the episodic nature of cognitive and behavioral issues among the TBI population and asked how these needs are addressed/identified in the UAS-NY Community Assessment. The Department noted that episodic behavioral issues are not time limited when reported in the UAS-NY Community Assessment.
- A Subcommittee member expressed concern regarding the interrater reliability of the tool and the assessor's knowledge of an individual's history. The Department suggested validating the assessment using an individual's medical records, but a Subcommittee member noted that this may not be possible given the amount of time allotted for an assessment. It was also noted that interrater reliability through Maximus has been very positive.
- A Subcommittee member noted that the UAS-NY Community Assessment may not be sensitive to individuals who have improved health or behaviors because they are receiving treatment that is working. As a result, these individuals may not be eligible to continue to receive the treatment based on their NFLOC score and be "cut off" from the system.
- A Subcommittee member stated that there is a need for more education for assessors regarding cognitive deficits.
- The UAS-NY Community Assessment is a licensed product from InterRAI that allows for a 5% variance from the InterRAI tool. The tool was modified with experts within the Department. The UAS-NY Community Assessment contains few additions or small changes in language for approximately a 1% variance from the InterRAI tool.
- InterRAI does not produce a report that designates level of care; it produces an assessment tool with validated questions and responses. The Cognitive Performance Scale within the UAS-NY was created by interRAI and is used internationally. The NFLOC generated based on responses to the UAS-NY Community Assessment is based on validated questions. A Subcommittee member asked how many participants currently on the waiver will not meet NFLOC with a UAS-NY Community Assessment. The Department responded that this is not possible to determine, but the intent of the Department is not to have high needs individuals being denied services or not receiving appropriate care.
- A Subcommittee member noted that the education that has been developed and offered through the UAS team to date has been very helpful in improving the skills of the evaluators utilizing the tool.
- A Subcommittee member asked if the RRDCs will still have "override" capabilities regarding the NFLOC generated based on the UAS-NY Community Assessment. The Department presented that the RRDC does not have an eligibility "override" process. The RRDC may provide another assessment or the fair hearing process may overturn the RRDCs denial of services.

- A Subcommittee member questioned the allocation of risk adjustment among the managed care plans after the transition of this population into managed care. The Department noted that this was addressed in the Finance and Rates Subcommittee, but should be discussed again within this subgroup.
- The Department noted that there are informal discussions of adding HCSS to the definition of Community Based Long Term Care (CBLTC) for eligibility into MLTC. This would catch individuals who do not need NFLOC but do have a need for HCSS. However, this has implications for risk adjustment and service utilization that need further research and discussion.
- The Department agreed to make the Fox Report available to the Subcommittee. The report was conducted by an external evaluator to report on the development and testing of a uniform assessment tool.
- A Subcommittee member asked about the ability to track people new to service after the transition for individuals who would have otherwise qualified for waiver services. The Department will keep this item on the agenda but there are additional issues to discuss, including who would have access to this data, why this population/diagnosis would be tracked and not others, and what is the intended use of this information.

The meeting was adjourned at 2:30 pm. The Subcommittee was reminded to continue to send questions, concerns, and ideas to the Department through the transition mailbox at waivertransition@health.ny.gov. The Department intends to have a draft transition plan prepared for the next workgroup meeting on January 27, 2016.