Department of Health | Office of Health Insurance Programs

Traumatic Brain Injury (TBI) Waiver and Nursing Home Transition and Diversion (NHTD) Waiver Transition to Managed Care

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Overview

- The purpose of the transition plan is to provide the Center for Medicare and Medicaid Services (CMS) with information regarding how waiver participants will experience the transition to managed care, including notification of the transition process, how services will be accessed during and after the transition, and more.
- The information being presented is a summary of the draft Transition Plan proposed by the Department of Health (DOH); it has not been approved by CMS. The full draft plan is available at: http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/tbi-nhtd_waiver_trans_ingo.htm.

Background

- The Care Management for All initiative began in SFY 2011-12 with the goal to serve all Medicaid enrollees through managed care in order to improve:

  - Coordination of care,
  - Quality of care, and
  - Patient outcomes across the health care system.

- NHTD and TBI Waivers will be eliminated and participants are scheduled to transition to managed care beginning January 1, 2018, contingent upon CMS approval.

Managed Care Eligibility

- **Managed Long Term Care (MLTC):**
  - Mandatory enrollment for individuals who are dually eligible, 21 years of age or older, and in need of Community-Based Long Term Care (CBLTC) for more than 120 days.
  - CBLTC services include: Home Health Care (CHHA services), Personal Care Services, Adult Day Health Care, and Private Duty Nursing.
- **Medicaid Managed Care (MMC):**
  - Mandatory for individuals who are Medicaid eligible only.

Access to Services

- MLTC and MMC plan benefit packages will be expanded to include all waiver services currently utilized by waiver participants.
- NYS will provide all current 1915(c) waiver services through the managed care benefit package.

Community First Choice Option

Waiver services available through CFCO include:

- Assistive Devices/Technology
- Environmental Modifications
- Social Transportation
- Congregate and/or home-delivered meals
- Supervision and/or cueing
- Moving Assistance
- Community Transitional Services

- Individuals eligible for CFCO:
  1. Are Medicaid eligible under the state plan.
  2. Reside in their own home or in the home of a family member
  3. Require Institutional Level of Care

Enhanced Benefits

Waiver services available as Enhanced Benefits include:

1. Community Integration Counseling
2. Independent Living Skills Training
3. Positive Behavioral Interventions and Support Services
4. Service Coordination
5. Structured Day Programs

Enhanced Benefits

- Individuals who require Community-Based Long Term Care will have the ability to access these Enhanced Benefits.
- Enhanced Benefits will be accessed initially through the Regional Resource Development Centers (RRDC).
- The RRDCs will complete a service assessment and provide a recommendation to the managed care plan for the Enhanced Benefits.

Enrollment into Managed Care

- The RRDCs will assist current participants transition into a managed care plan.
- Existing, dually eligible waiver participants will be granted eligibility for CBLTC and will not be required to go through the Conflict-Free Evaluation and Enrollment Center (CFEEC) prior to enrollment in MLTC.
- All existing waiver participants will be encouraged to select a MLTC/MMC plan in the announcement letter, followed by the 60-day and 30-day mailed notices.
- If a participant does not select a MLTC/MMC plan and is mandated to enroll, New York Medicaid Choice will auto-assign the participant to a MLTC/MMC plan.

Enrollment after Transition

- If a current waiver participant is not subject to mandatory enrollment and does not voluntarily enroll into a managed care plan by April 1, 2018, waiver services will no longer be available through the 1915(c) waivers.
- Individuals seeking services after the transition is effective will follow the existing MLTC/MMC enrollment processes.
  - For potential MLTC members, the process will include an evaluation through the CFEEC using the UAS-NY to determine the need for CBLTC services.
  - DOH is seeking to amend the definition of CBLTC to include Service Coordination as a CBLTC service.

Continuity of Care - Participants

- DOH is proposing that existing waiver participants transitioning to MLTC will be deemed eligible for CBLTC for two years:
  - If the participant is actively participating in services identified in the plan of care; and
  - If the participant continues to receive at least one service on a monthly basis.
- All existing services identified in the participant's service plan at the time of transition will remain in place for six months after the member's enrollment date.
  - After six months, the MLTC/MMC plan will reassess the member for specific service needs.

Continuity of Care - Participants

- Each participant will have a transition plan developed in conjunction with his/her current Service Coordinator and the Care Manager to ensure all services remain in place the first day of enrollment in a plan.
- Current waiver participants will have the choice to maintain his/her existing providers for up to two years, if his/her needs remain the same after the first six months of enrollment and if providers meet the following conditions (listed on the next slide).

Continuity of Care - Providers

- DOH is proposing that providers will be offered a two-year, continuity-of-care period. MCOs will be required to contract with current waiver service providers for a minimum of two years:
  - If the service provider is serving five or more current waiver participants; and
  - As long as the service provider assures that there are appropriately licensed personnel to provide and/or supervise services.
- DOH is proposing a two-year rate guarantee for providers based on the approved rate at the time of the transition.
- Managed care plans will be provided with a list of all approved waiver service providers prior to the transition date.

Initial Plan Assessment

- All new plan enrollees must have a UAS-NY assessment on record prior to plan enrollment.
- MLTC/MMC plans are required to complete a reassessment of plan members at least every six months or when there is a significant change in a member's condition.
- DOH continues to review the UAS-NY as related to cognitive deficits and will consider adjustments to the tool as warranted.
  - Due process and Fair Hearing rights continue to be afforded related to this determination.

Notification and Stakeholder Engagement

- In addition to this webinar for stakeholders upon submission of the transition plan to CMS, there will be a webinar for managed care plans to present on plan requirements.
- New York Medicaid Choice (NYMC) will serve as the State's enrollment broker for MLTC throughout the transition process and will assist with informing plan members about overall plan benefits, provider networks, complaint assistance, and provider education.
- DOH will train NYMC to work with the waiver populations. Training will begin 90 days prior to the first notice distribution.
  - Curriculum and material development will begin in Fall 2016 in conjunction with the transition workgroup.
- The RRDCs will host a provider meeting with all Service Coordination agencies to discuss transition planning for participants.

Plan Readiness

- RRDCs will continue to have a role in the coordination of services after the transition and will serve as technical assistance providers to plans and members.
- DOH will conduct a webinar for MLTC/MMC plans/providers related to the transition, as well as network readiness and provider qualification requirements.
- DOH will review plan networks prior to the transition to ensure that plans are in compliance with readiness requirements.

Network Capacity

- Plans must demonstrate and maintain, to DOH satisfaction, a sufficient and adequate network for delivery of all covered services.
- Plans must have a minimum of two providers that are accepting new members in each county in its service area for each covered service in the benefit package.
- If the network is unable to provide necessary services identified in the contract, the plan must furnish those services outside of the plan's network for as long as the plan is unable to provide them within the network.
- DOH will review plan networks prior to the transition to ensure that plans are in compliance with capacity requirements.

Provider Qualifications

- Plans will be required to implement written policies and procedures for the selection and retention of providers, including a credentialing and re-credentialing policy.
- Plans will ensure individuals providing services are qualified to provide such services.
- Plans will be required to submit an orientation and training plan that ensures all relevant staff receive training including, but not limited to:
  1. Complex care coordination needs of the population
  2. Effective communication strategies for individuals with TBI and cognitive deficits
  3. Assessment and functional needs analysis techniques
  4. Behavioral intervention and outreach/engagement strategies for individuals not actively engaged/participating in their care

Service Planning and Delivery

- Every managed care plan member must have a person-centered plan of care.
- The person-centered plan is developed by the member with assistance of the Care Manager, providers, and individuals chosen by the member.
- The person-centered plan must be consistent with federal HCBS regulations.
- Meetings related to the person-centered plan will be held at a location, date and time convenient to the member and his/her invited participants.
- Interpretation services must be available if needed and care must be provided in a manner consistent with the individual's culture and specific needs.

Appeals and Rights

- MMC/MLTC members have rights and responsibilities pursuant to Article 44 and 49 of the Public Health Law.
- All MMC/MLTC members must be informed of the Plan's grievance and complaint systems.
  - Grievances include any dissatisfaction about care/treatment that does not amount to a change in scope, amount or duration of service.
  - When a Notice of Action is issued, the member has the right to request an Internal Appeal and/or a State Fair Hearing.
  - When a Fair Hearing is requested, members are afforded the right to request Aid Continuing.
  - Members have a right to an independent external appeal by clinical reviewers not employed by the State or the managed care plan.

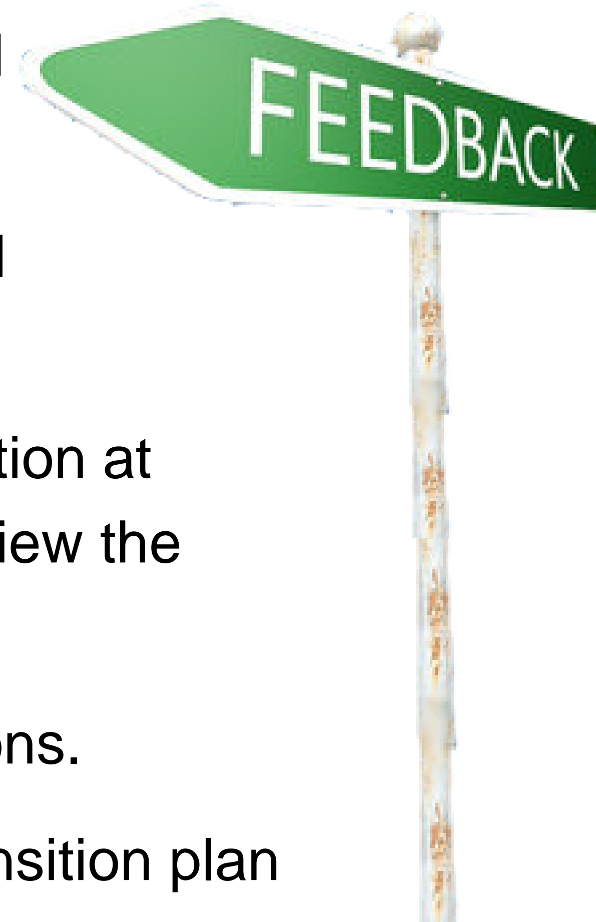
Consumer Support

- Independent Consumer Advocacy Network (ICAN) is a group of nonprofit advocacy organizations that provides assistance to individuals enrolled in or applying for MLTC/MMC services, including:
  1. Consumer advocacy
  2. Consumer information to individuals/caregivers
  3. Outreach about enrollees' rights and responsibilities
- NYMC will continue to be available during and after enrollment in a plan.
- DOH maintains toll-free complaint lines for MLTC and MMC enrollees.
- MMC/MLTC Technical Assistance Centers will handle complaints via phone or email.

Quality Assurance

- Plans must have policies and procedures in place for identifying, addressing and preventing critical incidents, including abuse, neglect and exploitation.
  - Plans must submit a Critical Incident Report and grievance and appeals information to DOH quarterly in a format specified by DOH.
- DOH is committed to track waiver participants at the time of the transition, in order to identify any future nursing home admissions or institutional placements.

Public Notice



- DOH is providing a minimum of a 30-day official public notice and comment period for the transition plan.
- The plan is available via the MRT #90 website. Printed copies will be made available to stakeholders upon request.
- Copies will be distributed to the RRDCs for review and consideration at upcoming provider meetings. Providers will be encouraged to review the content of the plan with service recipients.
- RRDCs and DOH waiver staff will be available to address questions.
- After the public comment period, upon submission of the final transition plan to CMS, DOH will post a summary of public comments online.

Questions

Contact Us:

Comments on the draft Transition Plan should be submitted electronically to:
waivertransition@health.ny.gov

Non-electronic responses may be sent to:
Waiver Transition Home and Community Based Waivers
Bureau of Community Integration and Alzheimer's Disease
New York State Department of Health, Office of Health Insurance Programs
One Commerce Plaza Rm. 1605
Albany, NY 12237

All comments should be submitted by August 24, 2016.

Website: http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/tbi-nhtd_waiver_trans_ingo.htm