NHTD and TBI Waiver Transition Workgroup Meeting
February 19, 2016, 12:00 pm – 2:00 pm
One Commerce Plaza, Room 1613

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

1. Introduction of Jason Helgerson, NYS Medicaid Director
2. Introduction of in-person meeting attendees
3. Review of meeting agenda
    a. NHTD/TBI Waiver Transition Q&A
    b. Provider qualifications for CIC, ILST, PBIS, and SDP providers
    c. Service Coordinator and Care Manager Qualifications
    d. Discussion on Transition Plan draft
    e. Handouts: *NHTD/TBI Waiver Transition Q&A, Crosswalk of Service Provider Qualifications, Crosswalk of Service Coordinator and Care Manager Qualifications*

Review of NHTD/TBI Waiver Transition Q&A - David Hoffman

Q – Will waiver participants have access to the same services they have now?

A – Yes, with the exception of peer mentoring (already available through the Money Follows the Person Transition Centers) and home visits by medical personnel, all services currently available will be available through managed care or existing resources. All other services will be available to all managed care members.

a. Discussion of the definition of Home and Community Support Services (HCSS) and the definition of the service under Community First Choice Option (CFCO). Concern was presented that the word "oversight" is not explicitly stated in the CFCO definition of the service. DOH confirmed that "supervision and cueing" is considered an "oversight."

Q – How will participants access the following services after the transition of the waiver programs?

a. Community Integration Counseling (CIC)
b. Independent Living Skills Training (ILST)
c. Positive Behavioral Intervention and Support Services (PBIS)
d. Structured Day Program (SDP) and
e. Service Coordination (SC)

A – Once eligibility for managed care is established and the participant is enrolled in a plan, they will be referred or can self-refer to the Regional Resource Development Center (RRDC). Plans will be informed of the referral by the RRDC. The RRDC will perform service assessments, and will assist with provider selection for those services. The providers will then make service specific recommendations that will be provided to the Plan Care Manager. This process will apply to Community Integration Counseling, Independent Living Skills Training, Positive Behavioral Intervention and Support Services, Structured Day Programs, and Service Coordination.

a. No questions/comments.

Q – Will participants have the same protections under managed care?

A – Yes, in fact they will have additional protections open to them including Independent Consumer Advocacy Network (ICAN), and administrative reviews. Comparable rights and protections currently afforded to waiver participants will be conveyed to the managed care

system. Discussion of Independent Consumer Advocacy Network (ICAN) as a resource for managed care members. ICAN offers advocacy and ombudsmen services for managed care members. It consists of a network of patient advocacy organizations and can facilitate resolution of issues or complaints within the structure of the managed care plans. ICAN will be an audience for training as the waiver transition proceeds.

a. Suggestion to develop a special unit within ICAN to work with this population if needed.
b. Suggestion to utilize ICAN to track outcomes and develop reports specific to this population.

Q – What about continuity of care?
A – DOH is proposing to establish a two-year continuity-of-care period for participants and service providers.
As a result, Managed Care Organizations will be required to contract with current service providers for a minimum of two years:
a. If the service provider is serving five or more current waiver participants;
b. If the service provider continues to serve participants unless a health/safety concern exists; and
As long as the service provider assures that there are appropriately licensed personnel to provide and/or supervise services;
Current waiver participants will have the choice to maintain his/her existing services and the providers of these services for 90 days;

a. Discussion of what will occur after the two-year continuity of care period for service providers. DOH intends to structure a balanced system so providers and managed care organizations will seek to continue contract with each other after the required two year continuity period. If it is necessary to extend the continuity of care period, DOH would consider an extension at a later date. Provider qualifications are included in the service definitions and DOH does not anticipate changes will be required after the two-year period.
b. Discussion of network capacity requirements. Network capacity requirements will need to be developed for the new services that will be added to the managed care benefit package. DOH welcomes stakeholder input in this process. Network capacity requirements are based on need for the service.
c. Discussion of two-year rate guarantee. Discussion of subcontracting, contracting/billing multiple MCOs, and protections for individual/small providers.
d. Discussion of rate setting. Concern raised over Per Member Per Month (PMPM) capitation rate and the potential incentive for MCOs to limit services for high cost members. Stakeholders asked DOH to consider establishing high risk pools for this population, establishing parameters within contractual requirements with MCOs, or establishing applicable performance metrics to counter the potential incentive.
e. Stakeholder suggested DOH consider developing specialized plans to provide targeted services to this population statewide.

Q – Some participants have housing support as an adjunct to the waiver, what will happen to them?
A – NYSDOH has committed to maintaining the housing subsidy for individuals who are receiving a subsidy at the time of transition subject to appropriation as long as they reside in the community. Additionally, OHIP is developing new housing resources.

a. Clarification that a member who receives a housing subsidy after the transition to managed care and has a stay in an institution for 30-days or less will continue to receive the housing subsidy as is allowed under the waiver programs currently.

Q – In the future, how will eligibility be decided for Community Integration Counseling (CIC), Independent Living Skills Training (ILST), Positive Behavioral Intervention and Support Services (PBIS), Structured Day Program (SDP), and Service Coordination (SC)?
A – Eligibility for the services listed above will continue to be decided based on need presented in the service assessment completed by the RRDC.

a. The assessment tool that will be used by the RRDC to determine need for services (CIC, ILST, PBIS, SDP, and SC) has yet to be defined.

Q – What about eligibility for participants who do not meet the required score for nursing facility level of care on the UAS-NY?
A – There are two parts to this answer. First: there have been a number of concerns expressed about the UAS-NY regarding assessing persons with cognitive impairment. DOH takes these comments very seriously. We are studying the questions thoroughly and if it is found that adjustments to the tool or algorithm are warranted, adjustments will be made. Second: in sampling of completed assessments to date, we found that approximately 28% of current TBI waiver participants and approximately 7% of NHTD participants did not score NFLOC on their first assessment. There are several possible explanations for this. As such, DOH implemented additional mandatory training related to cognitive impairment for all assessors. Additionally, DOH advised that a second assessment may be performed if there is a concern that the assessment outcome did not accurately reflect the needs of the individual.

a. Discussion of the UAS-NY as the assessment tool to determine Nursing Facility Level of Care (NFLOC).
b. Suggestions were presented by stakeholders seeking to improve the assessment outcomes for individuals with a cognitive impairment. They included: (a) utilize a different tool to assess this population; (b) conduct clinical review of medical records and member outreach for members who score below a certain level; (c) provide training for assessors specific to this population; (d) ensure family/caregivers are present at the time of assessment; (e) allow for a second assessment to be conducted; (f) include a narrative in addition to the UAS; and (g) study and review UAS-NY algorithm to determine sensitivity for capturing the needs of individuals with a cognitive impairment.

Q – What about rates for these essential services?
A – DOH is proposing a two year rate guarantee.
a. No discussion.

Q – There is concern about quality and tracking. How will DOH handle that?
A – DOH has a strong quality assurance in place for all managed care organizations. This will continue and we are committed to track current waiver participants in the event anyone is moved to an institutional placement. We take the Olmstead Plan and goals seriously and will continue to work to assure that people can successfully live in communities.

a. Discussion of developing performance metrics specific to this population and institutional placement, in addition to tracking and removing barriers for individuals to return to the community.

Q – What about the qualifications of providers?
A – DOH is committed to availability of high quality services. In order for that to occur we are requiring plans to offer two year contracts with current providers who meet the waiver provider qualifications for the five services (CIC, ILST, PBIS, SDP, and SC) mentioned above.

a. Provider qualifications are included in the service definitions and DOH does not anticipate changes will be required after the two-year continuity of care period.

Q – These populations are vulnerable and have specific characteristics, how will plans know how to address the unique needs of this group?
A – As part of the transition process: an extensive training and outreach program will be developed and implemented:
a. Education will be involved to address the extended needs of the population.
b. Outreach to members will include face-to-face education at the local level and phone support through call centers.
c. The Maximus call center has multiple language lines and contracts with a translation company. Additionally, the RRDCs may assist in participant contact and outreach.
d. Outreach calls/follow-up assistance calls continue throughout the timeline of the transition.
e. DOH will train Maximus, the managed care plans, and providers to effectively work with these specific populations.

DOH has offered to include stakeholders in future discussions related to training content and materials. Additionally, DOH has indicated that the Regional Resource Development Center (RRDC) will continue to have a role in the coordination of services after the transition to managed care. The RRDCs have demonstrated expertise and support when working with the target populations receiving services through the waivers.

a. There is an Outreach and Education subcommittee. When the planning meetings are convened, stakeholders are welcome.

Q – Sometimes the level of need for waiver participants may fluctuate. How can we avoid cycling participants in and out of managed care plans and causing individual and system disruption?
A – DOH is studying the Managed Long Term Care definition of Community Based Long Term Care (requiring more than 120 days of CBLTC for continued eligibility) as related to the transitioning population and is considering an amendment to the definition to include service coordination. This would allow many of those who might otherwise cycle on and off to remain in care.

a. Discussion of eligibility requirements for MLTC enrollment. DOH is considering amending the CBLTC service definition to include service coordination. Other options may also be presented, but will ultimately need the approval of CMS prior to implementation.
b. Current language in the Governor's budget proposes changing MLTC eligibility to NFLOC and the effect on this population.

The next meeting is scheduled for February 24, 2016, 10:00 am – 12:00 pm. DOH will circulate a list of open issues to the workgroup and the crosswalk of participant rights and responsibilities which was shared at a prior meeting. The meeting was adjourned at 2:00 pm.