NEW YORK STATE | Department of Health | Office of Health Insurance Programs

NHTD/TBI Waiver Transition Workgroup

Workgroup Webinar Review of Draft Transition Plan

December 7, 2017

Revised Timeline

- April 2018: Release of Revised Transition Plan for public comment
- June 2018: Submission of Transition Plan to Centers for Medicare and Medicaid Services (CMS)
- July 2018: Submission of the 1115 Waiver Amendment
- September 1, 2018: CMS approval of Transition Plan
- September 1, 2018: Begin training with Plans
- October 1, 2018: Cease enrollment of new waiver providers and expansion of existing providers
- November 1, 2018: Service Plan approval deadline for waiver participants and cease new referrals and intakes
- On or about December 1, 2018: Announcement letters
- January 1, 2019: 60 day notice and voluntary enrollment
- March, 2019: 30 day notice and implementation of mandatory enrollment
- April 1, 2019: Services begin

Services

- The majority of current 1915c waiver services, although the services may not retain the same title, will now be afforded to individuals beyond the scope of the target populations identified in the waiver programs.
- These services include:
  - o Assistive Technology (AT)
  - o Environmental Modifications (E-Mods)
  - o Non-emergency/Social Transportation
  - o Congregate and Home Delivered Meals
  - o Supervision and/or Cueing (HCSS)
  - o Moving Assistance
  - o Community Transitional Services (CTS)

Services Continued

- These services are provided through the Community First Choice Option (CFCO) under the Affordable Care Act (ACA).
- This option allows New York State (NYS) to expand state plan home and community based services and supports to individuals in need of long term care activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health related tasks.
- These services will continue to be provided through the auspices of the 1915c Waivers until transition in April 1, 2019.
- Additionally, Managed Long Term Care (MLTC) and Mainstream Managed Care (MMC) plan benefit packages will be expanded to include all those 1915c Waiver services currently utilized by waiver participants.

Services Continued

- Eligible members who require Community Based Long Term Care will have the ability to access the following enhanced benefits:
  - o Community Integration Counseling (CIC)
  - o Independent Living Skills Training (ILST)
  - o Positive Behavioral Interventions and Support Services (PBIS)
  - o Structured Day Program Services (SDP)
- During the transition planning process there was extensive discussion regarding Service Coordination and how this service may be implemented in a managed care environment.
  - o Primary concern is to offer a service that is conflict free and not duplicative of care management services provided in the managed care model but offers additional discrete services beyond the scope of care management.

Service Coordination

- Service Coordination will be a collaborative service between members and their Care Managers to assist with activities not provided by the Care Manager or cannot be provided with the frequency, duration or intensity offered in the care management model.
- MLTC Care Management must provide for one Case Management telephone contact per member per month and a minimum of one Case Management home visit every 6 months for each member.
- Service Coordination will be responsible to complete one face-to-face visit per member per month and at least one home visit every 6 months.
- Service Coordinators will work with the Managed Care Organization (MCO) Care Manager to ensure services are sufficient to allow the member to remain safely in the community.
- The MCO Contract requires that each plan establish caseload ratios based on acuity and severity of members' physical and mental condition.

Services that will not be added to the managed care benefit package

- Nutritional Counseling/Educational Services
- Respiratory Therapy
- Respite
- Wellness Counseling
- Home Visits by Medical Personnel
- Peer Mentoring
- Substance Abuse Counseling

❖These services will not be added because comparable services are approved under the current 1115 waiver or are available to members through other resources.

The Managed Care Person Centered Service Plan

- All managed care members are required to have a person centered service plan.
- The person centered service plan is a written description in the care management record of the member and is based on the initial assessment or re-assessment of their health care needs.
- The person centered service plan is developed in consultation with the appropriate healthcare professionals, the plan member and their informal supports.
- The person centered service plan must address all health and safety risk factors as well as specific healthcare objectives that include the amount, duration and scope of covered services.
- A comprehensive re-assessment and plan update will be performed as warranted by the member's condition or at least every 6 months.

The Regional Resource Development Center

- The Regional Resource Development Center (RRDC) will continue to have a role in the managed care model.
- The RRDCs will serve as a resource so that the managed care plans and providers have received appropriate training and education related to services and special needs populations.
- The RRDCs will serve as functional assessment and technical assistance centers to members and providers.
- Any plan member seeking the five enhanced benefits must seek the service through the RRDC and in conjunction with their managed care plan.
- The RRDC will complete a services assessment to establish the need for the service, advise the MCO of the assessment outcome and facilitate in-network provider selection.
- The role of the RRDC is to supplement and support the care planning initiated and implemented by the MCO

Contract Amendment Process

- Upon CMS approval, the MLTC and MMC model contracts will be amended.
- The following reflects the steps involved in the contract amendment process:
  - o Service definitions and provider qualifications are established by NYSDOH.
  - o Draft contract language is developed based on above parameters.
  - o Draft contract language is shared with the health plan trade associations.
  - o NYSDOH meets with health plan trade associations to discuss and/or amend draft contract language.
  - o NYSDOH Division of Legal Affairs (DLA) reviews the proposed contract changes and revisions are made as needed.

Contract Amendment Process Continued

- Proposed contract changes are submitted to CMS for review and approval.
- Upon CMS approval, contract amendment documents will be generated by NYSDOH and transmitted to the plans for review and endorsement.
- NYSDOH signs the contract amendments and they are forwarded to the Office of the Attorney General (OAG) for approval.
- OAG forwards the amendments to the Office of the State Comptroller (OSC) for approval.
- Upon approval by OAG and OSC the amendment is sent to CMS for final review and approval.

Transition of NHTD/TBI waiver participants

- The RRDCs will assist participants in transitioning to managed care.
- Waiver participants effective January 1, 2019, will be deemed eligible for Community Based Long Term Care services and will not be required to go to the Conflict Free Evaluation and Enrollment Center (CFEEC) prior to enrollment.
- Waiver participants will be encouraged to select a MLTC/MMC plan through an announcement letter followed by 60 day and 30 day notices.
- For those who are mandated to enroll, who do not select a plan, the State's contracted enrollment broker, New York Medicaid Choice (NYMC), will auto-assign the participant into a plan offering a MLTC/MMC product operating in the participant's county of fiscal responsibility.
- Each 1915c waiver participant will have a transition plan developed in conjunction with their current service coordinator and their MCO Care Manager to ensure that all services remain in place.

Transition of NHTD/TBI waiver participants continued

- Any waiver participant transitioning to MLTC will be deemed eligible for Community Based Long Term care for 2 years as long as the member actively participates in services identified in the person centered service plan.
- Once enrolled in managed care, the member must receive at least 1 service monthly in order to maintain eligibility for Community Based Long Term Care.
- Waiver participants effective January 1, 2019, are ensured continuity of care.
    - o All services in place at the time of transition will continue for the first 6 months of the transition to managed care or upon reassessment by the plan.
- Individuals not enrolled in the waiver at the time of transition who are seeking services will follow the existing MLTC/MMC enrollment processes.
- Each managed care plan member is assigned a care manager who will discuss services with the member and will assist in the development of the person centered service plan.

Transition of NHTD/TBI waiver providers

- NYSDOH is proposing to establish a 2 year continuity of care period for participants and service providers.
- MCOs will be required to contract with current waiver service providers for a minimum of 2 years if:
  - The service provider is serving 5 or more waiver participants
  - The provision of service does not present a health or safety concern
  - The service provider assures that appropriately licensed personnel are available to provide services
- Additionally, the NYSDOH has proposed a 2 year rate guarantee based on the approved rates at the time of transition.
- Managed care plans must continue to meet network access and adequacy requirements as established in their contracts.
- Services provided during the 6 month transition period will be accessed through Fee for Service.

Transition of NHTD/TBI waiver providers continued

- Provider credentialing establishes that the state must ensure each MCO implements written policies and procedures for selection and retention of providers.
- These policies and procedures must include a uniform credentialing and re-credentialing policy.
- Managed care plans are required to ensure that any contracted provider not employ or contract with any employee subcontractor or agent that has been debarred or suspended by the Federal or State government or excluded from participation in the Medicaid/Medicare programs.

Transition of NHTD/TBI waiver providers continued

- Plans are required to submit an orientation and training plan that ensures all relevant staff receive training in:
  - o Care coordination needs of the population
  - o Interdisciplinary approaches
  - o Effective communication
  - o Assessment and functional needs analysis
  - o Behavior intervention
  - o Person centered planning

Appeals and Rights

- MCO member handbooks and notices include, but are not limited to:
  - o Enrollment and disenrollment procedures
  - o Plan options and benefits
  - o Member choice
  - o Participation in activities
  - o Grievance processes
- Plan members have the same protections under managed care as those currently available under waiver programs, such as:
  - Protections afforded through Independent Consumer Advocacy Network (ICAN)
  - Administrative reviews
  - Grievances

Appeals and Rights Continued

- All MLTC/MMC enrollees must be informed of the plan's grievance and complaint systems, this information is available in the member handbook and through discussion with the Care Manager.
- The model contracts contain a full list of member rights and is available on the NYSDOH website.
- For a reduction/termination/suspension of service within the authorized plan period, the MLTC/MMC plan will issue a Notice of Action giving the person the right to request an internal appeal as well as a state Fair Hearing which affords the member Aid Continuing.

Member/Waiver Participant Support

- The plans and the RRDCs will provide consumer education and information for individuals and their caregivers. This includes, but is not limited to:
  - o Outreach to individuals and their caregivers to provide education on rights and responsibilities
  - o Consumer advocacy
  - o Training for staff, family and caregivers
  - o Technical assistance
  - o Complaint lines
  - o Call centers
  - o Community resource information referral

Quality Assurance (QA)

- Managed care plans must have policies and procedures for identifying, addressing and preventing critical incidents which include abuse, neglect and exploitation of members.
- Each managed care plan must have a QA and improvement program.
  - The plan includes goals and objectives that provide a framework for QA and improvement activities, evaluation and corrective action.
- Plans that do not meet certain thresholds will not receive quality payments.
- The plans must submit critical incident reports to NYSDOH pursuant to the terms of their contract.
- There are surveillance programs to ensure the plans remain in compliance with state and federal laws and regulations.

Home and Community Based Services (HCBS) Final Rule

- On January 16, 2014, CMS published the final rule related to HCBS settings for Medicaid funded long term services and supports provided in residential and non-residential settings.
- The final rule implements a number of changes to home and community based waivers and imposes new requirements on what is considered an appropriate home and community based setting.
- The rule establishes person centered requirements that identify the strengths, preferences and needs as well as the desired outcome of the individual.

Home and Community Based Services (HCBS) Final Rule Continued

- CMS requirements for HCBS settings establish community based services be delivered in settings that meet defined criteria.
- Settings that do not qualify as “home and community based settings” per federal regulation include:
  - o A nursing facility
  - o An institution for mental diseases
  - o An intermediate care facility for individuals with intellectual disabilities
  - o A hospital
  - o Any other settings that have the qualities of an institutional setting

Home and Community Based Services (HCBS) Final Rule Continued

- Settings presumed to have the qualities of an institutional setting, unless documented otherwise, includes:
  - o Any setting located in a building that is also publicly or privately operated that provides inpatient institutional treatment
  - o Any setting located in a building on the grounds of, or immediately adjacent to, a public institution
  - o Any other setting having the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals

Next Steps

- Training sessions will be developed for three target audiences:
  - Participants and Family members
  - Providers: Provision of services in a managed care environment e.g. contracting and access to services
  - Plans/Entities that work with the plans: managed care plans (MLTC/MMC), Maximus, ICAN etc.
- Materials will include letters, fact sheets and flowcharts available in both electronic and paper products.
- Identify provider capacity and develop links between providers and plans.
- Establish rates
- Update the transition plan document and timeline.

Useful Links

- Managed Care Organization (MCO) Plans by County: https://www.health.ny.gov/health_care/managed_care/plans/mcp_dir_by_cnty.htm
- Managed Long Term Care (MLTC) Plans by County: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/plan_directory/index.htm
- Fully Integrated Duals Advantage (FIDA) Demonstration Plans: https://www.health.ny.gov/health_care/medicaid/redesign/fida_plans_by_region.htm

Contact Us:

Transition questions:

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