Department of Health | Office of Health Insurance Programs

# Nursing Home Transition and Diversion (NHTD)

# Traumatic Brain Injury (TBI)

# 1915(c) Waiver Transition to Managed Care Stakeholder Workgroup

April 11, 2018

# Agenda

| | |
|---|---|
| 10:00 am – 10:15 am | Welcome and Introduction<br>*David Hoffman, D.P.S., C.C.E.*<br>*Director, Bureau of Community Integration and Alzheimer's Disease* |
| 10:15 am – 11:15 am | Waiver Announcements/Updates<br>*David Hoffman, D.P.S., C.C.E.*<br>*Maribeth Gnozzio*<br>*Bureau of Community Integration and Alzheimer's Disease* |
| 11:15 am – 11:30 am | Break |
| 11:30 am – 12:30 pm | Waiver Updates, Continued |

# Agenda, Continued

| | |
|---|---|
| 12:30 pm – 1:00 pm | HCBS Final Rule, Settings Update<br>*Mark Kissinger, Special Advisor to the Commissioner of Health*<br>*Office of Primary Care and Health Systems Management* |
| 1:00 pm – 1:45 pm | Lunch |
| 1:45 pm – 2:30 pm | Waiver Updates, Continued<br>-- Conflict of Interest and Compliance Implementation<br>-- UAS Update<br>-- Level of Care Alternate Route |
| 2:30 pm – 3:00 pm | Wrap up |

# Updates

- The Office of Health Insurance Programs has a new Medicaid Director.
- The Request for Proposals for the TBI and NHTD Housing Subsidy Program Payment Agent will be posted soon.
- Shortly thereafter, the Request for Applications for the Regional Resource Development Centers will be posted.
- Both the Housing and RRDC current contracts will continue under extension until the procurement process is completed.
- Money Follows the Person Request for Proposals for Person-Centered Care Training.

# Money Follows the Person (MFP)

# What is Money Follows the Person?

- A federal demonstration established under the Deficit Reduction Act of 2005 and extended through the Affordable Care Act.
- Supports:
  - Participant transitions from facilities to the community
  - Enhanced funding for rebalancing activities
- Funds *Open Doors,* a transition assistance program administered through NYAIL to facilitate successful transitions to participants' community of choice.

# What is *Open Doors?*

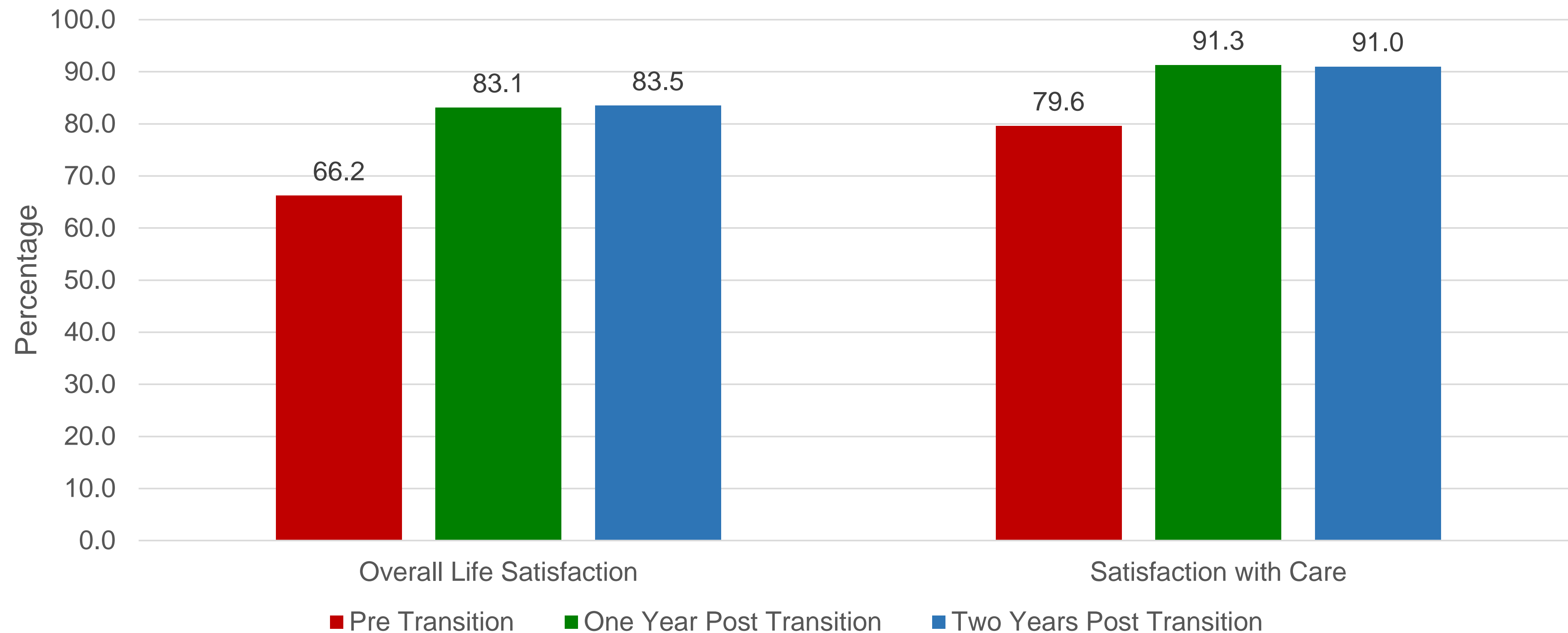
## Transition Centers:

- Regional Transition Specialists meet with the individual, family, and/or guardian in the facility to provide objective information on community services and supports
- Work with Discharge Planners, Service Coordinators, and Care Managers to develop a transition plan that meets the resident's needs
- Provide Community Preparedness Education
- Resolve individual barriers to transition, e.g., housing, security deposits, essential household items, and links to Assistive Technology through TRAID Centers

## Peer Outreach and Referral Program:

- Provides outreach to participants in nursing facilities and one-on-one peer support to individuals and families interested in transitioning to community living

# Improvements in Quality of Life




Source: Mathematica's analysis of MFP Quality-of-Life surveys and program participation data submitted to CMS through May 2016.

# Public Health Live on MFP

View the webcast to learn:

- The purpose of the *Money Follows the Person* demonstration
- Principles of the Olmstead decision
- Ways that a transition specialist or peer can help individuals return to their communities of choice
- Steps to take when an individual expresses an interest to return to community living from an institution

**The *Money Follows the Person* Program:**

**Facilitating Return to Community-based Settings**

**Webcast Recorded on: Thursday, February 16th, 2017**

**http://www.albany.edu/sph/cphce/phl_0217.shtml**

# Referral to Open Doors

## To Make a Referral:

- Call NYAIL/Open Doors at: 1-844-545-7108
- Access referral form at: http://www.ilny.org/programs/mfp/transition-center
- Fax: 518-465-4625
- Email: secq@ilny.org

## For More Information:

- http://ilny.org/programs/mfp
- https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm
- https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html

# Contact Us

Money Follows the Person
Division of Long Term Care
New York State Department of Health

- Andrea Juris, Project Director
- Stacey Agnello, Program Advisor
- Karen Smith, Program Coordinator

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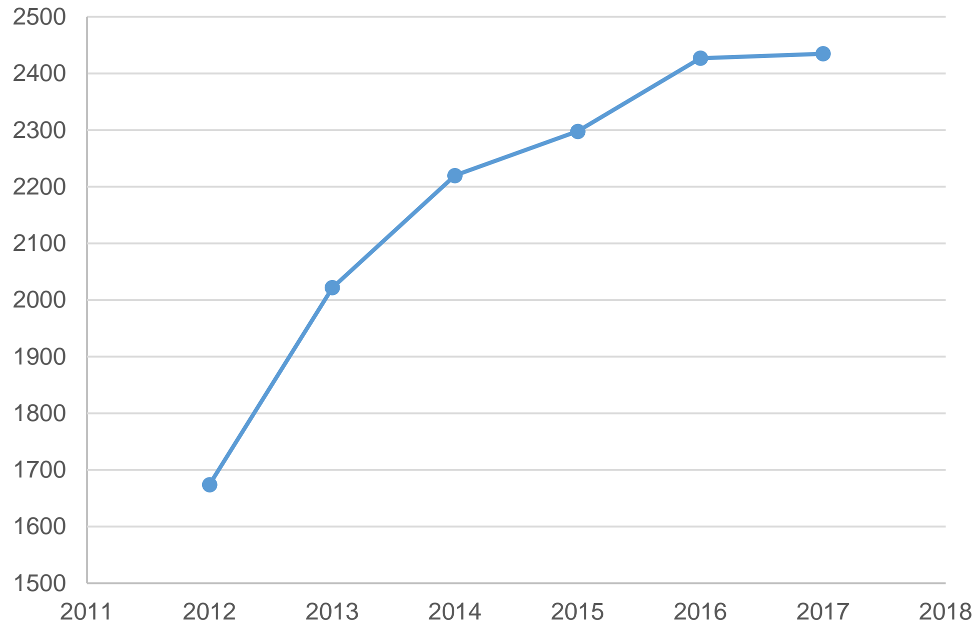
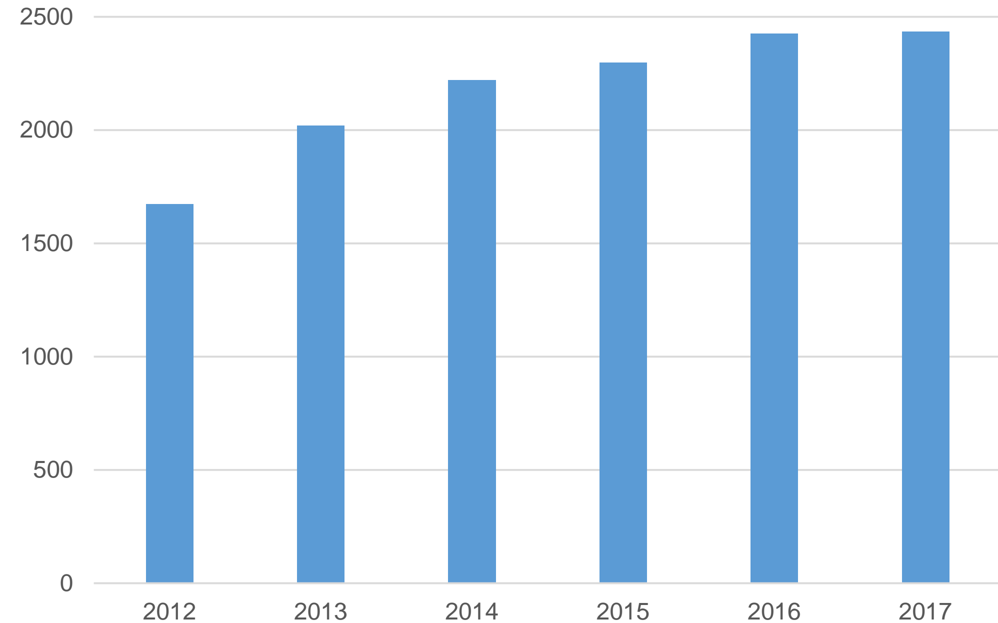
(518) 486-6562

# NHTD Program Statistics

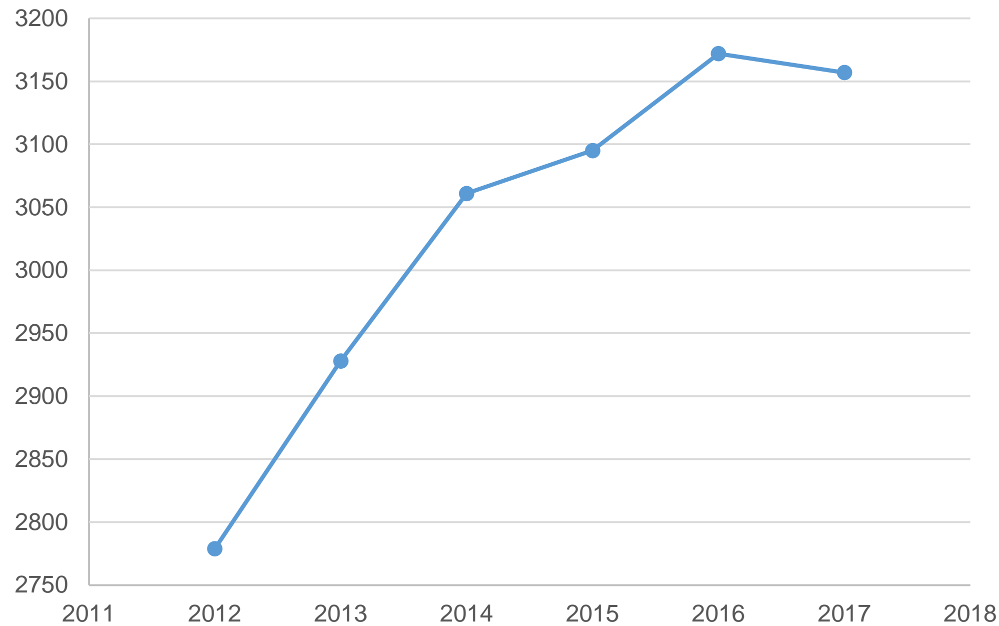


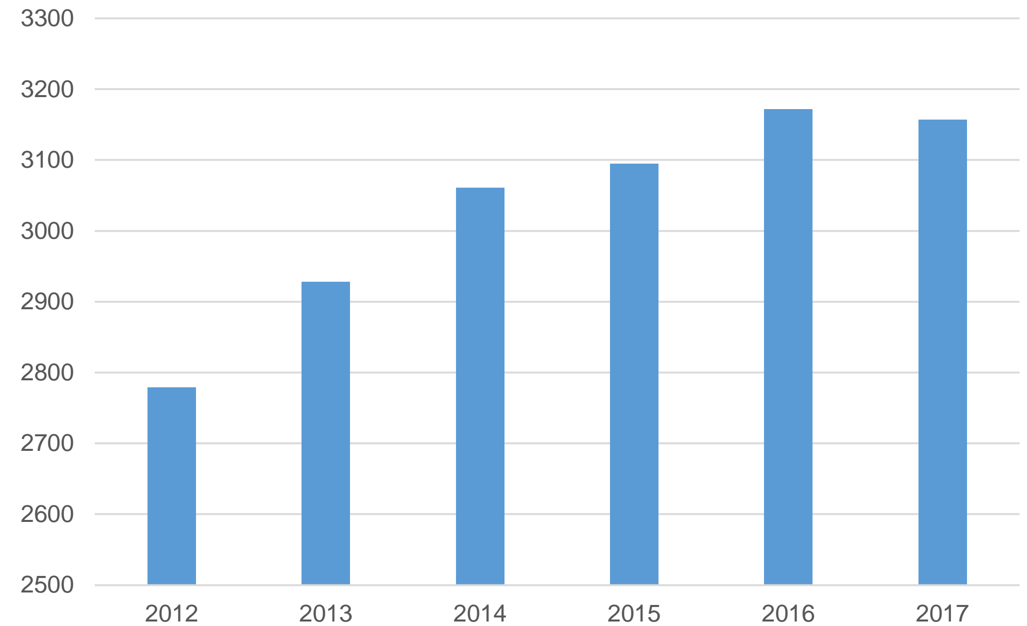




| Total Enrollment | | | | | |
|---|---|---|---|---|---|
| 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| 1674 | 2022 | 2220 | 2298 | 2427 | 2435 |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# TBI Program Statistics




| Total Enrollment | | | | | |
|---|---|---|---|---|---|
| 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| 2779 | 2928 | 3061 | 3095 | 3172 | 3157 |

NEW YORK STATE OF OPPORTUNITY. Department of Health

# 1915(c) Waiver Transition to Managed Care

- In keeping with the goal of Managed Care for All, the Division of Long Term Care began planning for the transition in 2014.
- The goal was to add recipients of 1915(c) home and community-based services provided through the NHTD and TBI waiver programs to the 1115 Partnership Plan Waiver, effective January 1, 2016.
- Subsequent budget language has changed the transition date multiple times over the years.

# 1915(c) Waiver Transition to Managed Care

Which brings us to today. The FY 2018-19 enacted budget establishes a new date that the NHTD and TBI 1915(c) waivers will transition to managed care as follows:

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§ 10. Paragraph (d-2) of subdivision 3 of section 364-j of the  social
  45  services  law,  as  added by section 20-a of part B of chapter 59 of the
  46  laws of 2016, is amended to read as follows:
  47    (d-2) Services provided  pursuant  to  waivers,  granted  pursuant  to
  48  subsection  (c)  of  section 1915 of the federal social security act, to
  49  persons suffering from traumatic brain injuries or qualifying for  nurs-
  50  ing  home  diversion  and  transition services, shall not be provided to
  51  medical assistance recipients through managed  care  programs  until  at
  52  least January first, two thousand [eighteen] twenty-two.
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# 1915(c) Waiver Transition to Managed Care

- At this point, DOH will focus on Waiver Implementation and Quality, including linkages with primary care.
- At a point when this shifts back to transition, the Department will continue to actively engage all stakeholders in the transition process.
- We anticipate that, going forward, stakeholder meetings will occur twice a year. Stakeholder feedback and engagement will continue to be an important part of the process.
- Future meetings will serve to provide program updates related to the NHTD, TBI 1915(c) waiver programs and the Money Follows the Person (MFP) demonstration.

# 1915(c) Waiver Transition to Managed Care

- NYSDOH mailboxes will remain active to receive participant and stakeholder comments:
    - nhtdwaiver@health.ny.gov
    - tbi@health.ny.gov
    - waivertransition@health.ny.gov
    - mfp@health.ny.gov

# Updates, Continued

NHTD and TBI Participant Complaints:

- Complaints cover all topics of the TBI waiver program including freedom of choice, waiver services, service providers and complaints regarding the Regional Resource Development Center (RRDC).

- NYSDOH waiver staff continue to receive complaints daily. This information may be conveyed to the RRDC. If the complaint is related to the action or operation of the RRDC, NYSDOH will initiate the review/investigation of the matter.

# Updates, Continued

NHTD and TBI Complaint Protocols:

- All NHTD and TBI waiver participants are advised of the NHTD and TBI waiver complaint line specific to each region, as well as the NYSDOH line.
  - Historically, waiver participants were given protocols explaining the waiver complaint line at application.
- Participants are free to submit their confidential complaint via multiple methods, including:
  - Phone,
  - Email,
  - Letter,
  - Text, or
  - In-Person.

# Updates, Continued

NHTD and TBI Participant Complaints:

- Recently, NYSDOH waiver staff completed a survey of RRDC complaint lines.
- The purpose of the survey was to confirm availability of alternate communication methods in order to file a complaint. The majority of RRDCs now use more current technology than a TTY/RTT. Real time phone applications, text messaging, email and video relay are the most common resources. As such, the complaint protocols and contact information have been updated and will be posted within the near future on the NYSDOH website.
- Additionally, participants will be receiving a notice explaining the complaint process. The notice will be provided to applicants/participants at the time of application and on an annual basis in conjunction with his/her annual service plan.

# Nursing Home Transition and Diversion Waiver

- The 1915(c) waiver application was formally submitted to CMS on December 29, 2017.
- The draft application was posted for public comment on November 3, 2017.
- A limited number of comments were received. The application and the public comment response is posted on the MRT#90 website at:

  https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/docs/2017_1915c_nursinghomeapp.pdf
- NYSDOH waiver staff continue to work with CMS to resolve any outstanding questions through the Request for Additional Information (RAI) process. At this point in time, outstanding program issues are resolved. The majority of the content of the application will be consistent with the language in the TBI application.
- The current application will continue to operate under **temporary extension until July 16, 2018.**

# Home and Community-Based Services (HCBS) Final Rule Update

- HCBS Final Rule Overview
- HCBS Final Rule & Person-Centered Planning
- Assessing for Compliance With the HCBS Final Rule
- Understanding Heightened Scrutiny
- HCBS Rule Implementation Update
- Questions and Answers

# HCBS FINAL RULE OVERVIEW

# Background on the HCBS Final Rule

- The HCBS Final Rule, a federal regulation effective March 17, 2014, set new standards to promote community involvement and independence for people who receive Medicaid-funded home and community-based services (HCBS).
- These federal standards apply to all HCBS provided through NY's 1915(c) waivers, Community First Choice Option, Managed Care and Managed Long Term Care because of the 1115 Waiver.
- The rule also set new person-centered planning and conflict of interest requirements.

# Home and Community-Based Services Defined

Per CFR 440.180(b) "Home and Community Based Waiver Services" include:

1. Case management services
2. Homemaker services
3. Home health aid services
4. Personal care services
5. Adult day health services
6. Habilitation services
7. Respite care services
8. Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services for individuals with chronic mental illness, subject to conditions specified in CFR 440.180(b)(8)(d)
9. Other services – requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization

# HCBS Setting Examples

Residential

- Group Homes
- Scatter Site Apartments
- Adult Care Facilities – Adult Homes

Non-Residential

- Adult Day Health Care
- Social Adult Day Care
- Day Habilitation
- Sheltered Employment Workshops

# New York's HCBS - Agencies and Offices

State agencies/offices that oversee HCBS and are part of NY's Statewide Transition Plan (STP) to come into compliance with the final rule are:

- New York State Department of Health (DOH)
  - AIDS Institute
  - Office of Health Insurance Programs (OHIP) - DLTC and DHPCO
  - Office of Primary Care and Health Systems Management (OPCHSM)
- Office for People With Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office of Children and Family Services (OCFS)

# HCBS Final Rule "Settings Standards"

- Below are the final rule's *standards for all settings* where HCBS are provided *and* where people receiving HCBS live, which must:
    - be integrated in and support full access to the greater community
    - be selected from among options by the individual (or their representative)
    - ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
    - optimize autonomy and independence in making life choices
    - facilitate true choices and options for an individual's services and who provides them

# Settings Presumed Compliant With the Final Rule

- CMS assumes that an individual's home, or the home of a family member, is compliant with the HCBS rule
- Most people in NY who receive HCBS live in such settings, presumed to be compliant
- CMS is requiring states to develop a process to ensure that people living in such settings are afforded the HCBS standards that apply to all settings *(see previous slide)*

# Key Dates

- The HCBS Final Rule took effect:
  - March 17, 2014 for 1915(c) waivers (TBI, NHTD, CAH, etc.),
  - July 6, 2012 for 1915(k) (CFCO) programs, and
  - December 4, 2014 for the 1115 Demonstration (Managed Care and Managed Long Term Care).
- The Transition Period to achieve full compliance with the HCBS Final Rule is March 17, 2022, which applies to:
  - The settings standards for 1915 (c), 1915 (k), and 1115 Demonstration
  - Making any modifications to, or restrictions of, a persons rights given by the Final Rule's *additional standards*, on case-by-case basis within individual Person-Centered Plans

# HCBS FINAL RULE & PERSON-CENTERED PLANNING

# HCBS Rule Person-Centered Plan Requirements

The HCBS Final Rule established many new standards in regards to Person-Centered Planning (PCP) such as requiring:

- A person-centered service plan for every person who receives Medicaid-funded HCBS – *42 CFR 441.301(c)(1)*
- A significantly enhanced version of PCP, most conditions of which are required as of the rule's March, 2014 effective date

*The Person-Centered Plan requirements are included in Section 2402(a) of the Affordable Care Act*

# Person-Centered Plan Requirements

Person-Centered Plans must identify individuals:

- Strengths
- Preferences
- Needs (clinical and support)
- Desired outcomes

# Person-Centered Plan Requirements – Cont'd

Person-Centered Plans must also:

- Assist the person in achieving outcomes they define for themselves in the most integrated community settings they desire
- Be developed through a process where individuals get the right information and support so that they can direct the process as much as possible
- Document the individual's choice of services and supports they receive, and from whom
- Document settings options provided that are not specifically designed for people with disabilities

# Person-Centered Plan Requirements - Cont'd

Person-Centered Plans must also:

- Include people in the planning meeting that are chosen by the person served
- Be updated at least once a year at times and locations convenient to the individual
- Take into consideration the person's culture and background
- Use non-technical or plain language, adjusting language as needed
- Include strategies for solving disagreement(s) and managing risk factors
- Provide a method for the individual to request updates

# Allowable Modifications in Person-Centered Plans

In Provider-Owned and Controlled settings, where the HCBS provider owns the individual’s residential service, there are times when supporting the individual may require modifications of the *additional standards* of the HCBS rule, which is allowed.

These additional standards, which mostly apply to *residential* settings, are:

- Individuals in residential units have legally enforceable agreements giving them the same protections and responsibilities as any tenant living in that jurisdiction
- Privacy in sleeping or living unit
- Units have lockable entrance doors
- The individual served and appropriate staff have keys/codes to doors
- There is a choice of roommates in shared units
- Freedom to furnish and decorate sleeping or living units
- Freedom and support to control one’s own schedule and activities
- Access to food and visitors at any time

# Allowable Modifications in Person-Centered Plans - Cont’d

Modifications, aka “rights restrictions,” to any of the additional standards on the previous slide, cannot be made on an entire setting. They must be made on a *case-by-case basis,* and be:

- Supported by a specific assessed need; and
- Justified in the person-centered service plan.

**States have until March 2022** to comply with making modifications to the additional provisions within person-centered plans.

# Modifications to Additional Standards

Modifications to the additional standards must be documented in the person-centered plan and include the following:

- A specific and individualized need
- Positive interventions and supports used prior to any modifications
- Less intrusive methods of meeting the need that were tried and did not work
- Clear description of the condition that is directly proportionate to the specified need

# Modifications to Additional Standards - Cont'd

Modifications to the additional standards must be done in the person-centered plan and document the following:

- Regular collection and review of data measuring the ongoing effectiveness of the intervention(s) used
- Established time limits for periodic reviews to determine if the modification is still necessary (at 3 months, 6 months, etc.)
- Informed consent of the individual being supported
- Assurance that interventions and supports will cause no harm

# ASSESSING FOR COMPLIANCE WITH THE HCBS FINAL RULE

# Two Types of Assessment Required to Determine HCBS Compliance before March, 2022:

**Systemic Assessment**

- CMS requires states to assess their existing standards, rules, regulations, policies, etc., related to HCBS
- States must remove any systemic barriers to meeting the rule, providing remediation plans when the settings standards are not present and when there are rules in place that are in direct conflict with the HCBS Rule
- Eight Systemic Compliance Charts within New York's STP contain our state's most recent systemic review

**Site-Level Assessment**

To decide whether a states settings where HCBS is provided and where individuals live are in compliance with the rule, states may use:

- Licensing reviews, provider qualification reviews
- Site visits preformed by state personnel, case managers who are not affiliated with the HCBS provider, or Managed Care Organizations (MCOs)
- A statistically significant sample of site visits of HCBS settings to determine compliance now and going forward

# New York's HCBS Site-Level Assessment

The eight State agencies and offices that oversee Medicaid HCBS in New York each:

- Have their own existing surveillance and monitoring processes in place to assess for compliance with various State and Federal rules and policies
- Are building site-level assessment of HCBS compliance into their systems to achieve compliance by 2022 and monitor compliance going forward
- Are using a CMS approved process of assessing for compliance of the settings they oversee/license, such as
  - site visits to a statistically significant sample of settings, or
  - site visits to all their settings, or
  - provider self-surveys/attestations, with validation of a statistically significant sample of settings.

# UNDERSTANDING HEIGHTENED SCRUTINY

# What is Heightened Scrutiny?

- It's a more intensive form of HCBS site-assessment required by CMS
- Settings with certain characteristics are presumed institutional by CMS
- State must submit evidence on those settings if it wants to receive Federal Financial Participation (FFP) for those settings past the 2022 deadline
- Evidence for each setting is required to go through a public comment period

# Settings Subject to Heightened Scrutiny

The HCBS Rule describes three types of settings CMS presumes to be institutional, and therefore subject to heightened scrutiny:

- Settings in a public/privately operated facility providing inpatient institutional treatment (i.e., nursing facility, ICD/IID, IMD, or hospital)
- Settings in a building on the grounds of, or adjacent to, a public institution
- Settings having the effect of isolating individuals receiving Medicaid HCBS from the broader community:
  - Designed specifically for individuals with disabilities, or a specific type of disability
  - Serving primarily/exclusively individuals with disabilities
  - Where individuals have limited-or-no interaction with those not receiving HCBS

# New York's Approach to Heightened Scrutiny

- The Department of Health is working in collaboration with agencies and offices overseeing HCBS to:
  - Develop a coordinated, consistent, and efficient approach to heightened scrutiny
  - Ensure that HCBS recipients' privacy is protected as much as possible throughout the heightened scrutiny process
  - Ensure individuals receiving HCBS are living and receiving services in HCBS Rule compliant settings by 2022

# HCBS RULE IMPLEMENTATION UPDATE

# Recent CMS Guidance and Feedback on NY's STP

- New York is close to approval of our systemic/regulatory assessment plan
- CMS' goal for initial approval of all states' STPs by the end of 2018
- Through our **system-level** assessment we must revise and provide more info on our regs/policies/procedures to assess for/achieve **site-level** compliance

# HCBS Implementation Team Status Update

DOH is:

- Responding to the latest feedback from CMS on our updated STP and coordinating the State's response to CMS (with OPWDD, OMH, OASAS, and OCFS)
- Providing technical assistance for site-and-system-level assessment of HCBS settings and systems, and the revision of agency/office transition plans
- Working with Interagency Committee to develop and refine the heightened scrutiny process plan

# QUESTIONS & ANSWERS

# Conflict of Interest (COI) and Case Management/ Service Coordination

- Requirements at 42 CFR 431.301(c)(1)(vi)
- Existing COI requirements are specified in:
  - The HCBS Final Rule, published in March 2014: Medicaid Program; State Plan Home and Community-Based Services, Five-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the Act)
  - The intent of the Final Rule is to ensure that individuals receiving long-term services and supports through HCBS programs under the 1915(c), 1915(i), and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most appropriate integrated setting.

# HCBS Final Rule

The Final Rule is very broad across HCBS Services. In part, it:

- Defines, describes, and aligns home and community-based setting requirements as they relate to 1915(c) HCBS waivers.
- Defines person-centered planning requirements for persons in HCBS settings under 1915(c) HCBS waivers.
- Defines conflict of interest provisions for 1915(c) HCBS waivers.
- Defines that person-centered service plan development cannot be performed by the individual's provider of direct services unless there is no other willing and qualified entity available to that individual.

# COI Expectations

- CMS does not expect states to develop an entirely new service system. CMS expects:
  - States to draw on existing organizations and resources and to encourage existing providers to expand and improve how they do business.
  - Service Coordinators cannot act as promoters for the agency that employs them.
  - Service Coordinators must provide individuals' choice of service providers.
  - The service coordinator cannot have a direct or indirect financial relationship with the other service providers working with/for the waiver participant.
  - Current waiver service providers may have to choose to offer either service coordination or other waiver services.

# COI Expectations, Continued

- CMS and NYSDOH share the same goal:
  - Strengthen program integrity by improving accountability and transparency.
  - More information about the final regulation is available: http://www.Medicaid.gov/HCBS
- CMS approved the state's corrective action plan to move toward compliance with this regulation. At this point in time, interim measures and firewalls are being implemented with the support and review by CMS. The waivers must meet full compliance by January 1, 2019.

# Conflict of Interest Compliance Implementation Plan

- To ensure fair and equitable treatment of all providers, NYSDOH has developed the Conflict of Interest Compliance Implementation Plan form.

- As per NYSDOH's agreement with CMS and included in the State's approved Corrective Action Plan (CAP):

    - Temporary measures which include firewalls to avoid conflict must be in place immediately;
    - Full compliance with COI must occur by January 1, 2019; and
    - NYSDOH is required to provide oversight of the CAP implementation.

# COI Compliance

- NYSDOH waiver staff completed a webinar for providers on January 9, 2018.
- The majority of waiver service providers submitted compliance plans to the Regional Resource Development Centers on March 1, 2018. The RRDC reviewed the plans and submitted them to NYSDOH on April 1, 2018.
- NYSDOH waiver staff are currently reviewing the compliance plans.
- Upon completion of the review, providers will be notified of the outcome of the review. This could include:
  - Identification of the potential for conflict
  - Identification of rural and cultural exempted providers
  - Needed corrections in provider information
- New provider agreements will be executed.

# COI Compliance

- NYSDOH has received 195 Conflict of Interest Compliance Implementation Plans for NHTD and 207 plans for TBI.
  - There are only a small amount withstanding and a small amount waiting for correction.
- Rural/Cultural Exemptions will need to be considered.
- The plans are considered to be a quality assurance measure in order to confirm data such as: provider IDs, service codes and approved services.
- Note: In the pending NHTD application, independent providers are now included as providers of Service Coordination.

# COI Expectations

- NYSDOH waiver staff continue to have monthly conference calls with CMS to review progress.

- Anticipated issues:

  - Staff capacity: the ability to recruit and maintain a sufficient workforce to meet the needs of community based care
  - Steering of business and transfer of case loads
  - Reorganization of the business structure of providers to accommodate the requirements of the regulation
  - Amendment to the surveillance and OMIG audit protocols
  - Site reviews of co-located services in congregate settings
  - Next steps to full compliance

# Cost Report Implementation (CFR)

- The Consolidated Fiscal Report (CFR) is the report utilized by all governmental and non-governmental providers to communicate annual costs incurred as a result of operating 1915(c) waiver services.
- The year end cost report is used to set rates and analyze the appropriateness of fees and contracts.
- Approval of the NHTD/TBI waiver applications by CMS requires the implementation of cost reporting for both the NHTD and TBI 1915(c) waiver programs.

# Cost Reconciliation Process

- CMS is requiring that NYSDOH engage in a retrospective reimbursement reconciliation process using service provider cost of all services compared to the final allowable Medicaid reimbursement rate for each service.
- Federal Financial Participation (FFP) would be limited to the actual cost of the service(s) at the service provider level.
- Cost reporting is completed using a consistent reporting methodology/format in order for data to be comparable between providers, regions and services.
- Cost reporting for 1915(c) waiver services will be subject to review by NYSDOH.

# Cost Reconciliation Process, Continued

- If a provider fails to file a complete and compliant annual CFR for any reporting period, the provider will be considered delinquent.
- Similar programs' Cost Reports were used as a basis for report creation.
- Cost Reporting Period to be initiated: July 1, 2018 - June 30, 2019; every July 1 - June 30 going forward.
- The report will reflect the accumulation of all costs and the allocation of costs when appropriate.
- The report will include information regarding shared programs.

# Cost Reconciliation Process, Continued

- Service providers will be provided additional information as cost reporting is implemented.
- The CFR shall include all expenses of the service provider.
- NYS to forward cost reporting instructions to all 1915(c) providers for review and feedback.
  - **Comments from NHTD and TBI 1915(c) providers due end of April 2018**.
- NYSDOH will reconcile comments in May 2018, and will distribute final instructions to NHTD and TBI 1915(c) providers early June 2018.

# Cost Reconciliation Process

All questions should be e-mailed to:

1915CR@health.ny.gov

# Level of Care (LOC) Assessment

- According to the Social Security Act Section 1915, all participants in 1915(c) waivers must meet the state's eligibility requirements for services in an institutional setting.

- The Uniform Assessment System New York (UAS-NY) Community Assessment is a comprehensive assessment system used by the state to determine level of care (LOC).

- The approved TBI Waiver Application, effective September 1, 2017, provides that the UAS-NY will be used to determine level of care for the TBI waiver.

- The UAS-NY was approved to determine level of care for the NHTD waiver effective April 1, 2014. Additionally, the tool is used to establish level of care for other long term care services.

# Uniform Assessment System-New York (UAS-NY)

- The Uniform Assessment System - New York (UAS-NY) is used to initially and annually re-evaluate an individual's level of care (LOC).
- The PRI/SCREEN continues to be used for individuals transitioning out of a nursing home or hospital.
- If a PRI/SCREEN is completed, the UAS-NY must be conducted within ninety (90) days of enrollment and annually thereafter.
- The UAS-NY must be completed upon enrollment and annually thereafter by a trained assessor and signed by a Registered Professional Nurse (RN).
- Access to the UAS-NY is available through the Health Commerce System (HCS).

# Uniform Assessment System-NY (UAS-NY)

- Concerns regarding the implementation of the UAS-NY as the approved and validated tool to assess individuals' nursing facility level of care (NFLOC) have been ongoing for several years.
- There have been concerns that this assessment is not completely identifying all the needs of individuals with cognitive deficits.
- To be determined NFLOC, a person must receive a score greater than five.
- 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)
  - Cognition (items related to memory & decision making)

# UAS-NY, Continued

- NYSDOH & IPRO conducted an audit of the TBI population who were previously assessed to validate the accuracy of those assessments.
- This audit determined the TBI population exhibits particular needs unique to the condition and likely to differ from issues found in the general long term care population.
- Due to issues presented by stakeholders, participants, and the findings of the audit, NYSDOH has made adjustments to the assessment process for the TBI population including a second assessment; requirement for review of patient history; and a third assessment by a physician when eligibility is not clear.

# UAS-NY, Continued

- NYSDOH has established that NFLOC is a score of five (5) or more (>) using the UAS-NY assessment.

- For individuals seeking or receiving both NHTD and TBI waiver services: If the first UAS-NY results in a LOC score of less than (<) five (5), a second UAS-NY may be scheduled. If the individual seeks another assessment, the RRDC and the Service Coordinator will assist the applicant/participant in obtaining a second assessment.

- Every attempt must be made to secure the assessment in a timely manner using available resources. If the second assessment determines a sufficient NFLOC (5 or >) and the applicant/participant meets the other waiver eligibility criteria, he/she will be determined eligible for the waiver or continued waiver services.

# UAS-NY and Additional Assessments

- For current waiver participants, services will continue to be provided until the second assessment is completed.

- Should the second assessment fail to support NFLOC, the Regional Resource Development Center will be advised of the outcome and the RRDC will discuss available options with the individual. The applicant/participant will be issued a Notice of Decision: Denial/Discontinuation by the Regional Resource Development Center (RRDC).

# UAS-NY and Additional Assessments, Continued

- Once the NOD is issued, the individual may seek a case conference and/or request a fair hearing.

- The participant is encouraged to request a fair hearing and request “aid continuing” in order to ensure continuance of waiver services. The RRDC will discuss available options with the individual.

- For individuals seeking or receiving **TBI waiver services** after the second assessment with a score of less than (<) five (5), the applicant/participant may pursue the alternate route eligibility process.

# TBI Alternate Route Process

- At the case conference, the RRDC may discuss the referral for a clinical evaluation. Since coordinating a clinical assessment may require time to schedule, waiver participants will be encouraged to request a fair hearing with "aid continuing," so as not to experience an interruption in waiver services.

- The applicant/participant may choose not to challenge the decision and the Notice of Decision will stand. Plans to transition from waiver services will be developed by the Service Coordinator.

# TBI Alternate Route Process, Continued

- Simultaneous to the fair hearing process, the individual may continue to seek a clinical evaluation completed by a provider qualified to make a determination of the individual's need for NFLOC and/or related diagnosis.  This is referred to as "alternate route" (from the UAS-NY) assessment.

- The evaluation must be completed by specialists with expertise in TBI disability and/or cognitive deficit examinations. The clinical evaluation must demonstrate evidence of neurocognitive, behavioral and/or functional deficits on physical examination or diagnostic and may include findings which focus on cognitive and functional deficits, including the Instrumental Activities of Daily Living (IADL) challenges outlined above, mood disorders, and balance concerns.

# TBI Alternate Route Process, Continued

- Information included in the report must be presented with consideration of the waiver eligibility.
- Clinicians may choose not to complete an independent report, and instead complete a Clinical Assessment Form developed by NYSDOH.
- Upon completion of the evaluation, the specialist must clearly determine and prescribe that the applicant/participant meets NFLOC as a result of the Traumatic Brain Injury.
- Should a fair hearing date be scheduled prior to the completion of the evaluation, the RRDC will support the individual in requesting the fair hearing be adjourned pending the completion of the evaluation and "aid continuing" remain in effect. Or the individual may ask the Court to render a decision based on the information available at the time of the hearing.

# TBI Alternate Route Process, Continued

- A copy of the report and all supporting documents are submitted to NYSDOH by the RRDC for review and action.
- Should the outcome of the assessment determine the applicant/participant is waiver eligible, at the direction of NYSDOH, the RRDC will withdraw the prior Notice of Decision.
- Should it be determined that the assessment and related documentation do not support waiver eligibility and a fair hearing is in progress, the information will be presented for consideration by the Court for decision. The applicant/participant may continue to seek adjudication through fair hearing. Or the applicant/ participant may withdraw from the alternate route process at any point in time.

# TBI Alternate Route Process, Continued

- All waiver participants are required to have an annual re-assessment of waiver eligibility, including NFLOC, regardless of the method of the NFLOC assessment. In the case of alternate route determinations, the annual re-assessment must be completed within one year of the date of the NYSDOH letter confirming the outcome of the clinical review.

# TBI Alternate Route Process, Continued

- Since September 1, 2017, 1579 TBI UAS-NY assessments were completed.
  - 291 individuals (waiver applicants/participants) did not meet LOC (a score of 5 or more) upon initial assessment.
  - 20 individuals chose not to challenge his/her eligibility determination.
  - 281 chose to have a second UAS-NY assessment completed.
  - 97 individuals who completed a second assessment still did not meet LOC.
  - 61 chose to seek the alternate route by securing a clinical assessment.
  - To date, NYSDOH has completed 27 clinical reviews.
  - 6 individuals did not meet LOC upon review of their clinical assessment.
  - 51 fair hearings remain in progress.
  - 1 fair hearing decision was rendered, upholding the Department's decision to discontinue waiver services.

# Community First Choice Option

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# Questions???