Introduction

In 2011, Governor Andrew Cuomo created the Medicaid Redesign Team (MRT). The goal of the MRT was to create significant reforms in New York's Medicaid program. The reforms take a "triple aim" approach of: 1) improving the quality of care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency and equity; 2) improving health by addressing root causes of poor health, e.g., poor nutrition, physical inactivity, and substance use disorders; and 3) reducing per capita costs[1].

A critical component of the "triple aim" is Care Management for All. This initiative began in State Fiscal Year 2011-12 with the stated goal to have all Medicaid enrollees served in Managed Care. The Care Management for All approach will improve benefit coordination, quality of care and patient outcomes over the full range of health care, including mental health, substance abuse, developmental disability and physical health care services.

In keeping with this goal, the State is submitting this transition plan to eliminate the 1915c Home and Community Based Services (HCBS) Waiver for the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Programs and will transition participants into managed care programs operated by New York State (NYS). The timeline for this accomplishment has now moved on several occasions and the current target date is for the transition to begin January 1, 2018.

Background

The TBI and NHTD Medicaid waiver programs were developed based on the philosophy that individuals with disabilities, individuals with traumatic brain injury, and seniors, may be successfully served and included in their surrounding communities. The individual is the primary decision maker and works in cooperation with care providers to develop a plan of services that promotes personal independence, greater community inclusion, self-reliance and participation in meaningful activities and services.

Many of the services provided through the NHTD and TBI waivers are comparable to services now available through Community First Choice Option (CFCO) as Medicaid State Plan services. As such, Managed Care Organizations (MCOs) are preparing to provide these services to a broad base of individuals residing in the community.

In 2010, the Home and Community Based Services Expansion Program (HCBS Expansion Program) was added to the New York Partnership Plan 1115 Demonstration (1115 waiver). This provision allows for certain adults with significant medical needs to receive cost-effective home and community based services so they can remain in the most integrated community based setting. The HCBS Expansion Program eliminated a barrier to receiving care at home posed by eligibility rules that would otherwise lead to spousal impoverishment. The program allows special spousal budgeting provisions. This program is currently available in the Nursing Home Transition and Diversion Waiver Program and the Traumatic Brain Injury Waiver Program and will continue to be available in Managed Long Term Care and Medicaid Managed Care.

Upon implementation of this transition plan, as well as approval of a corresponding 1115 waiver amendment, individuals currently receiving services through the NHTD and TBI waivers who

[1] *A Plan to Transform the Empire State's Medicaid Program: Better Care, Better Health, Lower Costs: Multi Year Action Plan,* New York State Department of Health

wish to continue receiving services must enroll into one of two managed care programs: Managed Long Term Care or Medicaid Managed Care.

Managed Long Term Care

Managed Long Term Care (MLTC) is a system that streamlines the delivery of long term care services to people who are chronically ill or disabled and who wish to reside, or continue to reside, safely in their homes and communities. The entire array of services to which an enrolled member is entitled can be received through the MLTC plan the member has chosen.

As New York transforms its long term care system to one that ensures care management for all, enrollment in a MLTC plan may be mandatory or voluntary, depending on individual circumstances.

Enrollment in a MLTC plan is mandatory for individuals who are dually eligible (eligible for both Medicaid and Medicare), equal to or over 21 years of age, and need community based long term care (CBLTC) services for more than 120 days. Effective July 1, 2015, on a statewide basis, dually eligible nursing home residents who are age 21 and older and determined to need permanent nursing home placement were included in MLTC.

Enrollment in a MLTC plan is voluntary:

- For those who are dually eligible and are 18 through 20 years of age and need nursing home level of care and community based long term care services for more than 120 days.
- For those who are non-dually eligible, over 18 years of age and are assessed as both nursing home eligible and require community based long term care for more than 120 days (and are not otherwise required to mandatorily enroll in Medicaid Managed Care).
- Effective October 1, 2015, for those new admissions who are dually eligible, age 18 and over and were previously determined as permanent placements in a nursing home.

Individuals excluded from enrollment into a MLTC plan are included in **Attachment 1**. Individuals exempt from mandatory enrollment into a MLTC plan are included in **Attachment 2**. Exclusions and exemptions may be subject to change prior to the January 1, 2018 transition.

Medicaid Managed Care

Medicaid Managed Care (MMC) is for individuals who are Medicaid eligible only, and provides Medicaid State plan benefits to enrollees through a managed care delivery system comprised of Managed Care Organizations (MCOs).

All Medicaid recipients, except for those who are eligible for an exemption or exclusion, must enroll in a MMC plan.

Medicaid recipients *exempt* from enrollment in MMC plans are found in NYS SSL §364-j(3)(d) **(Attachment 3)**. A Medicaid recipient is *excluded* from enrollment in a MMC plan if the recipient meets one of the criteria identified in §364-j(3)(c) of the NYS SSL **(Attachment 4)**. Exclusions and exemptions may be subject to change prior to the January 1, 2018 transition.

Transition Narrative

This transition plan is submitted for consideration to the Centers for Medicare and Medicaid Services (CMS) with the primary goal of improving access to services, enhancing health care for plan members and improving the quality of life for service recipients. The goal is not to control costs of services but to increase service capacity, enhance value and improve the quality of services provided across the state.

A. Access to Services

The NHTD and TBI waiver programs offer a coordinated plan of care and services for individuals who would otherwise be medically eligible for placement in a nursing facility. The waiver programs have enabled the State to provide participants with a number of supportive services historically not available under New York's State Plan for Medicaid services. The provision of waiver services has proven to be effective in preventing premature institutionalization of program participants and allowing those who are at risk for nursing home placement to remain safely in the community.

Individuals enrolled in a Medicaid MCO must receive, from the managed care plan, all medically necessary benefits identified in the benefit package, as appropriate. For all NHTD/TBI waiver participants receiving long term services and supports, who are transitioned to managed care, each plan must coordinate, as appropriate, needed State plan services, comparable or expanded services.

In 2011, the Community First Choice Option (CFCO) became available to all states under the Affordable Care Act (ACA). This option allows for states to expand state plan home and community based services and supports to individuals in need of long term care for Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and health-related tasks. CFCO is not a program, a waiver or a particular service. Effective July 1, 2015, CFCO services were approved in New York State as Medicaid State Plan services. CFCO services are available to individuals who are Medicaid eligible without deeming, reside in their own home or in the home of a family member, and require nursing home level of care. 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 a 1915c waiver programs, greatly expanding access to services.

These services include:

- Assistive Devices/Technology (AT): AT may include an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or to improve the functional capabilities of participants. AT is a service that directly assists the participant in the selection, acquisition, or use of an AT device. The service will only be approved when the requested equipment and supplies improve or maintain the member's level of independence, ability to access needed supports and services in the community, or, maintain or improve the member's safety and health.

- Environmental Modifications (Emods): These services are internal and external physical adaptations to the home that are medically necessary to promote the plan member's

safety and independence in the home or community. Vehicle modifications or adaptive equipment may also be included.

- Transportation: Non-Emergency Medical – Transportation for members to and from medical appointments and services. Non-Emergency Social – Transportation for members to and from social gatherings in the community.

- Congregate and/or home-delivered meal services: This service provides meals to members who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. Home-delivered and congregate meals will be provided in accordance with each individual member's plan of care.

- Supervision and/or cueing, currently identified as the waiver service Home and Community Support Services (HCSS), will be incorporated into personal care. This service is utilized when oversight and/or supervision as a discrete service is necessary to maintain the health and welfare of the person living in the community. Oversight and/or supervision may be needed for health and safety monitoring to prevent an individual from harmful activities (for example, wandering or leaving the stove on unattended). Oversight and/or supervision can be accomplished through cueing, prompting, direction and instruction. This service can also be provided to members needing oversight and/or supervision who also require assistance with personal care services. Personal Care Services are defined as some or total assistance with ADLs, activities such as dressing, bathing, hygiene/grooming, toileting, ambulation/mobility, transferring and eating, and/or IADLs, such as housekeeping, shopping, meal preparation, laundry, transportation and telephone use essential to the maintenance of the participant's health and welfare in the community.

- Moving Assistance: Moving Assistance services are individually designed services intended to transport a plan member's possessions and furnishings when the member must be moved from an inadequate or unsafe housing situation to a viable environment that more adequately meets the member's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the person is moving to a location where more natural supports will be available, and thus allows the person to safely remain in the community in a supportive environment. Moving Assistance does not include purchase of items such as security deposits, including broker's fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control or cleaning prior to occupancy.

- Community Transitional Services (CTS): This service is provided to individuals transitioning out of a nursing home into the community. Expenditures may include rent and utility deposits, bedding, basic kitchen supplies and other necessities required to make the transition from a nursing facility to community based life.

Additionally, MLTC and MMC plan benefit packages will be expanded to include all those 1915c waiver services currently utilized by waiver participants that are not included in CFCO. These services are not currently included in the current Standard Terms and Conditions (STCs). Upon

CMS approval, the MLTC and MMC Model Contracts and the Section 1115 amendment will be amended.

The following reflects the steps involved in the contract amendment process:

- Service definitions and provider qualifications are established by the New York State Department of Health (NYSDOH).
- Draft contract language is developed based on these parameters.
- The draft contract language is shared with the Health Plan Trade Associations for comment.
- NYSDOH meets with Health Plan Trade Associations to discuss, and/or amend draft contract language.
- NYSDOH Division of Legal Affairs reviews the proposed contract changes and suggested revisions are made.
- NYSDOH submits proposed contract changes to CMS for review and approval.
- Upon CMS approval, NYSDOH creates contract amendment documents and obtains internal NYSDOH approval to issue amendments. NYSDOH transmits contract amendments to the Health Plans for review and endorsement.
- NYSDOH signs the contract amendments and forwards them 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.

Eligible members who require Community Based Long Term Care will have the ability to access the following enhanced benefits:

- Community Integration Counseling (CIC): CIC assists members, on a short-term basis, who are experiencing significant problems managing the emotional responses inherent in adjusting to a significant physical or cognitive disability or life event while living in the community. CIC is provided by professional staff (not Personal Care Aides, Home Health Aides or Direct Service Professionals). It is a counseling service provided to members coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the individual's home. It is available to anyone involved in an ongoing significant relationship with the member when the issues to be discussed relates directly to the plan member. The plan member must be present at the time of service delivery.

- Independent Living Skills Training (ILST): This service assists in recovering skills that may have decreased as a result of onset of a disability. ILST is primarily targeted to those individuals with progressive illnesses to maintain essential skills. ILST is provided by professional staff (not Personal Care Aides, Home Health Aides or Direct Service Professionals). It may be provided in the person's home or in the community, but must be provided in the environment and situation that will result in the greatest positive outcome for the plan member. This service will primarily be provided on an individual basis, but can be provided in a group setting if the member will receive greater benefit from it. Services may include assessment, training, and supervision of an individual with self-care, medication management, task completion, communication skills, interpersonal skills, socialization, sensory/motor skills, mobility, community transportation skills,

reduction/elimination of maladaptive behaviors, problem solving skills, money management, pre-vocational skills and skills to maintain a household.

- Positive Behavioral Interventions and Support Services (PBIS): This service is provided by professional staff (not Personal Care Aides, Home Health Aides or Direct Service Professionals). Service recipients will include those who have significant behavioral difficulties that jeopardize their ability to remain in the community of choice due to inappropriate responses to events in their environment. PBIS should be provided in the situation where the significant maladaptive behavior occurs. Services include but are not limited to: a comprehensive assessment of the individual's behavior (in the context of their medical diagnosis and disease progression as determined by the appropriate health or mental health professional), skills and abilities, existing and potential natural and paid supports and the environment; the development and implementation of a holistic structured behavioral treatment plan that includes specific realistic goals that can also be utilized by other providers and natural supports; the training of family, natural supports and other providers so he or she can effectively use the basic principles of the behavioral plan; and regular reassessments of the effectiveness of the behavioral treatment plan, making adjustments to the plan as needed. The plan member must be present at the time of service delivery.

- Structured Day Program: Structured Day Program services are individually designed services provided in a community setting, and is designed to improve or maintain the plan members' skills and ability to live as independently as possible in the community. This service is provided by professional staff (not Personal Care Aides, Home Health Aides or Direct Service Professionals). Services may include assessment, training and supervision to an individual with self-care, task completion, communication skills, interpersonal skills, problem-solving skills, socialization, sensory/motor skills, mobility, community transportation skills, reduction/elimination of maladaptive behaviors, money management skills and ability to maintain a household. All services will be provided in home and community based settings that comply with 42 CFR §441.530.

During the transition planning process, there was extensive discussion regarding Service Coordination, and how this service may be implemented in a managed care environment. Of 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. Additionally, the goals of this discrete service may not conflict with the overall goals of the care plan developed by the MCO Care Manager. Stakeholders presented concern that transitioning waiver participants may require more intensive case supervision and support than offered through managed care. With these considerations in mind, the following service definition was established and the service will be offered as an enhanced benefit:

- **Service Coordination** is an individually designed service that supplements and enhances care management services. 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 required frequency, duration or intensity offered in the managed care model. MLTC care management must provide for one care management telephone contact per month per member and a minimum of one (1) care management home visit every six (6) months for each member. MCO Care Managers will remain responsible for the ongoing coordination and management of

services included in the members' person-centered plan and the members' health and welfare. Service Coordinators will work with the 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 a mechanism of care managers to enrollees taking into consideration a hierarchical structure based on the acuity and severity of enrollees' physical and mental condition.

Service Coordinators will be responsible to complete one (1) face-to-face visit per month per member and at least one (1) home visit every six (6) months per member. The Service Coordination home visit will not coincide with the home visit completed by the Care Manager. Plans and NYSDOH will monitor provider selection by members in order to ensure that conflict free choice takes place. An individual who provides other services to a plan member or an individual who has a business relationship with or is employed by a provider of other services to the plan member, may not serve as a Service Coordinator. Activities may include but are not limited to:

- Housing Assistance;
- Crisis intervention and support;
- Back-up for informal or community supports or when there are gaps in other services;
- Assist with social and recreational needs;
- Assist in the member's health and safety;
- Address problems in service provision; and
- Assuring the member's health and welfare, increasing independence, integration and productivity.

For MLTC/MMC eligible individuals seeking Service Coordination as an enhanced benefit, a referral will be made to the Regional Resource Development Center (RRDC) to complete a service assessment and provide a recommendation to the plan. **(Attachment 5)**

The RRDC will continue to have a role in the managed care model. In order to access the enhanced benefits noted above, NYSDOH will continue to contract with RRDCs. The current RRDC contracts with NYSDOH terminate June 30, 2016. A contract arrangement is being sought to continue these functions until a new competitive procurement process can be implemented in 2017. The RRDCs will serve as a resource to ensure that the managed care plans and providers have received appropriate training and education related to services and special needs populations. Additionally, the centers will serve as functional assessment and technical assistance centers to members and providers. Any plan member seeking the five enhanced benefits listed above must seek the service through the RRDC and in conjunction with their managed care plan. The RRDC will complete a service assessment to establish the need for the service, advise the MCO of the assessment outcome and facilitate in-network provider selection in conjunction with the plan member. The decision to provide the service will be based on need. The role of the RRDC is to supplement and support the care planning initiated and implemented by the Managed Care Organizations.

Current waiver services that will not be added to the existing managed care benefits package(s) because comparable services are currently approved under the current 1115 waiver or are available to members through other resources include:

- Nutrition/Nutritional Counseling;

- Respiratory Behavior Therapy;
- Respite;
- Wellness Counseling;
- Home Visits by Medical Personnel;
- Peer Mentoring; and
- Substance Use Counseling.

42 CFR 440.180 describes "home or community based services" as those services **not otherwise furnished under the State's Medicaid plan.** As such, since all of the current 1915c waiver services are provided through CFCO and/or the proposed 1115 waiver amendment, NYS will no longer provide these services as 1915c waiver services.

Comparable to 1915c waiver requirements, all managed care members are required to have a Person-centered Service Plan. The plan of care is a written description in the care management record of the individual enrollee and is based on the initial assessment or reassessment of their health care needs. The person-centered service plan is developed in consultation with the appropriate healthcare professionals, the plan member and his or her informal supports. The plan must address all health and safety risk factors, as well as member-specific health care objectives that include the amount, duration and scope of the covered services, in order to achieve the member's goals. The care plan takes into consideration the current and unique psycho-social and medical needs and history of the plan member, as well as their functional level and support systems. The effectiveness of the person-centered service plan is closely monitored through reassessment. A comprehensive reassessment of the plan member and a person-centered service plan update will be performed as warranted by the member's condition but in any event at least once every six (6) months. A determination will be made on whether the health care goals are being met or whether the goals need to be reevaluated.

Non-covered services that interrelate with the covered services identified in the care plan, must clearly be identified on the person-centered service plan or elsewhere in the care management record.

B. Transition Timeline (Attachment 6)

New York State Department of Health (NYSDOH) sent a letter to CMS on May 27, 2015, indicating its intent to terminate the NHTD 1915c waiver and to request an extension of the existing waiver, which expired on August 30, 2015. NYSDOH has sought to continue requesting 90-day temporary extensions of the existing NHTD waiver until the waiver is eliminated, which is expected to be on June 30, 2018 or until all current NHTD waiver participants are safely and successfully transitioned to managed care plans.

NYSDOH submitted the application for renewal of the TBI 1915c waiver on April 26, 2013. CMS has granted temporary extensions to the current application in order for the State to fully respond to CMS' formal request for additional information (RAI). The extensions have allowed the waiver program to operate while NYSDOH finalizes the transition plan outlining the timeline and process by which TBI waiver participants will enroll in MMC/MLTC plans.

NYSDOH seeks to obtain CMS approval of this transition plan by September 1, 2017. Upon approval by CMS, effective October 1, 2017, all pending waiver applicants will be contacted by the RRDCs and advised of the opportunity to voluntarily enroll into MLTC/MMC services directly instead of seeking waiver services. Additionally, NYSDOH will cease enrollment of any new

waiver service providers and will no longer approve expansion of existing waiver service providers effective October 1, 2017.

NHTD/TBI waiver participants will receive an announcement letter on or about December 1, 2017 indicating that voluntary enrollment of existing waiver participants into a managed care product will be effective statewide January 1, 2018 and that the NHTD/TBI waiver programs will no longer be available effective April 1, 2018. If the current waiver participant wants to continue receiving long term care services, he or she must enroll in MLTC or MMC, depending on his/her program eligibility. Waiver participants will have the opportunity to voluntarily enroll into managed care effective January 1, 2018. Individuals required to mandatorily enroll in a managed care product who do not voluntarily enroll by March 1, 2018, will be auto assigned for services, effective April 1, 2018. If he or she is not subject to mandatory enrollment and do not voluntarily enroll into a managed care product by April 1, 2018, waiver services will no longer be available. Participants will be sent a 60-day notice on January 1, 2018, a 30-day notice on February 1, 2018 and, if applicable, an auto assignment letter on March 1, 2018.

All new referrals and intake meetings provided through the 1915c waiver will cease on January 1, 2018. Individuals who have completed their intake meeting and have not selected a Service Coordinator by January 1, 2018, will be referred to New York Medicaid Choice (NYMC) for counseling on enrollment into MLTC or MMC. Voluntary enrollment can be initiated immediately and receipt of waiver services will no longer be an option. As managed care plan members who are nursing home level of care, these individuals will be able to access CFCO services. Additionally, Money Follows the Person (MFP) Transition Center staff will work with individuals transitioning from nursing homes to identify the most appropriate service and will facilitate the referral process to NYMC.

Individuals applying for 1915c waiver services who have selected a Service Coordinator must have a service plan approved by the RRDC and it must be in place by December 1, 2017 or he or she will be referred to New York Medicaid Choice (NYMC) for counseling and enrollment into MLTC or MMC.

The MFP Transition Centers and Identification and Outreach Program will cease referrals to the RRDCs effective January 1, 2018. MFP Transition Center staff will work with nursing home discharge planners to identify services and to facilitate the transition process.

Additionally, those NHTD waiver participants located within the Fully Integrated Duals Advantage (FIDA) demonstration area may voluntarily enroll in the FIDA program at any point in time. All of the existing NHTD waiver services are included in the FIDA benefit package, which also includes a 90-day continuity-of-care period in which existing services and providers will continue until the Person Centered Care Plan (PCSP) is complete. TBI waiver participants located within the FIDA demonstration area may voluntarily enroll in the FIDA program, effective January 1, 2018.

C. Enrollment of Existing NHTD/TBI Waiver Participants

The nine RRDCs currently contracted to administer the daily operations of the 1915c NHTD/TBI waivers will assist participants as they move to managed care. These efforts will include, but are not limited to, issuing additional notices, addressing phone calls, offering regional community forums as needed, ensuring transition of services, records retention and ensuring member choice of providers. After full implementation to managed care, the RRDCs will continue to

serve as technical assistance and service assessment centers to the managed care plans and members.

Existing participants of the NHTD/TBI waiver programs effective January 1, 2018 will be deemed eligible for community based long term care (CBLTC) services and will not be required to go to the Conflict-Free Evaluation and Enrollment Center (CFEEC) prior to enrollment into MLTC.

Waiver participants will be encouraged to select a MLTC/MMC plan through the announcement letter, followed by 60-day and 30-day notices. For those that are mandated to enroll, if they do not select a plan, the State's contracted enrollment broker: New York Medicaid Choice (NYMC) will auto assign them to a plan offering a MLTC/MMC product operating in the eligible person's county of fiscal responsibility.

Any waiver participant transitioning to MLTC will be deemed eligible for CBLTC for two years as long as the member actively participates in services identified in the plan of care. The member must receive at least one service at least monthly in order to maintain CBLTC eligibility. Current NHTD/TBI waiver participants effective January 1, 2018 are ensured continuity of care: all services in place at the time of transition will continue for the first six months of the transition period into MLTC/MMC. All existing services identified in the service plan at the time of enrollment will continue to be provided for at least six months after the member's enrollment date. After six months of service transition, the plan will reassess the member for specific service needs. Any individual seeking CFCO services at this time must be assessed to confirm the member meets the eligibility criteria for CFCO services.

D. Enrollment after the Transition

Individuals who are 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 Conflict Free Evaluation and Enrollment Center (CFEEC). The CFEEC is a statewide resource that provides independent and conflict-free evaluation, education, and enrollment services for new applicants in need of community based long term care services. Managed Long Term Care plans are not permitted to enroll new individuals until the CFEEC has conducted an initial evaluation to determine Community Based Long Term Care (CBLTC) eligibility and/or nursing home level of care, if necessary. The organization that conducts the evaluations for NYS is not affiliated with any managed care plan, or with any provider of health care or long term care services. It is a conflict free third party entity that provides evaluation, education and enrollment services.

MLTC Policy 13.03 defines Community Based Long Term Care Services as: Nursing Services in the home, Home Health Care (which is further defined as traditional CHHA services such as therapies or home health aide service in the home), Personal Care Services in the home (including Level 1), Adult Day Health Care and Private Duty Nursing. A requirement of eligibility for enrollment in a Managed Long Term Care plan is for the member to demonstrate need for CBLTC services for more than 120 days. Additionally NYS Public Health Law Article 44, Section 4403-f(7)(b) indicates that the Commissioner specifies who may require community based long term care services. As such, with the submission of this transition plan, NYSDOH will seek to amend the definition of CBLTC to include Service Coordination as defined in this transition plan as a CBLTC service.

A trained registered nurse from the CFEEC will visit potential members to learn about their care needs. The nurse will conduct the evaluation using the Uniform Assessment System-New York (UAS-NY), which will determine if they qualify for MLTC enrollment and/or CFCO services. The evaluation does not include a medical exam. Once the evaluation is completed, the consumer determined eligible for MLTC will have the option of selecting a plan and allowing the CFEEC to assist with connecting them to the selected plan. Appropriate notice will be sent to consumers indicating their eligibility for CBLTC. Plans are required to complete the UAS-NY assessment following the CFEEC evaluation and every six months following enrollment into the plan or upon significant change in condition.

A CFEEC evaluation remains valid for seventy-five (75) days. After such time, a new evaluation is required if the consumer does not select a plan, but continues to seek CBLTC. If a consumer is deemed ineligible for enrollment into a MLTC because of failure to meet CBLTC eligibility, the consumer will be educated on the enrollment options that are available. Any appropriate referrals will also be made at that time. The consumer will receive a notice indicating a determination of ineligibility for MLTC enrollment, including fair hearing rights. Additionally, a dispute resolution process is available should an MLTC plan disagree with the CFEEC's eligibility finding.

The Enrollment Broker will assist consumers who are determined ineligible for MLTC in accessing their options. Consumers who are Medicaid eligible will be provided with assistance in determining available plan enrollment options and with the enrollment process. If not otherwise exempt or excluded, NYMC will assist consumers in enrolling in MMC.

Once enrolled in a plan, members will receive a confirmation letter from New York Medicaid Choice (NYMC). The letter indicates the effective date of enrollment. The new managed care plan will also send a welcome letter, a plan identification card and member handbook with information about services to new members. The plan's member services phone number will appear on the plan identification card. Members may call the phone number on the card if he or she has any questions or need services.

Each managed care plan member is assigned a Care Manager who will talk with the member about his or her services. The Care Manager will assist members and anyone else they want to involve in developing a Plan of Care that meets their specific needs.

Enrollment is prospective and is effective on the first day of the month. MLTC members may change their health plan at any time and services will be effectuated the first of the month. The plans are responsible for providing a smooth transition of services. Members may change providers within their network at any time.

MMC members have an initial ninety (90) day grace period in which to dis-enroll for any reason and enroll in another MMC plan. This is followed by a nine (9) month "Lock-In Period" following the effective date of enrollment, in which the member may dis-enroll with cause and enroll in another MMC plan. Enrollees may request transfer from an MMC plan to an HIV Special Needs Plan (SNP) or from a SNP to another SNP at any time. Members may also change providers within their network at any time.

E. Continuity of Care During Transition

NYSDOH is proposing to establish a two (2) year continuity-of-care period for participants and service providers. As a result, MCOs will be required to contract with current waiver service providers for a minimum of two years:

- If the service provider is serving five (5) or more current waiver participants;
- If the service provider continues to serve participants/members 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.

Any waiver participant transitioning to MLTC will be deemed eligible for CBLTC for two years as long as the member actively participates in services identified in the plan of care. The member must receive at least one service at least monthly in order to maintain CBLTC eligibility. Current NHTD/TBI waiver participants effective January 1, 2018 are ensured continuity of care: all services in place at the time of transition will continue for the first six months of the transition period into MLTC/MMC and the member will not be required to go to the Conflict Free Evaluation and Enrollment Center (CFEEC) prior to enrollment into MLTC. All existing services identified in the service plan at the time of enrollment will continue to be provided for at least six months after the member's enrollment date. After six months of service transition, the plan will reassess the member for specific service needs. Any individual seeking CFCO services at this time must be assessed to confirm the member meets the eligibility criteria for CFCO services.

Current waiver participants will have the choice to maintain his or her existing providers for up to two years, if his or her needs remain the same after the first six (6) months of service provision and if the providers meet the conditions above.

Additionally, NYSDOH has proposed a two-year rate guarantee for providers based on the approved rate at the time of the transition.

Managed care plans will be provided a list of all approved waiver service providers, prior to the transition date in order to encourage managed care plans to contract with as many waiver service providers as available.

Managed care plans must continue to meet the network access and adequacy requirements established in their contracts with NYSDOH.

The goal is a seamless transfer of waiver participants with no gaps in service. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR §438.404 and 42 CFR §460.122 which clearly articulates the participant's right to file an appeal. All services will be provided in a community based setting.

Each 1915c waiver participant will have a transition plan developed in conjunction with his or her current Service Coordinator and their MCO care manager to ensure that all services remain in place the first day of enrollment in a plan. Services provided during the six (6) month transition period will be accessed through fee for service.

F. Initial Plan Assessment for NHTD/TBI Transitions

The MLTC/MMC plans will conduct an initial assessment in the individual's home to assess his or her need for community based long term care services using the UAS-NY. All new plan enrollees (not waiver eligible effective January 1, 2018) must have a UAS-NY on record prior to plan enrollment. The assessment must be completed within thirty (30) days of enrollment into the plan.

The MLTC/MMC plans are required to complete a reassessment at least every six (6) months or whenever a significant change in the member's condition occurs.

During workgroup discussions related to the transition plan, stakeholders presented concerns regarding the accuracy of the UAS-NY to assess cognitive deficits in individuals. There is concern that individuals in need of community based long term care services, will not "qualify" to receive those services. NYSDOH has presented that the UAS-NY Community Assessment is a licensed product from interRAI. It should be noted that interRAI did not develop a product that designates level of care; it produced an assessment tool with validated questions and responses. The Nursing Facility Level of Care (NFLOC) is generated based on responses to validated questions contained in UAS-NY Community Assessment. 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 Performance Scale within the UAS-NY was created by interRAI and is used internationally. The cognitive domain includes items related to memory and decision making. 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. Additionally there are questions in the UAS-NY Community Assessment for both expressive and receptive language, including making oneself understood and the ability to understand others.

An independent contractor conducted an external quality review of the UAS-NY Community Assessment in three different program areas: MLTC, Assistive Living Program (ALP) and the TBI waiver. The Semi-Annual Assessment of Members (SAAM) the tool previously used to establish functional abilities and the UAS-NY Community Assessment were compared in a sample of ten (10) members from a MLTC plan. The contractor also reviewed the Patient Review Instrument (PRI) and the UAS-NY Community Assessment with ten (10) ALP and ten (10) TBI waiver participants. Results 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. NYSDOH remains committed to the implementation of the tool and continues to explore options to improve its accuracy and efficacy as related to individuals with cognitive deficits. Going forward, the Department will encourage others involved in an individual´s care to be present at the time of the assessment to assist with these issues. Additional assessor training has been developed and is mandatory. NYSDOH continues to monitor the ongoing assessment findings and has noted improvement in assessment outcomes.

NYSDOH continues to review the UAS-NY as related to cognitive deficits and will consider adjustments in the tool or algorithm as warranted. Additionally, NYSDOH will seek to implement an additional review of assessment outcomes when the findings are in dispute. All individuals continue to be afforded due process and fair hearing rights related to this determination.

G. Notification Requirements and Stakeholder Engagement (Attachment 7)

When the transition from fee-for-service to MLTC began in 2012, NYSDOH utilized existing state enrollment broker functions with New York Medicaid Choice (NYMC) to assist with the transition and to educate plan members on overall benefits, provider networks, complaint assistance, and provider education. Additionally, NYMC continues to serve as the State's enrollment broker throughout the transition process. During this period, notification and member education has worked to address the evolving and extended needs of the population. NYSDOH will continue to utilize this resource during the implementation of this transition plan.

Efforts have included, and will continue to include, outreach through phone support using contracted call centers and ongoing communication with Local Departments of Social Services (LDSS)**.** Outreach to providers and plan members includes presentations to various provider groups. New York Medicaid Choice has provided written notices and materials to plan members and has ensured compliance with cultural competency and accessibility standards. NYMC conducts focus groups to test materials prior to broad dissemination. NYSDOH encourages member and stakeholder feedback regarding consumer materials, letters and notices. The NYMC call center provides multiple language lines and contracts with a translation company in order to better serve the needs of consumers. The calls are scripted for each specific service population. Scripts are proprietary and owned by NYMC, and are approved by the Department. The company is open to feedback on how to improve call support. Different scripts may be needed for the transition period and after transition is complete. Three-way calls are an option for the consumers, NYMC staff, and a third party if necessary. All calls are logged and recorded. Outreach calls and follow-up assistance will continue throughout the timeline of the transition.

NYSDOH trains NYMC to effectively work with specific populations and can bring in subject matter experts. NYMC requires its employees to complete training and also provides written training materials. Training will begin ninety (90) days prior to first notice distribution. NYMC staff are also trained to work with parents, guardians, and other supports. Curriculum and material development for NYMC and MCOs will begin in the fall of 2016 in conjunction with the transition workgroup.

NYMC conducts satisfaction surveys on its services, as well as satisfaction surveys with the managed care plans through phone or face-to-face interviews with plan members at set dates after enrollment/contact. Case numbers are linked to the member so appropriate follow up can be made. Additionally, NYMC will adjust its outreach efforts based on need. For example, outreach activities can be provided in convenient locations, such as day programs and RRDCs. Text messages and email may also be utilized as needed. Outreach to current Service Coordinators will be an important component of the transition process. NYSDOH remains sensitive that some individuals will not be able to return calls or may require multiple contacts. Adjustments to the outreach plan will occur based on need, review of responses, and feedback from stakeholders.

NYSDOH will seek input from current waiver participants and providers regarding future training materials and content. Additionally, a subcommittee of the workgroup that included participant representation reviewed service recipient notifications to ensure that information is consistent with the needs of the "audience" receiving the notifications. Information will be provided in "plain language," reflecting cultural considerations, and offered in a manner that is accessible to individuals with disabilities and/or limited English proficiency.

Public Notice

Throughout the transition planning process, NYSDOH has maintained a website to specifically provide an opportunity for ongoing public review (http://www.health.ny.gov/health_care/medicaid/redesign/). Additionally, the site provides information, materials and FAQs on the transition process. A mailbox to address questions specific to the NHTD/TBI 1915c waiver transition process is established at: waivertransition@health.ny.gov.

NYSDOH anticipates that the draft transition plan will be posted for public comment in the New York State Register by July 15, 2016. This will provide for a thirty-day comment period. Additionally, stakeholders will be informed of the public comment period via listserv notification, and email distribution. The draft transition plan will also be posted on the MRT#90 website at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/.

As the transition process moves forward, information related to the 1115 amendment will be made available by utilizing these public forums.

Tribal Notices **(Attachment 8)**

Pursuant to Presidential Executive Order #13175, NYSDOH provided the 13 federally recognized Tribal Governments with written notification of the intent to transition all NHTD/TBI 1915c waiver participants to Medicaid managed care in 2015. Native Americans with Medicaid coverage may enroll in Medicaid managed care plans but are not required to do so. This exemption from mandatory enrollment for Native Americans will continue. In addition, existing policies related to Native Americans who choose to enroll in Medicaid managed care plans will continue. We anticipate that the elimination of the NHTD/TBI 1915c waivers and the transition of these services to managed care will have limited impact on Tribal Nations. Due to delays associated with the transition planning process, new tribal notices will be distributed by July 15, 2016.

Stakeholder Engagement

NYSDOH began the transition planning process to move 1915c Medicaid waivers to managed care in 2014. The original plan included transitioning NHTD waiver services, effective January 1, 2016 and TBI waiver services, effective April 1, 2016. At the request of the provider community, in June 2015 the Medicaid Director agreed to extend the implementation date to January 1, 2017. At that time NYSDOH agreed to convene a transition workgroup advising providers of the goal to submit transition recommendations to CMS by August 1, 2016. Additionally, NYSDOH agreed that in order to minimize disruption, NYSDOH would maintain the current reimbursement that NHTD and TBI waivers were receiving in the fee-for-service system for two (2) years after the transition.

The first meeting of the NHTD/TBI Waiver Transition Workgroup was conducted on August 24, 2015 with over 200 participants in person or electronically. There have been twelve subsequent two- to three-hour meetings conducted. All meeting notes have been posted on the NYSDOH MRT#90 website. Additionally, NYSDOH staff have met weekly since April 2015 to identify issues related to the transition. Prior to the August meeting, monthly conference calls were held with stakeholders and Division of Long Term Care (DLTC) staff.

In addition to posting in the New York State Register, the proposed plan will be posted for at least 30 days on the NYSDOH website for review and public comment prior to submission to

CMS. Subsequent to the public comment period, NYSDOH will post its responses and FAQs on the MRT#90 website.

Additionally, NYSDOH will host a webinar for stakeholders to present the submitted transition plan and the timeline associated with its implementation. NYSDOH will also host a webinar specifically for managed care plans to present the transition plan and timeline as well as to present requirements such as network capacity and plan readiness requirements that must be met prior to the transition of NHTD/TBI participants into managed care.

The Medicaid Director and staff from the Office of Health Insurance Programs (OHIP) meet with representatives from the health care plans on a monthly basis to discuss issues related to the transition to managed care and transition of service recipients into the care system.

Upon submission of the plan to CMS, NYSDOH will direct the RRDCs to host a provider meeting with all Service Coordination agencies to discuss transition planning for participants. Throughout the transition process, the RRDCs will remain available to waiver participants to answer questions and facilitate the transition process. The RRDCs will work with NYMC, managed care plans, Care Managers, waiver participants' current Service Coordinators and participants' informal supports to facilitate plan selection.

A subcommittee of the larger workgroup met on several occasions to discuss member/participant notifications and provider/plan training. The content of the notices was reviewed by waiver participants in order to ensure clarity of the content and readability by the waiver population at large. Additionally, training topics for NYMC and provider staff were identified. As the transition process moves forward, stakeholders and providers will participate in developing training materials and curricula. NYSDOH anticipates that a significant amount of the training materials currently utilized in the waiver programs will be amended to accommodate the managed care environment.

H. Plan Readiness

MMC/MLTC plans determine which organizations they contract with to provide services. The State assures, through a review of provider networks, that a Plan has the network capacity to provide all services in the benefit package. NYSDOH will provide MCOs with a list of current NHTD/TBI waiver providers early in the transition process to encourage NHTD/TBI waiver providers to develop contractual relationships with the plans. NYSDOH is proposing to establish a two (2) year continuity-of-care period for participants and service providers. As a result, MCOs will be required to contract with current waiver service providers for a minimum of two years:

- If the service provider is serving five (5) or more current waiver participants;
- If the service provider continues to serve participants/members 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.

All approved NHTD/TBI waiver providers that continue to provide services will be afforded two years of rate protection through April 1, 2020.

As part of the transition process, an extensive training and outreach program will be developed and implemented:

- Education will be involved to address the extended needs of the population.
- Outreach to members will include face-to-face education at the local level and phone support through call centers.
- The New York Medicaid Choice call center has multiple language lines and contracts with a translation company. Additionally, the RRDCs may assist in participant contact and outreach.
- Outreach calls/follow-up assistance calls will continue throughout the timeline of the transition.
- DOH will train NYMC, the Managed Care Plans, and providers to effectively work with these specific populations and each other.

NYSDOH has offered all stakeholders the opportunity to have input to the content of the training when training materials are developed. Additionally, NYSDOH has indicated that the 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. The RRDCs will serve as technical assistance providers to plans and service recipients.

NYSDOH will conduct a MLTC/MMC plan/provider webinar to inform stakeholders of the transition, as well as to outline network readiness and provider qualification requirements.

NYSDOH will review plan networks prior to the transition to ensure that plans are in compliance with readiness requirements. This review includes and is not limited to such critical elements as:

- The plans' organizational structure and personnel management including responsibilities and reporting relationships;
- Network development, staffing, provider relations, training plans;
- Information systems, reporting and data exchange;
- Member services and provisions for consumer choice;
- Network management and credentialing of providers;
- Utilization management, stabilization of care, facility admissions and continuing stays;
- Dispute resolution processes;
- Clinical management practices and specialties, cultural and linguistic supports;
- Outreach and engagement activities;
- Quality management and demonstrated experience, supervision of monitoring protocols, documentation and audit functions;
- Monitoring of Care Managers and physician advisors;
- Service authorization processes; and
- Access to services in underserved communities and identification of underserved populations.

Network Capacity

MCOs currently have broad care coordination responsibilities. Accordingly, contractual arrangements clearly articulate responsibilities between the entities to ensure non-duplication of

care coordination services. NYSDOH will work with stakeholders to clarify responsibilities and expectations and to ensure safe transition and discharge plans.

The plans must demonstrate and maintain, to the Department's satisfaction, a sufficient and adequate network for delivery of all covered services.

The MCO is responsible to recruit, hire, train, supervise and, if necessary, terminate such professional, paraprofessional, and support personnel as necessary to carry out the terms of the contract and meet performance standards contained therein. MCOs are required to add additional health resources as necessary to meet these obligations. All staff will have the training, education, experience, and credentials, as applicable, to perform assigned job duties. In addition to key staff, the MCO is required to employ a sufficient number of qualified managerial and operational staff to oversee and carry out the MCO's operations relating to the provision of services and support to enrollees with behavioral health needs.

The plan must have a minimum of two (2) providers that are accepting new members in each county in its service area for each covered service in the benefit package, unless the county has an insufficient number of providers licensed, certified or available in that county as determined by NYSDOH. Services carved out of the MCO contract will be delivered on a fee-for-service basis.

If the network is unable to provide necessary services identified in the contract for a particular member, the managed care plan must certify to NYSDOH to adequately and timely furnish these services outside of the plan's network for as long as the managed care plan is unable to provide them within the network.

NYSDOH will review plan networks prior to the transition to ensure that plans are in compliance with capacity requirements. This review includes such critical elements as:

- How the plan will be available twenty-four (24) hours per day, seven (7) days a week three hundred sixty-five (365) days per year;
- Referral protocols and up-to-date provider files and the ability to offer choice of providers;
- Member service call center operations and telephone back-up systems and crisis line;
- Supervision of providers, staff and related monitoring protocols, ability to identify available providers;
- Contractual requirements for providers and credentialing;
- Communications and member outreach, process for member notifications; and
- Response to change of provider requests.

Provider Qualifications

The provider credentialing criteria described in 42 CFR §438.214 and 42 CFR §460.68 must apply to providers of long term care services and supports. This criteria provides that the State must ensure, through its contracts, that each MCO implements written policies and procedures for selection and retention of providers and that those policies and procedures include, a uniform credentialing and re-credentialing policy that each MCO must follow.

Managed care plans will be required that any contracted provider not employ or contract with any employee, subcontractor, or agent who has been debarred or suspended by the federal or

state government, or otherwise excluded from participation in the Medicare or Medicaid program. The managed care plan will ensure that individuals providing services possess the qualifications to provide such services.

Attachment 9 provides the basic staff qualifications for the current waiver services transitioning to managed care. The plans will be required to submit an orientation and training plan that ensures all relevant staff receive training including, but not limited to:

- Care coordination needs of the population served, specifically traumatic brain injury, cognitive deficits and dementia;
- Interdisciplinary approaches to complex care coordination;
- Effective communication strategies for individuals with traumatic brain injury and cognitive deficits;
- Assessment and functional needs analysis techniques;
- Behavioral intervention and outreach and engagement strategies for individuals not actively engaged or participating in their care; and
- Person-centered planning processes.

Service Planning and Delivery

MCO plans cover a wide range of services at home and in the community, including care management services. In each plan type, enrollees have a person-centered plan of care. Each MCO member has a Care Manager who asks about service needs and assists the member and family in developing a plan of care that meets the enrollee's specific needs. The person-centered plan is developed by the plan member with the assistance of the Care Manager, providers and those individuals the member chooses to include. The plan includes the services and supports that the member needs.

The Community Technical Assistance Center Person and Family Centered Planning presents that the components of a care plan include, but are not limited to: goals, strengths, objectives, interventions and care techniques. The goal of the Care Manager is to translate conversations, observations and assessments of the plan member into individual care plans. Plans should be written and spoken in language that is strength based, using person-first terms, avoid negative terms and connotations and reflect the needs and choices of the individual. Information contained in the plan should support the medical necessity of the service, identify appropriate interventions, be effective, and time and resource sensitive.

The managed care plan contract requires the use of a person-centered and directed planning process intended to identify the strengths, capacities and preferences of its members. The service plan identifies the members' long term care needs and the resources available to meet those needs, and to provide access to additional care options identified by the contract.

The managed care plan contract requires that services be delivered in accordance with the service plan, including the type, scope, amount and frequency of service. Additionally, the person-centered planning process must be consistent with federal HCBS regulations, which require that the process is led by the plan member or representative, includes people chosen by the member, supports informed choice, is timely, occurs at time and locations convenient to the member, reflects the member's cultural considerations, reflects risk factors, includes conflict of interest guidelines and indicates who is responsible for monitoring the plan.

Meetings related to the member's person-centered plan will be held at a location, date and time convenient to the member and his or her invited participants. In addition, the MMC/MLTC plans must have interpretation services available if needed and provide care that is consistent with the individual's culture and specific needs.

I. Appeals and Rights

Managed care federal rules guarantee plan members numerous rights that include, but are not limited to: enrollment and disenrollment procedures, plan options and benefits, and member choice and participation in activities. As such, NYSDOH reviews MCO member handbooks, notices and monitors the plans' grievance processes.

Enrollees in MMC and MLTC have rights and responsibilities pursuant to Article 44 and 49 of the Public Health Law. Individuals will have the same protections under managed care as those currently available in the waiver programs. In fact, they will have additional protections, including the 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.

A grievance is an expression of dissatisfaction by the member or provider on the member's behalf about care and treatment that does not amount to a change in scope, amount or duration of service. A grievance can be verbal or in writing. Plans cannot require that members put grievances in writing. Plans must designate one or more qualified personnel who were not involved in any previous level of review or decision-making, to review the grievance, and if the grievance pertains to clinical matters, the personnel must include licensed, certified or registered health care professionals.

Grievances that can be immediately (same day) determined to the member's satisfaction do not need a response in writing. Plans are required to document the grievance and decision, as well as track the grievance and decision for quality improvement purposes. If the grievance cannot be determined immediately (same day), the plan must decide if the grievance is expedited or standard.

All MMC/MLTC enrollees must be informed of the Plan's grievance and complaint systems. This information will be made available through the Member Handbook and through discussion with the care manager. NYSDOH maintains a toll-free complaint line at: 1-800-206-8125 for MMC members, and 1-866-712-7197 for MLTC members.

Contained within the model contracts for the MLTC and MMC plan is a full list of member rights. This information is provided to each plan member and the model contract will be available on the DOH website.

For a reduction, termination or 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 to continue.

A change in State law in 2014 affected all MLTC/MMC plan products and now requires that aid-continuing be provided *without regard* to the expiration of the MLTC/MMC plans prior service authorization. This means that, if a MLTC/MMC plan assesses a member and determines a reduction or discontinuation of previously authorized services, and the member timely requests

a fair hearing and asks that benefits continue pending the fair hearing outcome, the member is entitled to receive the previously authorized services *unchanged* pending the outcome of the fair hearing *even if* the enrollee's service authorization period has expired.

The Office of Administrative Hearings at the NYS Office of Temporary and Disability Assistance is responsible for issuing an aid-continuing directive regarding the member and the MLTC/MMC plan must comply promptly with that aid-continuing directive *even if* the member's service authorization period has expired. The MLTC/MMC plan must comply with the aid-continuing directive until the fair hearing decision is issued. The member also has the right to an independent external appeal by clinical reviewers that do not work for the State or the managed care plan.

J. Consumer Support

Members will have additional safeguards such as access to New York's recently implemented Ombudsman Program, the Independent Consumer Advocacy Network (ICAN). ICAN is available to provide assistance to individuals enrolled in or applying for services in all MLTC and MMC products and for those receiving long term care services. ICAN provides plan members with direct assistance in navigating their coverage and in understanding and exercising their rights and responsibilities.

ICAN was created through a contract between NYSDOH and Consumer Services Society of New York. ICAN is a group of nonprofit advocacy organizations, independent of any health insurance plan, which provides the following services:

1. Consumer education and information to individuals and their caregivers on various topics, such as:
    a. Differences between Medicare and Medicaid programs for people receiving long term care;
    b. The MLTC/MMC enrollment process, CFEEC assessment for potential MLTC enrollees and MLTC/MMC plan selection;
2. Outreach to the individuals and/or their caregivers/legal representatives to educate enrollees on their rights and responsibilities, among other topics; and
3. Consumer advocacy, including:
    a. Counseling (e.g., explaining to recipients their rights and responsibilities, including the availability of the grievance, appeal, and fair hearing processes; assistance regarding the appropriate interpretation of statutes, rules or regulations);
    b. Resolution of enrollees' problems through informal negotiation with a plan or provider;
    c. Preparation and filing of grievances and appeals on members' behalf; and
    d. Representation in appeals, grievances, and fair hearings (for members in MLTC and MMC at the plan and State levels; for members in FIDA, at the plan, State, and Medicare Appeals Council levels).

ICAN help is free and confidential.

- The service maintains a toll-free number: 1-844-614-8800.
- TTY Relay Service 711.
- Email: ican@cssny.org.
- Online: icannys.org.

Managed care plans must provide NYSDOH on a quarterly basis, within fifteen (15) business days of the close of the quarter, a summary of all grievance and appeals received during the preceding quarter.

NY Medicaid Choice is also a resource not currently available to current waiver participants. Plan members can contact the call center for assistance even after enrollment in managed care is completed.

Both MMC and MLTC programs have Technical Assistance Centers; the phone numbers and websites are provided to members. The Technical Assistance Centers handle complaints via phone or email. Their designated intake staff and calls are triaged immediately. Performance review for MLTC TAC has indicated that on average, the unit is receiving 350 calls a month and is tracking an average resolution time of five days.

NYSDOH maintains toll-free complaint lines for both MLTC and MMC enrollees:

For MLTC: 1-866-712-7197 or mltctac@health.ny.gov.
For MMC: 1-800-206-8125 or managedcarecomplaint@health.ny.gov.

K. Quality Assurance

NYSDOH has strong quality assurance(s) in place for all Managed Care Organizations. Each managed care plan must have a quality assurance and performance improvement program that includes a health information system consistent with the requirements of 42 CFR §438.242, and a NYSDOH approved written quality plan for ongoing assessment, implementation and evaluation of overall quality of care and services. The plan will include goals and objectives that provide a framework for quality assurance and improvement activities, evaluation and corrective action. These goals and objectives should be reviewed and revised periodically, and should be supported by data collection activities that focus on clinical and functional outcomes, encounter and utilization data, and client satisfaction data. Plans that do not meet certain thresholds will not receive quality payments.

All MCOs and their networks will be measured on meeting basic contract standards, as well as quality metrics. If a plan fails to meet certain metrics, there will be reimbursement implications.

Managed care plans must have policies and procedures for identifying, addressing and seeking to prevent critical incidents, which include instances of abuse, neglect and exploitation of its members, on a continuous basis. The MCO is required to provide critical incident monitoring and investigations of critical incidents including, but not limited to:

- wrongful death;
- use of restraints;
- medication errors that resulted in injury; and

- any other incidents as determined by the Department.

The plan must submit critical incident reports to the Department regarding member health and welfare pursuant to the terms of their contract. The plan submits to the Department, within fifteen (15) days of the close of each quarter, a Critical Incident Report, in a format specified by the Department, which includes the following: the number of critical incidents that were investigated, including the outcome of the investigation. MCOs are expected to involve law enforcement agencies and/or refer incidents to Adult Protective Services as appropriate. NYSDOH monitors this data.

There are several surveillance activities to ensure plans remain in compliance with state and federal laws and regulations, including, but not limited to: operational surveys, focused audits, member services "secret shopper" calls, provider directory reviews and validation, and utilization management.

Quarterly reporting by the State will include information related to critical incidents, the number and types of grievances and appeals, and an analysis of the 1115 waiver budget neutrality.

NYSDOH is committed to track waiver participants at the time of the transition, in order to identify any future nursing home admissions or institutional placements. NYSDOH takes the goals of its Olmstead Plan seriously and will continue to work to assure that people can live successfully in the community.

L. Budget Neutrality

NYDOH is required to meet the Budget Neutrality requirements as set forth in the 1115 waiver Standard Terms and Conditions. NYSDOH has determined that transitioning the NHTD/TBI populations into the 1115 waiver will allow the State to remain under the budget neutrality cap throughout the demonstration period.

M. Administration and Oversight

NYSDOH will work with the health care plans to ensure that the services delivered are appropriate and person-centered for the individuals served, cost efficient, authorized and implemented by qualified providers.

N. HCBS Final Rule

On January 16, 2014, CMS published the final rule related to Home and Community Based Services (HBCS) Settings for Medicaid-funded long term services and supports provided in residential and non-residential settings under the following authorities of the Social Services Act: 1915(c), 1915(i) and 1915(k). This rule implements a number of changes to home and community based waivers, finalizes regulatory changes to the 1915(i) State plan home and community based services, and imposes new requirements on what is considered an appropriate home/community based residential setting for all the authorities in its scope. The crux of this final rule is to provide person-centered requirements that identify the strengths, preferences and needs (clinical and support), as well as the desired outcomes of the individual.

Public Notice Requirements

In order to ensure compliance with the regulation, NYS must provide a minimum of a 30-day public notice and comment period for this transition plan. At least two forms of public notice will be provided, along with at least two ways for the public to provide input. The State will make the complete transition plan available for review by the public via the New York State Register. Waiver participants have been involved in the transition planning workgroups and will be included in the notification of the posting of the plan. The transition plan document will be available at that MRT#90 website, in order to provide access by people with disabilities, and NYSDOH will also provide an alternative method for those without internet access. Printed copies are made available to stakeholders, distributed at meetings and available upon request. The transition plan will be distributed to the RRDCs for review and consideration at an upcoming Provider Meeting. Providers will be encouraged to review the content of the plan with service recipients. RRDCs will be available to service recipients to address telephone calls and conversations related to the transition plan. NYSDOH waiver management staff will also be available to address questions.

After the public comment period, when the State submits its transition plan to CMS, it will post the complete transition plan with a summary of comments online and provide a URL to CMS.

Over the past year, NYSDOH has demonstrated to CMS that it has provided timely public notice of the opportunity to comment on its transition plan via its inclusion in the transition workgroup process, conference call and publication of meeting notes on the MRT#90 website. It is noted that meeting with representative groups only and/or discussing/providing information on the transition plan without providing the transition plan itself to the public will not fulfill the public notice/input process requirements.

CMS regulatory requirements for HCBS Settings require community based services to be delivered in settings that meet defined criteria. The setting must be integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. CMS also clarifies those settings that do not qualify as “home and community-based settings.” Individuals residing in these non-qualifying settings may not receive community based services.

Settings that do not qualify as “home and community-based settings” per federal regulation include:

- A nursing facility;
- An institution for mental diseases (IMD);
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; and
- Any other settings that have the qualities of an institutional setting.

Settings presumed to have the qualities of an institutional setting, unless documented otherwise, include:

- Any setting located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

- Any setting located in a building on the grounds of, or immediately adjacent to, a public institution; and
- Any other setting having the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid services.

HCBS Transition Plan

NYSDOH published its Statewide Transition Plan for HCBS Settings in January 2015 (https://www.health.ny.gov/health_care/medicaid/redesign/docs/hcbs_statewide_transition_plan_2.pdf). In addition, NYSDOH intends to hire a consultant to assist the State in assessing current compliance, validating provider self-assessments, developing a process to identify settings subject to heightened scrutiny, and developing and monitoring the implementation of any remediation strategies that may be necessary to bring settings that do not fully meet the requirements into compliance prior to March 17, 2019.