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 goal to have all Medicaid enrollees served in Managed Care by 2018. 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 and developmental disability and physical health care services.

In furtherance of this goal, the State is submitting this transition plan to eliminate the 1915c Home and Community Based Services Waivers for the Nursing Home Transition and Diversion (NHTD) Program (control # 0444) and the Traumatic Brain Injury (TBI) Program (control #0269) and will transition its participants into managed care programs operated by New York State (NYS).

Background

The NHTD and TBI Medicaid waiver programs were developed based on the philosophy that individuals with disabilities, 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 Managed Long Term Care (MLTC) as a result of the inclusion of the Long Term Home Health Care Program (LTHHCP) into the New York Partnership Plan 1115 Demonstration (1115 waiver). Additionally, NHTD/TBI waiver participants utilizing spousal budgeting were previously included in the 1115 waiver and will continue to be as MLTC recipients. With the approval of New York's Community First Choice Option (CFCO) services, which include hands on assistance, safety monitoring, and cueing for assistance with activities of daily living, instrumental activities of daily living and health related functions based on need, not diagnosis or age, will be available as Medicaid state plan services. Many of these services are currently provided through these 1915c waivers. The inclusion of these services in CFCO as State Plan benefits, excludes them as Home and Community Based Services (HCBS) waiver services. Further detail regarding CFCO services is available at: https://www.health.ny.gov/health_care/medicaid/redesign/community_first_choice_option.htm.

The NHTD/TBI waiver programs, however, will continue to offer these services until such time that CFCO is fully implemented or the waiver programs are successfully transitioned to managed care.

[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

In 2010, the Home and Community Based Services Expansion Program (HCBS Expansion Program) was added to the 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 and allows special spousal budgeting provisions. This program is currently available in three waiver demonstrations: the Nursing Home Transition and Diversion Program, the Traumatic Brain Injury Program and the Long Term Home Health Care Program. Currently Chapter 59 of the Laws of 2011 excludes participants in the NHTD and TBI waiver programs from participation in a managed long term care program. Upon the approval of this transition plan and the elimination of these 1915c waivers, this condition will be amended.

Upon implementation of this transition plan, as well as approval of a corresponding 1115 waiver amendment, individuals currently receiving services through the NHTD/TBI waivers who wish to continue receiving services must enroll into one of two Managed Care Organizations (MCOs): Managed Long Term Care (MLTC) or Mainstream Managed Care (MMC). MCOs will be required to contract with waiver service providers who serve five (5) or more waiver participants; who will continue to provide services to participants unless a health/safety concern exists; and who assure that appropriately licensed personnel are employed to provide or supervise services. Waiver participants at the time of the transition, will have the choice to maintain his/her existing services and providers for 90 days after the date of transition into a managed care plan. If the same need remains after 90 days, participants will have the option to keep the same providers for up to two years, if the providers meet the required conditions.

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, with a primary focus of supporting those who wish to stay 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.

The primary threshold to determine eligibility for enrollment in a Managed Long Term Care Plan continues to be that an individual, based on a functional assessment conducted in the home environment, must need and receive, or expect to receive, more than 120 days of Community Based Long Term Care Services (CBLTC). CBLTC is defined as Home Health Care, Personal Care Services or Consumer Directed Personal Assistance Services (CDPAS), Private Duty Nursing, and Adult Day Health Care.

Enrollment in a MLTC plan is mandatory:

- For those who are dual eligible (eligible for both Medicaid and Medicare) and equal to or over 21 years of age and in need of CBLTC services for more than 120 days. Effective February 1, 2015, enrollment for individuals 21 years of age or older, who are dual eligible, and new to permanent placement in nursing homes in New York City became mandatory for MLTC enrollment. This extended to Nassau, Suffolk, and Westchester Counties effective April 1, 2015, and expanded Statewide as of July 1, 2015.

Enrollment in a MLTC plan is voluntary:

- For those who are dual eligible and are 18 through 20 years of age and need nursing home level of care and CBLTC services for more than 120 days.
- For those who are non-dual eligible and over 18 years of age and are assessed as both nursing home eligible and requiring CBLTC services for more than 120 days (and are not otherwise required to mandatorily enroll in Medicaid Managed Care).
- For those who are dual eligible and age 18 and over and were previously determined as permanent placements in a nursing home may enroll in MLTC effective October 1, 2015.

A dual eligible individual who no longer needs, nor accepts, the CBLTC services of the plan is appropriate for disenrollment.

Some individuals may request an exemption from receiving benefits through the MLTC plan. Exempt individuals include, but are not limited to:

- Individuals aged 18-21 who are nursing home certifiable and require more than 120 days of community based long term care services;
- Native Americans;
- Individuals who are eligible for the Medicaid buy-in for the working disabled and are nursing home certifiable; and
- Aliessa Court Ordered individuals.

Excluded individuals cannot receive benefits through the MLTC plan. Excluded individuals include, but are not limited to:

- Residents of psychiatric facilities;
- Residents of intermediate care facilities for the mentally retarded (ICF/MR);
- Individuals receiving hospice services at the time of enrollment; and
- Individuals with limited Medicaid eligibility: treatment for an emergency condition, TB, etc.

Mainstream Managed Care

Mainstream Managed Care (MMC) provides Medicaid state plan benefits to enrollees through a managed care delivery system comprised of Managed Care Organizations (MCOs).

Mainstream Managed Care enrollees are individuals with Medicaid only. All Medicaid recipients, except for those who are eligible for an exemption or are excluded, must enroll in a MMC Plan.

Exempt individuals can choose to enroll in a plan or remain in Fee-For-Service (FFS) Medicaid. Exempt individuals include, but are not limited to:

- A person with chronic medical conditions with a non-participating physician – limited to a single six month exemption, after which time they are required to enroll in a plan;
- Residents of long term chemical dependence treatment programs;
- Developmentally Disabled and other waiver individuals; and
- Native Americans.

Excluded individuals cannot enroll in MMC. Excluded individuals include, but are not limited to:

- Recipients with original Medicare;
- Recipients with other comprehensive private health insurance;
- Recipients with limited Medicaid eligibility: treatment for an emergency condition, TB etc.; and
- Recipients receiving hospice services at the time of enrollment.

All MMC enrollees residing in local social service districts where enrollment in the MMC Program is mandatory are subject to a nine (9) month lock-in period following the effective date of enrollment, with an initial ninety (90) day grace period in which to disenroll without cause and enroll in another MCO's MMC product, if available.

Each enrollee that transitions to MLTC or MMC will have continuity of care under the enrollee's pre-existing service plan for at least ninety (90) days, or until a care assessment has been completed by the Plan, whichever is later.

In MLTC and MMC, each enrollee will have a:

- Person-centered plan of care; and
- Care Manager who will ask about service needs and assist the enrollee and family in developing a plan of care that meets the individual's specific needs. The Care Manager also coordinates the delivery of services and maintains contact with the plan member, at a minimum, on a monthly basis.

Transition Narrative

A. Access to Services

The Nursing Home Transition and Diversion (NHTD) waiver and Traumatic Brain Injury (TBI) waiver programs offer a plan of care and services for individuals who would otherwise be eligible for placement in a nursing facility. The NHTD/TBI waiver programs enable the State to provide participants with a number of supportive services not currently available under New York's State Plan for Medicaid services because the provision of waiver services is effective in preventing institutionalization of program participants and allows those who are at risk for nursing home placement to remain in the community. With the implementation of CFCO, the availability of many of these services will be open to all eligible Medicaid recipients as State Plan services. Eligibility requirements for CFCO include:

1. The individual lives in their own home or in the home of a family member;
2. The individual is Medicaid eligible without deeming; and
3. The individual is assessed as needing an institutional level of care.

Individuals enrolled in a Managed Care Organization (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 and comparable or expanded services.

Managed Long Term Care (MLTC) and Mainstream Managed Care (MMC) plan benefit packages will be expanded to include 1915c waiver and CFCO services currently utilized by

1915c waiver participants and not previously included in the current Standard Terms and Conditions (STCs). With the following exceptions:

- Home Visits by Medical Personnel: This service is currently only available through the NHTD waiver program. Review of CMS 372 NHTD reports indicate that Home Visits by Medical Personnel has never been fully implemented nor utilized as a 1915c waiver service. Therefore, we are not requesting that this service be transitioned to the 1115 waiver.
- Peer Mentoring: This service is intended to improve self-sufficiency, self-reliance and ability to access needed services, goods and opportunities in the community. This is accomplished through education, teaching, information sharing and self-advocacy training. This service is currently only available through the NHTD waiver program and has consistently not been utilized or underutilized. Comparable services are available through other community resources such as Independent Living Centers and the Money Follows the Person program. Therefore, the service will not be offered through the 1115 waiver.
- Substance Abuse Programs: These services are provided in an outpatient group setting and may include an assessment of the individual's substance abuse history; learning/behavioral assessment; development of a structured treatment plan which reflects an understanding of the participant's substance abuse history and cognitive abilities; implementation of the plan; on-going education and training of the participant, family members, informal supports and all other service providers; individualized relapse strategies; periodic reassessment of the plan; and ongoing support. The service is currently only provided in the TBI waiver program and will not be included as a discrete service specific to TBI. The service is currently available through Fee-for-Service (FFS), clinics or behavioral health services.

Within the managed care service model, Care Management is a service that assists plan members to access necessary covered services as identified in the care plan. It also provides referral and coordination of services in support of the care plan. Care Coordination services assist members to obtain all medical, social, educational, psychosocial, financial and other services in support of the care plan regardless of whether the needed services are covered under the capitation payment of this agreement. There are several waiver services that will be added to both MLTC and MMC upon approval of this transition plan and the 1115 waiver amendment:

- Community Integration Counseling (CIC) has been redefined as Community Integration Services (CIS). CIS includes individualized services designed to assist the person to more effectively manage their functional, social and/or emotional difficulties associated with community living as related to their medical, physical, and/or psychosocial needs. These services are provided to a recipient coping with altered physical/medical condition(s), abilities and skills. The service is needed to help the person sustain their life in the community and acquire necessary social and environmental supports. These interventions are expected to result in assuring the person's health and welfare, increasing independence, integration and productivity. Activities are individualized and consumer-driven with an emphasis on quality of life from the recipient's perspective. Activities will promote family involvement and may include caregiver education and support. The services will provide unbiased information to the individual, family, significant others, informal and natural supports to enable informed decision-making.

Education/training opportunities may be used to promote service acquisition and social/financial stability in conjunction with their care manager.

These services are person centered based on demonstrated need and may be provided in the provider's office or the participant's home. Services may include, counseling, navigation of service and support systems, service planning as well as direct care service and replicates the functions of Service Coordination, which is therefore eliminated.

- Independent Living Skills Training (ILST). This service assists in recovering skills that may have decreased as a result of onset of a disability. ILST will primarily be targeted to those individuals with progressive illnesses to maintain essential skills. ILST 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 participant will receive a 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. ILST may also be used to assist a participant in returning to, or expanding involvement in meaningful activities, such as paid or unpaid (volunteer) employment. Based on the individual's needs and the method of service provision, this service may also be included as a CFCO service.

- Positive Behavioral Interventions and Support Services (PBIS). This service is provided to plan members 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 including specific realistic goals which can also be utilized by other providers and natural supports; the training of family, natural supports and other providers so they 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. Based on the individual's needs and the method of service provision, this service may also be included as a CFCO service.

- Structured Day Program. Structured Day Program Services are individually designed services provided in an outpatient congregate setting or in the community to improve or maintain the participant's skills and ability to live as independently as possible in the community. 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. This service may augment some other services when reinforcement of skills is necessary. Based on the individual's needs, the method of

service provision, and the environment where the service is provided, this service may also be included as a CFCO service.

The following services are being eliminated as discrete services in managed care, as they are currently available through the existing benefits package.

- Wellness Counseling Service currently offered in the NHTD waiver program defined as: Intermittent evaluation visits to waiver participants who are medically stable to assist them in maintaining optimal health status.
- Nutritional Counseling/Educational Services currently offered in the NHTD waiver program defined as: Assessment, planning, education and counseling for the waiver participant's nutritional needs and eating patterns.
- Respiratory Therapy currently offered in the NHTD waiver program defined as: Services providing preventive, maintenance and rehabilitative airway-related techniques and procedures to the waiver participant in his/her home.

B. Transition Timeline (see Attachment X)

New York State Department of Health (NYSDOH) sent a letter to the Centers for Medicare and Medicaid Services (CMS) on May 27, 2015, indicating the intent to terminate the NHTD 1915c waiver and to request an extension of the existing waiver pending the transition. NYSDOH has not sought to renew the waiver and continues to request temporary extensions in order for the waiver to continue to operate pending CMS approval to transition to managed care. The TBI waiver submitted an application for renewal in June 2013 and continues to operate under temporary extension (T/E) pending the resolution of issues presented in the request for additional information (RAI) process.

With the approval of CMS, in order to effectively transition all current waiver participants, the NHTD and TBI waivers will cease enrollment of new waiver participants ninety (90) days prior to the beginning of voluntary enrollment eligibility into MLTC/MMC (January 1, 2017). Additionally, all pending waiver applicants will be contacted by the Regional Resource Development Centers (RRDCs) and will be advised of the opportunity to enroll into MLTC/MMC services directly instead of seeking waiver services. Upon approval by CMS, referral of new applicants to the NHTD/TBI 1915c waiver programs will cease on or about October 1, 2016. Additionally, NYSDOH will cease enrollment of any new waiver service providers and will no longer approve expansion of existing waiver service providers.

Voluntary enrollment for waiver participants into MLTC and MMC will be effective statewide on or about January 1, 2017. NHTD/TBI waiver participants will receive an announcement notice in December 2016 indicating that the NHTD/TBI waiver programs will no longer be available effective on or about April 1, 2017. If the current waiver participant wants to continue receiving long term care services, they must enroll in MLTC or MMC depending on which program they are eligible. Participants will have the opportunity to select a MLTC or MMC plan. However, if they do not make a selection and are required to mandatorily enroll into managed care, a plan will be selected for them by New York's enrollment broker, New York Medicaid Choice. Currently enrolled MMC members will receive notification that their waiver services will be provided by their MMC plan.

Individuals required to mandatorily enroll that do not choose to voluntarily enroll by March 1, 2017 will be auto-assigned to a managed care plan (MMC or MLTC) for services effective on or

about April 1, 2017. Participants will receive a voluntary enrollment notice 60 days before auto-assignment, on or about January 1, 2017, and a reminder notice 30 days before auto-assignment, on or about February 1, 2017. An auto-assignment confirmation notice will be sent upon auto-enrollment. If they are not subject to mandatory enrollment and do not voluntarily enroll into MLTC or MMC by March 1, 2017, they will no longer be able to receive NHTD/TBI waiver services effective on or about April 1, 2017. Managed care services will begin on or about April 1, 2017.

All new referrals and intake meetings provided through the 1915c waiver will cease on or about October 1, 2016. Individuals who have completed their intake meeting and have not selected a Service Coordinator will be referred to New York Medicaid Choice (NYMC) for enrollment counseling for enrollment into MLTC or MMC.

Individuals currently applying for 1915c waiver services that have selected a Service Coordinator must have a service plan approved by the Regional Resource Development Center (RRDC) and in place by December 1, 2016.

The Money Follows the Person (MFP) Transition Centers and Identification and Outreach Program will cease referrals to the RRDCs by October 1, 2016. MFP Transition Center staff will work with nursing home discharge planners to identify services and to facilitate referrals to MLTC/MMC.

C. Enrollment of Existing NHTD/TBI 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 relevant correspondence, addressing phone calls, offering regional community forums, ensuring transition of services, records retention and ensuring member choice of providers.

Participants will be encouraged to select a MLTC/MMC plan through the announcement notice, followed by the 60 day and 30 day notices as described above. For those that are mandated to enroll, if they do not select a plan, the State's enrollment broker, New York Medicaid Choice will auto-assign them to a plan offering a MLTC product/MMC product in the eligible person's county of fiscal responsibility. Waiver individuals enrolled in MMC at the time of transition will continue to receive those services after the transition date through their MMC plan.

Current NHTD/TBI waiver participants will not experience service limits during or after the transition to MLTC/MMC, as the service plan is need-based and not subject to expenditure or service caps. MLTC/MMC plans must ensure that individuals transitioning from Medicaid FFS to managed care have continuity of the long term care services they are currently receiving for at least 90 days or until the plan of care is implemented, whichever is later.

D. Enrollment after the Transition

Individuals who are seeking services after the transition is effective will follow the existing MLTC/MMC enrollment processes. Individuals seeking enrollment to MLTC will be referred to the Conflict Free Evaluation and Enrollment Center (CFEEC) which will conduct an evaluation to determine eligibility for MLTC. The state ensures through its contracts that each MCO must

complete an initial assessment in the individual's home within 30 days of referral or initial contact.

E. Continuity of Care During Transition

Each managed care plan, its subcontractors, vendors and employees, is required to adhere to its contractual requirements and applicable laws, regulations and policies. The NYSDOH contracts with MCOs will stipulate that the plans will contract with currently approved NHTD or TBI waiver providers for a two year period if the waiver provider is serving five or more waiver participants at the time of transition. The provider is expected to serve participants unless a health/safety concern exists; and the service provider must ensure that there are appropriately licensed personnel to provide and/or supervise the provision of services. Additionally, MCO contracts will be amended to reflect the terms approved by CMS in the transition plan. The managed care plan is responsible for coordinating all services, even those not covered under the plans. Any decision by the plan to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than that requested must be made by a health professional who has appropriate clinical expertise in treating the enrollee's condition(s) or identified needs.

Each participant who is receiving community based long term care services provided through the NHTD/TBI waiver that qualifies for MLTC/MMC must continue to receive services under the participant's existing service plan for at least 90 days after enrollment or until a care assessment has been completed by the MCO, whichever is later. This means that for any individual transitioning to managed care, regardless the circumstance, the plan must provide 90 days of continuity of care. The goal is a seamless transfer of these individuals 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. If the individual requests a State fair hearing to review a Plan's adverse determination, aid-to-continue is to be provided until the fair hearing decision is issued.

Each 1915c waiver participant will have a transition plan developed in conjunction with their current Service Coordinator to ensure that all services remain in place the first day of enrollment in a plan. Services provided during the 90 day transition period will be accessed through fee-for-service.

Current waiver participants will have the choice to maintain his/her existing services and the providers of these services for ninety (90) days. Individuals will have the option to keep the same providers for up to two years, if his/her needs remain the same after the 90 days, and if the providers meet the conditions above.

The RRDC will continue to have a role in the coordination of services including but not limited to, Community Integration Services and other related services.

F. Initial Plan Assessment for NHTD/TBI Transitions

The MLTC/MMC plans will conduct an initial assessment in the individual's home to assess their need for long term care services using the UAS-NY.

The MLTC/MMC plans are required to complete a reassessment at least every 6 months or whenever a significant change in the member's condition occurs. The assessment is conducted by nurses employed or contracted with the managed care plans.

NYSDOH will continue to utilize the UAS-NY as the needs assessment tool. The UAS-NY presents the level of functioning of the individual and provides information for assessors to analyze and make service decisions based on assessment outcomes.

G. Notification Requirements and Stakeholder Engagement

Public Notice.

NYSDOH will publish public notice of the proposed transition in the NYS Public Register as well as at the Medicaid Reform Team (MRT) #90 website.

NYSDOH established the 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.

Tribal notices.

Pursuant to Presidential Executive Order #13175, NYSDOH previously provided the thirteen (13) federally recognized Tribal Governments with written notification of the intent to begin transitioning all NHTD/TBI 1915c waiver participants to Medicaid managed care. As the new timeline is implemented, additional notifications will be sent to the Tribal Governments on April 1, 2016. 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 addition of these two specific target populations receiving services through these 1915c waivers will have limited impact on Tribal Nations.

Stakeholder Engagement.

The proposed plan will be posted on April 1, 2016 for 30 days on the MRT website for review and public comment prior to submission to CMS. Subsequent to the public comment period ending May 1, 2016, NYSDOH will post its responses and FAQs on the Department website. Additionally, NYSDOH will host a webinar with stakeholders to present the 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 final transition plan will be submitted to CMS by June 30, 2016.

The Medicaid Director and staff from the Office of Health Insurance Programs have engaged stakeholders and representatives from the health care waiver community on a regular basis. The first "kick-off" meeting was held on August 24, 2015. Internal NYSDOH workgroup meetings began in September 2014. Additional workgroup and subcommittee meetings have occurred routinely. Meeting minutes, stakeholder attendance, FAQs and slide presentations have been posted on the NYSDOH MRT #90 website and available to the public for review and

comment (www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm). Additionally, NYSDOH has established a waiver transition mailbox at (waivertransition@health.ny.gov) to address questions and comments regarding the transition process.

NYSDOH will direct the RRDCs to host a provider meeting with all Service Coordination agencies to discuss transition planning for participants. The RRDCs will remain available to waiver participants to answer questions and facilitate the transition process. The RRDC will work with NYMC and the waiver participant's current Service Coordinator to facilitate plan selection.

A subset of the subcommittee was convened to review participant notices. The subset included a current waiver participant and members from the RRDC which proved to be most helpful. Notices will be presented in plain language and supports will be available to discuss the content with waiver participants.

Additionally, the subcommittee discussed the role of New York Medicaid Choice (Maximus) as the enrollment broker through the transition process. NYSDOH will train Maximus staff to effectively work with the specific waiver populations transitioning to managed care. Currently, Maximus requires its employees to complete training and provides written training materials to call center staff. Outreach calls and follow-up assistance calls will be provided throughout the transition process. The call center has multiple language lines and contracts with a translation company. Outreach may include face to face educational opportunities in addition to call center response. Also, Maximus will establish a focus group to review participant notices.

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. All approved NHTD/TBI waiver service providers that continue to provide services will be afforded rate protection for two years.

NYSDOH will conduct a MLTC/MMC plan webinar to inform them of the transition as well as to outline their network readiness requirements. NYSDOH will review plan networks prior to the transition to ensure that Plans are in compliance with requirements.

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

The MCOs must contract with at least two providers 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. Services carved out of the MCO contract will be delivered on a fee-for-service basis.

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.

MCOs may only subcontract with subcontractors who are in compliance with all applicable State and Federal licensing, certification, and other requirements, who are generally regarded as having a good reputation and who have demonstrated capacity to perform the needed contracted services.

Training

A specific subcommittee of the workgroup was established to discuss training needs of contractors, plans and providers. Each component of the managed care system must understand the roles and responsibilities it assumes as related to needs of the waiver populations. Education will be provided to address the extended needs of these service recipients. Outreach to enrollees will include face-to-face education at the local level and phone support will be provided through call centers. The call center(s) have multiple language lines and the contractor offers translation services. Outreach calls and follow-up assistance will continue throughout the timeline of the transition. NYSDOH will train New York Medicaid Choice (Maximus) staff to work with these specific populations, such as individuals with Traumatic Brain Injury (TBI) so that they may more effectively communicate, offer choice and ensure informed decisions. Additionally, Maximus requires its employees to complete training and provides written training materials. With the assistance of the stakeholders involved in the transition planning, these materials and training opportunities will be enhanced and expanded.

I. 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 enrollee has a Care Manager who asks about service needs and assists the enrollee 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. All managed care plans must ensure that their Care Management protocols meet NYSDOH requirements. This includes but is not limited to: a minimum of one care management telephone contact per month, a minimum of one care management home visit every six (6) months, and ensures that the level and degree of care management and the plan of care for each member addresses his/her needs based upon the acuity and severity of the person's physical and mental condition(s).

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 contract states: Care management entails the establishment and implementation of a written care plan and assisting enrollees to access services authorized under the care plan. Care management includes referral to and coordination of other necessary medical, and social, educational, psychosocial, financial and other services of the care plan irrespective of whether such services are covered by the plan.

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.

Meetings related to the member's person centered plan will be held at a location, date and time convenient to the member and his/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.

J. Appeal and Rights

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 coordinator. The State maintains a toll free complaint line at: 1-800-206-8125 for MMC members and 1-866-712-7197 for MLTC members.

For a reduction, termination or suspension of service within the authorized period, the MLTC/MMC plan will issue a Notice of Action, giving the person the right to request a State fair hearing and an internal appeal offering aid to continue.

A change in State law in 2014 affected all MLTC/MMC plan products and now requires that aid to continue be provided *without regard* to the expiration of the MLTC/MMC plans prior service authorization. This means that when a MLTC/MMC plan assesses an enrollee and determines to reduce or discontinue previously authorized services and the enrollee timely requests a fair hearing and asks that benefits be continued pending the outcome of the fair hearing, the enrollee 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 that enrollee. The MLTC/MMC plan must comply promptly with that aid-continuing directive *even if* the enrollee'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 enrollee also has the right to an independent external appeal by clinical reviewers that do not work for the State or the MMC plan.

All MCOs must provide the Department on a quarterly basis, and within fifteen (15) business days of the close of the quarter, a summary of all grievance and appeals received during the preceding quarter using a data transmission method that is determined by the Department.

K. Consumer Support

Each managed care plan must have effective mechanisms to identify, address and seek to prevent instances of abuse, neglect and exploitation of its enrollees in receipt of services on a continuous basis. Such mechanisms will include, at a minimum:

i) A process to include information in education materials distributed to plan enrollees and providers to enable reporting of such instances to the Contractor or providing available community resources for enrollee assistance;

ii) Provisions in subcontracts to ensure providers of services comply with State requirements for worker criminal background checks; and

iii) Reporting critical incidents to NYSDOH as provided by the managed care contract.

Participants will have additional safeguards such as access to New York's recently implemented ombudsman program known as the Independent Consumer Advocacy Network (ICAN). ICAN is available to provide assistance to individuals enrolled in or applying for services in all MLTC products and for those receiving long term care services through MMC.

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; and
    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;
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, and assistance regarding the appropriate interpretation of statutes, rules or regulations);
    b. Resolution of enrollee problems through informal negotiation with a plan or provider;
    c. Preparation and filing of grievances and appeals on behalf of enrollees;
    d. Representation in appeals, grievances, and fair hearings (for enrollees in MLTC and MMC at the plan and state levels; for enrollees 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

L. Quality Assurance

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. Each health plan is required to develop comprehensive quality assurance monitoring programs, including beneficiary satisfaction surveys, external quality reviews, review of level of care assessments, and the health and welfare of its members. Plans who do not meet certain thresholds will not receive quality payments.

It is the obligation of the plans to designate a compliance officer and establish a compliance committee pursuant to 42 CFR 438.608(b)(2). It is the obligation of the compliance officer and compliance committee to:

- monitor the plan reporting obligations and ensure that the required reports are accurate and submitted in a timely manner;
- develop written policies, procedures and standards of conduct that articulate the plan commitment to adhere to all applicable Federal and State Standards;
- conduct appropriate staff training activities in an atmosphere of open communication;
- establish provisions for internal monitoring and auditing; and
- have provisions for prompt responses to detected offenses with provisions for corrective action initiatives where appropriate.

All MCOs must have a quality assurance and performance improvement program which includes a health information system consistent with the requirements of 42 CFR 438.242 or 42 CFR §460.130, and a Department approved written quality plan for ongoing assessment, implementation, and evaluation of overall quality of care and services. The MCOs must submit any proposed revisions to the approved quality plan for Department approval prior to implementation. The quality assurance and performance improvement program must identify specific and measurable activities that the plan will initiate in providing oversight of services.

The MCO must collect, maintain, validate and submit data for services furnished to members as stipulated by NYSDOH in its contract with the health plans.

Quarterly reporting by the NYSDOH 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 will track any nursing home placements of prior waiver participants and review the reason/cause of the placement.

M. 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 population into the 1115 waiver will allow the state to remain under the budget neutrality cap throughout the demonstration period.

N. Finance and Rates

Capitation rates shall be determined prospectively and shall not be retroactively adjusted to reflect actual Medicaid FFS data or MCO experience for the time period covered by the rates. Capitated rates shall be certified to be actuarially sound in accordance with 42 CFR §438.6(c).

O. 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, and authorized and implemented by qualified providers.

P. HCBS Final Rule

On January 16, 2014, the Center for Medicare and Medicaid Services (CMS) published the final rule related to Home and Community Based Settings (HBCS) 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 which 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 on the 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, including individuals being served and individuals eligible to be served by the program. The transition plan document will be available at NYSDOH website in order to provide access by people with disabilities, and NYSDOH will also provide an alternative method for those without internet access. A copy of the transition plan will be distributed via the NHTD/TBI eMedNY listserv and distributed to providers. 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. Contact information is available on the Statewide Waiver Program Contact List.

Further, when NYSDOH 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.

NYSDOH will submit evidence to CMS that it has provided timely public notice of the opportunity to comment on its transition plan. Acceptable evidence will include dated copies of letters, emails, and web postings. 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.

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, to address the transition of the NHTD/TBI population into the 1115 waiver, NYSDOH intends to hire a consultant to assist NYSDOH in assessing current compliance, validating provider self-assessments, developing a process to identify and review through heightened scrutiny those settings that CMS may consider as presumed institutional in the final rule. Subsequently NYSDOH will develop and monitor 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.