NEW YORK ASSOCIATION ON INDEPENDENT LIVING

155 WASHINGTON AVE | SUITE 208
ALBANY, NY 12210
518.465.4650 PHONE | 518.465.4625 FAX
INFO@ILNY.ORG | WWW.ILNY.ORG

August 22, 2016

Response to the draft NHTD and TBI Waiver Transition Plan

The New York Association on Independent Living (NYAIL) is a membership organization, which represents people with disabilities and Independent Living Centers (ILCs) across New York State. ILCs are unique disability-led, cross-disability, locally administered not-for-profit organizations, providing advocacy and supports to assist over 87,000 people with disabilities of all ages a year to live independently and fully integrated in their communities. ILCs have been transitioning and diverting people from institutions for more than 20 years and have played a critical role in implementing the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) Medicaid waiver programs, with five ILCs serving as the NYS Department of Health funded Regional Resource Development Centers (RRDC) for the waivers, and many others providing waiver services. The Independent Living community vigorously advocated for the creation of the TBI and NHTD Waivers to ensure that people with disabilities would have appropriate supports and services in place to live in the community. As a result, there is a suite of highly specific supports and services provided to these populations under the Waiver, which has enabled thousands of individuals to successfully live in the community. However, as the State is determined to transition these individuals and the vast majority of Waiver services to managed care, we offer these comments to ensure a smooth transition and ensure a comparable level of services and supports in this new managed care environment.

Access to Services

Community Transitional Services

Community Transitional Services (CTS) is defined as being 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."

NYAIL is concerned that CTS is being limited to individuals leaving institutions. Many people with disabilities currently living in the community are unsafely or unstably housed. These individuals may be staying with family or friends, living in housing which is inaccessible or has other health and safety violations, but cannot move until they receive a rental subsidy. Further, landlord harassment can also cause a person to need to move. While these individuals may not need the level of assistance as one leaving an institution, they should not need to first be institutionalized to receive the assistance they require to live safely in the community. NYAIL recommends changing the definition of CTS to a person either who is leaving an institution, or who requires these services to prevent institutionalization. DOH should not make leaving a nursing home the only criteria for Community Transitional Services. DOH can make it a criteria that individuals moving from one location in the community to another first go to their local department of social services to seek financial assistance. However, as many of these moves will prevent nursing home placement, they should be able to access CTS. When facing a move, be it from an

institution, or from one location in the community to another, the individual's need through the development of the Person Centered Service Plan should determine whether they would receive CTS.

Service Coordination

NYAIL strongly supports including service coordination as part of community based long-term care (CBLTC) under MLTC. As many Independent Living Centers (ILC) have been providers under the NHTD and TBI Waivers, we know the integral role that Service Coordination plays in stabilizing individuals leaving institutions and maintaining them in the community. ILCs, through their work assisting people to live in the community with appropriate supports and services, have found numerous instances where a lack of quality Care Management within managed care organizations have put the participant at risk of homelessness, run-ins with the law, or institutionalization. This is because certain individuals require intensive support to remain stable in the community. Care Management under managed care simply isn't designed to troubleshoot daily problems that, without assistance, turn quickly into emergencies. While certainly not all MLTC participants will require this service, many individuals at the institutional level of care require a level of assistance and support that Care Managers will not have the capacity to provide. Including Service Coordination as a service offered to those found eligible by the RRDCs, will greatly help people to live and receive services in the community.

While supportive of including service coordination as a service under managed care, we believe that DOH is unnecessarily holding Service Coordinators to a conflict-free standard. We will spell out how, if properly defined, service coordination can supplement and complement care management while still complying with the HCBS rule.

CMS's recently updated regulations for Person Centered Planning under Medicaid Managed Care, at 42 CFR §438.208(c)(3)(ii)), appear at 42 CFR §441.301(c)(1) and (2), and the specific conflict-of-interest regulation is at 42 CFR 441.301(c)(1)(vi) reads:

"Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."

In seeking to comply with this rule, DOH has proposed that providers of service coordination must be conflict-free, meaning that these providers would not be able to provide any other HCBS services. However, given the description of service coordination in this Transition Plan, NYAIL believes that DOH can clearly draw a line of distinction between the advocacy responsibilities of a Service Coordinator and the case management and care planning responsibilities of Care Managers within MCOs.

DOH proposes Care Managers, working for the managed care plan, conduct the person centered service plan (PCSP) with the participant. In addition, Care Managers should be responsible for case management services such as arranging for assessments, connecting participants to service providers, ensuring that requests for referrals and/or pre-approvals are handled, and ensuring compliance with applicable policies and regulations when approving and paying for services.

Service Coordinators on the other hand, should serve as an advocate for the participant. DOH describes the role of Service Coordinators as "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."

The Transition Plan describes Service Coordination activities as including:

- 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.

In the draft plan, 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 Service Coordinator will have a crucial role in ensuring the participant is stable in the community and mitigate preventable crises. Service Coordinators should also be available to attend important meetings, such as those lead by the Care Manager when developing the PCSP. While Service Coordinators will not be responsible for developing the PCSP, they can be a trusted support and advisor for the participant during this process. However, given the types of activities outlined above, they are not responsible for developing the PCSP, or for typical case management activities.

Holding Service Coordinators to the conflict-free standard, who are not conducting evaluations, assessments, providing case management, or creating service plans, will unnecessarily limit the provider pool. Currently, most agencies providing service coordination under the Waivers, are also providers of HCBS. If DOH were to unnecessarily hold service coordinators to the conflict-free standard, many people would lose their current Service Coordinators as those Service Coordinators would be ineligible to provide the service in most instances. Agencies would be forced to choose between providing Service Coordination and a whole array of HCBS services, whether it be under DOH, OMH, or OPWDD. This will severely limit the ability of participants to maintain their current Service Coordinators. Given the intensive relationship developed between Service Coordinators and the people they serve, this would be very disruptive for many participants.

NYAIL does believe that the conflict-free standard is extremely important to maintain for those conducting evaluations, assessments, providing case management, or creating service plans. We do not believe that Care Managers are truly conflict free, as they work directly for the MCO. MCOs have a financial interest in providing as few services as possible, and therefore, cannot truly provide conflict-free service coordination. It would be strongly preferable if the State developed a model whereby the development of the person-centered service plan was conducted by someone independent of the MCO and who had expertise in this type of plan development.

In the Transition Plan, Service Coordinators will be responsible to complete one (1) face-to-face visit per month. NYAIL recommends that this read that “Service Coordinators will be responsible to complete a minimum of one (1) face-to-face visit per month”. Participants may need more support in a given month than one face to face. Events such as transitioning from a nursing home, or other major life event will cause a participant to need intensive services from their Service Coordinator. There should not be anything in the plan to limit their ability to meet those needs and stabilize the individual in the community.

Finally, NYAIL strongly supports maintaining a role for RRDCs by, in part, having them assess participants for the five enhanced services. However, DOH should clarify the timeline when participants are referred to the RRDC and expand who can make those referrals. In attachment 5, DOH indicates that referrals for the enhanced services can come from the Care Manager, the MCO, or the individual. Referrals to the RRDC should be accepted from any source, including family members, social workers and discharge planners.

In the Transition Plan, it states that “the role of the RRDC is to supplement and support the care planning initiated and implemented by the Managed Care Organizations.” However DOH does not spell out if the referral to the RRDC would happen prior to the care planning process, or after. Certainly, a plan of care should not be completed until the participant has been assessed for all services, including the enhanced services.

NYAIL recommends that DOH clarify the timing so that it is clear that the care planning process must happen after all assessments have been conducted and a Service Coordinator has been assigned. Participants should have the option to include their Service Coordinator during the development of the PCSP. Service Coordinators have a lot of experience working with people at the institutional level of care and with development of Individualized Service Plans under the NHTD and TBI Waivers. While the Service Coordinators will not be responsible for the development of the PCSP, they can provide support to the participant, who may lack other supports.

Transition Timeline

In attachment 6, DOH lays out the timeline for awarding contracts for the RRDCs. DOH plans to send out requests for applications in September 2017 and then award these contracts one month later, by October 2017. These contracts will then take effect by January 2018 to coincide with voluntary enrollment.

NYAIL is concerned that this timeline is unrealistic, not allowing sufficient time for RRDCs to prepare applications or sufficient time for DOH to review these applications and award contracts. Given that the role of RRDCs will be significantly different under managed care than it was under the NHTD and TBI Waivers, NYAIL recommends allowing ample time for RRDCs to prepare their applications. Further, New York State typically directs awardees of state contracts to wait for fully executed contracts before beginning a program or providing a service. DOH must not expect RRDCs to provide services until their contracts are fully executed. As such, NYAIL recommends DOH allow significantly more time between when the contracts are awarded and when RRDCs are expected to begin providing functional assessments, technical assistance, and other services.

Enrollment of Existing NHTD/TBI Waiver Participants

NYAIL strongly supports having the nine RRDCs play an active role in transitioning current NHTD and TBI Waiver participants into managed care. The RRDCs have extensive experience working with the Waiver participants and are uniquely positioned to ensure that the participants in their regions understand the transition process and choose a new provider accordingly. However, NYAIL does recommend that DOH spell out more specifically exactly what they expect from RRDCs to ensure that participants are well informed and have the assistance they need to make a smooth transition into managed care. Many participants have significant cognitive impairments and may need significant assistance to understand the transition, what it means for their services, and to choose a plan.

The draft plan states that 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.

NYAIL recommends that DOH spell out what auto-assignment process will be used and how they will ensure continuity of care in this instance.

Continuity of Care during Transition

NYAIL strongly supports the two-year continuity of care provision in the Transition Plan whereby a participant may keep their service providers for up to two years, providing they maintain eligibility. As stated above, participants come to trust and rely on their service providers. A change in providers for many of these services would be very disruptive to the participants and to their stability. As participants will already have a major change by transitioning from a Waiver to receiving services through a managed care organization, it is in the participant's best interest to ensure they can maintain their service providers following this transition.

However, once again, participants will not be able to maintain their Service Coordinators if DOH holds them unnecessarily to the conflict-free standard. Under the NHTD and TBI Waivers, Service Coordinators were/are responsible for the development of their Individualized Service Plan and case management responsibilities. However, as DOH is recommending that the Care Managers, working for the MCOs are responsible for the development of the PCSP and other typical case management duties, this standard should not apply to Service Coordinators. We take the opportunity to point this out once again as it is crucial for the participant's continuity of care to be able to maintain their Service Coordinators.

Initial Plan Assessments for NHTD/TBI Transitions

In the Transition Plan, DOH establishes the UAS-NY as the assessment tool that MLTC/MMC plans will use to establish eligibility. While the Transition Plan acknowledges that there is significant concern that the UAS-NY has proven to be ineffective at accurately measuring cognitive deficits, DOH defends this decision by stating that the UAS-NY has a Cognitive Performance Scale, which is used internationally. DOH does take the concerns of the community seriously by committing to additional mandatory training on the UAS-NY and encouraging family members be present at the time of assessment. Yet, DOH has not been able to demonstrate the

effectiveness of the tool in assessing people. NYAIL recommends that additional mandatory training be conducted by consultants with a long history of working in the mental health and TBI field.

Granted, 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. Yet, the sample size was a mere ten individuals from each of the stated categories. This sample size is far too small for DOH to claim this proves that concerns and deficits of the UAS-NY have been addressed.

In their Transition Plan, DOH states that they will seek to do an additional assessment when an individual is found ineligible. However, DOH does not spell out who will perform the reassessment. NYAIL proposes that anyone found ineligible when assessed by the UAS-NY, regardless of the type of impairment, automatically be referred to an impartial third entity for assessment. NYAIL recommends that the RRDC, who will already be responsible for assessing people for the enhanced services, assess anyone found ineligible using the UAS-NY. The RRDCs have a lot of experience assessing people at the institutional level of care, including those with cognitive and other impairments and can be a trusted evaluator for DOH and for people with disabilities seeking services.

We thank DOH for the opportunity to comment on this draft Transition Plan. We are available to answer any questions regarding these comments.

Respectfully Submitted,

Meghan Schoeffling
Policy Analyst