Long Term Care Highlights

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DLTC

Balancing Incentive Program (BIP)
Home and Community Based Services (HCBS)

Fully Integrated Duals Advantage (FIDA)

Managed Long Term Care (MLTC)

Conflict Free Evaluation and Enrollment Center (CFEEC)
Home and Community Based Services (HCBS) Final Rule

- On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) published the Final Rule related to Home and Community Based Settings for Medicaid-funded Long Term Services and Supports (LTSS) 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 HCBS and imposes new requirements on what is considered an appropriate Home and Community Based residential setting for all the authorities in its scope.

HCBS Settings Final Rule: Overall Intent

- 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 for the individual.

- Requirements maximize the opportunity for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting.

- Align policies and procedures for individuals in need of HCBS across disability populations using three distinct Medicaid-funded authorities: 1915(c), 1915(i), and 1915(k).

- The final rule took effect March 17, 2014. States were required to submit transition plans to CMS within one year of the effective date indicating how they intend to comply with the new requirements within a reasonable time period.
HCBS Settings Final Rule: Requirements

- The Final Rule establishes:
  - Mandatory requirements for the qualities of Home and Community Based Settings, including discretion for the U.S. Department of Health and Human Services (HHS) Secretary to determine other appropriate qualities;
  - Settings that are not Home and Community Based;
  - Settings presumed not to be Home and Community Based; and
  - State compliance and transition requirements.
- An individual’s rights of privacy, dignity, respect, and freedom from coercion and restraint;
- An individual’s initiative, autonomy, and independence in making life choices; and
- An individual’s choice regarding services and supports, and who provides them.

HCBS Settings Final Rule: Requirements

- Allowable Home and Community Based Settings:
  - Are integrated in and support access to the greater community.
  - Provide opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources.
  - Ensure the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
  - Selected by the individual from among setting options, including non-disability specific settings, and an option for a private unit in a residential setting.
  - Person-centered service plans document the options based on the individual’s needs and preferences; and for residential settings, the individual’s resources.
HCBS Settings Final Rule: Requirements

Provider-Owned or Controlled Residential Settings

• Additional requirements:
  • Specific unit/dwelling is owned, rented, or must be occupied under legally enforceable agreement.
  • Same responsibilities/protections from eviction as all tenants under the landlord/tenant law of the state, county, city or other designated entity.
  • In New York State (NYS), residents of Adult Homes do not have leases. However, a written residency agreement is required extending these protections for Assisted Living Program (ALP) residents and others living in adult care facilities pursuant to Sections 461-g and 461-h of Social Services Law. This complies with the federal requirement.

• Each individual has privacy in their sleeping or living unit.
• Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed.
• Individuals sharing units have a choice of roommates.
• Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
• Individuals have freedom and support to control their schedules and activities and have access to food any time.
• Individuals may have visitors at any time.
• Setting is physically accessible to the individual.
HCBS Settings Final Rule: Requirements
Provider-Owned or Controlled Residential Settings

• Modifications of the additional requirements must be:
  • Supported by specific assessed need;
  • Justified in the person-centered service plan; and
  • Documented in the person-centered service plan.

Types of Settings

NOT Home and Community Based:
• Nursing Facilities;
• Institutions for Mental Diseases (IMD);
• Intermediate Care Facilities (ICFs) for Individuals with Intellectual Disabilities; and
• Hospitals.

PRESUMED NOT to be Home and Community Based:
• Settings in a publicly or privately-owned facility providing inpatient treatment;
• Settings on grounds of, or adjacent to, a public institution; and
• Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

PRESUMED NOT to be Home and Community Based - heightened scrutiny:
• These settings may NOT be included in states’ 1915(c), 1915(i) or 1915(k) HCBS programs, unless:
  • A state submits evidence (including public input) demonstrating that the setting does have the qualities of a Home and Community Based setting and not the qualities of an institution; and
  • The HHS Secretary finds, based on a heightened scrutiny review of the evidence, that the setting meets the requirements for Home and Community Based Settings and does not have the qualities of an institution.
NYS Systemic Assessment Review

- Staff from all waiver operating agencies reviewed the rules, regulations, standards, practices, licensing and provider requirements and determined that the NYS framework is in compliance with the federal requirements.
- However, there are settings that are not currently in full compliance, for which NYS will be submitting a remediation plan to ensure that these settings comply within the timeframe stated in the State Transition Plan (STP).
- Notably, we know that many service recipients live in provider-owned settings that may partially comply with the settings requirements (e.g. Adult Homes, Supportive Housing). In addition, service recipients may live in group settings that partially comply with the requirements.
- There are also settings in NYS that are presumed institutional that we know meet or can meet the intent of community integration. The STP calls for identifying these settings and submitting evidence that proves they are appropriate HCBS settings. Some of the comments received on the revised STP point to evidence that we should submit as part of the heightened scrutiny process.

HCBS Settings and Assisted Living Programs (ALPs)

- ALPs are in a unique situation in NYS, as the program is administered under the personal care benefit in the Medicaid State Plan.
- The regulation does not extend to State Plan services.
- However, it appears to be CMS' intent to eventually apply these standards to all Medicaid-funded recipients of HCBS.
- ALPs would be included in the requirements sooner than later, if the program transitions as planned into Managed Long Term Care (MLTC) next year. This is because CMS required similar setting requirements in the NYS Standards Terms and Conditions (STCs) of the 1115 Partnership Waiver.
Assisted Living Programs

- The ALP must comply with requirements if moved into MLTC and/or Medicaid Managed Care (MMC).
- The Preamble makes clear that an individual’s resources can be a factor in whether or not a private room is provided; that written residential agreements can substitute for formal leases as long as protections from eviction exist; and that the rule is not intended to banish congregate living arrangements.
- LeadingAge submitted comments, which included examples of how ALPs currently assure dignity, privacy, choice, and freedom to individuals under existing state and provider standards.
- Working together, we can assure that ALPs remain a viable option for individuals with lower-acuity needs.

Other Housing Providers

- All settings in which recipients of Medicaid-funded HCBS under the specified authorities (1915-k, i, or c) or pursuant to STCs of the 1115 Waiver must be in compliance with the new federal rule as outlined in the STP.
- This means Adult Homes, Assisted Living Residences, Adult Care Facilities, Enriched Housing, Supportive Housing, Group Homes, and other residential settings.
- It doesn’t matter where the services are provided. The requirement is based on where the service recipient lives.
- CMS may withhold funds from states that fail to ensure compliance in accordance with their approved STP.
NYS Assessment: Non-Residential Settings

- NYS provides Medicaid-funded HCBS LTSS in the homes of enrolled individuals and in the greater community.
- The final rule requires states to assess their non-residential settings and ensure that they possess the qualities and characteristics described at 42 CFR 441.301(c)(4).
- NYS currently provides some HCBS LTSS in settings that are presumed to be institutional under the federal rule. These include day programs in institutional settings like Nursing Homes (NH), Hospitals or ICFs. NYS must submit evidence to the HHS Secretary that the setting has the qualities and characteristics that render it Home and Community Based vs. institutional in order to claim Federal Financial Participation on services provided there beyond the transition period approved in the STP.
- The STP includes a timeline for assessing non-residential settings to determine compliance and developing remediation activities that may be necessary.

Revised STP

- The revised STP was submitted to CMS by the deadline of March 17, 2015, and DOH is waiting for CMS approval.
- The revised STP is available on the Medicaid Redesign Team (MRT) website at: [www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm](http://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm)
- The revised STP includes:
  - Specific assessment of current compliance;
  - Stakeholder input and involvement in implementation and ongoing assessment of certain residential and non-residential settings; and
  - A timeline for implementing changes to non-compliant settings over a five-year period.
MLTC Transition

- The MLTC transition is almost complete.
- **Purple** = Counties that are **not** yet mandatory.
- **Gray** = Counties that are mandatory.
- Counties we are planning to transition in May include: Chemung, Essex, Hamilton, Chautauqua, Schuyler, Seneca, and Yates.

MLTC Statewide Enrollment

As of May 1, 2015

- **New York City** 113,456
- **Rest of the State** 21,572
- **Total Enrollees in MLTC Statewide** 135,028
- **Number of Plans Statewide Actively Enrolling** 49
  - Medicaid Advantage Plus (MAP) Serving New York City 8
  - Program of All-Inclusive Services for the Elderly (PACE) Serving New York City 8
  - Partially Capitated Serving New York City 33
MLTC Recent Updates

- Recent updates regarding enrollee rights:
  - Elimination of exhaustion of Internal Appeal right requirements
  - Direct access to Fair Hearings
  - Must request a Fair Hearing to get Aid to Continue
  - Can have Internal Appeal with Plan and file Fair Hearing request
  - Can file Internal Appeal and Fair Hearing simultaneously
  - Can file External Appeal and Fair Hearing simultaneously
  - New MLTC notices for Partial Plans:
    - MLTC Initial Adverse Determination
    - MLTC Action Taken – Denial, Reduction of Termination of Benefits

1915c Waivers Update

- Current 1915c Waivers are set to expire this year: Nursing Home Transition and Diversion (NHTD), Traumatic Brain Injury (TBI), and the Long Term Home Health Care Program (LTHHCP).

- DOH will seek an extension of the current NHTD Waiver set to expire on August 31, 2015.

- The extension of TBI Waiver is currently with CMS for approval.

- The LTHHCP Waiver also expires on August 31, 2015, and we are evaluating options.

- The process of transitioning NHTD Waiver participants to Managed Care is underway internally. DOH hopes to have a draft Transition Plan out for public comment next month. Contingent upon approval by CMS, the NHTD Waiver participants will begin the transition process on January 1, 2016.
What is CFEEC?

- On October 1, 2014, NYS implemented a Conflict Free Evaluation and Enrollment Center (CFEEC) for individuals seeking Community Based Long Term Care (CBLTC) services for more than 120 days.

- CFEEC is operational in Regions 1 through 6.

- The implementation timeline is available on MRT #90 website: [www.health.ny.gov/health_care/medicaid/redesign/docs/2015-03-26_updated_cfeec_timeline.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-03-26_updated_cfeec_timeline.pdf)

CFEEC Eligibility

CFEEC evaluates a consumer’s eligibility for one of the four MLTC products:

- Partially Capitated Plans
- PACE
- MAP
- FIDA (Downstate demonstration counties only)
What Does CFEEC Do?

- **MAXIMUS** is serving as the CFEEC, providing evaluation and education services. Staff Nurse Evaluators are performing in-home evaluations – including Hospitals and NHs – using the Uniform Assessment System for New York (UAS-NY).
- CFEEC activities include scheduling initial eligibility evaluations for people new to service seeking CBLTC.
  - The CFEEC has five to seven business days from when a call is received to schedule an evaluation.
  - Scheduling is based on the consumer’s availability. Factors, such as a consumer insisting a family member or caregiver be present, could delay the timeframe.
  - The CFEEC Nurse Evaluator will not conduct the evaluation unless the appointment can be confirmed.
- CFEEC must complete the UAS-NY for all evaluations prior to all MLTC Plan enrollments.
- Staff at CFEEC, including the Nurse Evaluators, are trained in the UAS-NY and have the appropriate levels of access granted.
- Once the evaluation is completed, if consumers are eligible for MLTC, they will have the option of selecting a Plan and allowing CFEEC to assist with connecting them to the Plan. A notice will be sent to consumers indicating their eligibility for CBLTC.
- Plans are required to complete the UAS-NY assessment within 24 hours following the CFEEC evaluation and every six months following enrollment into the Plan or upon a significant change in condition.
CFEEC Highlights

• 144 trained nurses and more coming if needed to meet the timelines
• Low number of complaints
• MAXIMUS is obtaining quality metrics
• Implementation in Upstate counties will not occur until these counties are mandatory

What is FIDA?

• The FIDA demonstration program is designed for dual eligible (Medicare and Medicaid) to:
  • Improve the Participant’s experience in accessing care.
  • Deliver person-centered care.
  • Promote independence in the community.
  • Improve quality through improvements in care and coordination.
• The FIDA Program began on January 1, 2015, and is operational in New York City and Nassau County.
• The FIDA demonstration period runs from January 2015 to December 2017.
FIDA Highlights

• **Care Coordination** and the **Interdisciplinary Team (IDT) approach** – integration of medical, behavioral health, substance abuse, LTSS, and social needs.

• **Full Medicare and Medicaid coverage**, long term care, Part D and Medicaid drugs, and additional benefits from a single, integrated Managed Care Plan. FIDA covers additional services most of which are **not** currently available through the MLTC Plans.

• A **continuity-of-care period** of at least 90 days after the enrollment effective date to have access to all Providers, including Non-Participating Providers, all authorized services, and pre-existing service plans – including prescription drugs. If the individual receives behavioral care, their continuity-of-care period will be two years.

• Integrated and **streamlined** Grievances and Appeals process.

FIDA Highlights

• **NO** new deductibles, premiums, or copayments to the Plan.

• **NO** referrals to see specialists.

• **One** phone number at the Plan for all questions regarding benefits.

• **One** ID card to receive all FIDA benefits.

• Have a Care Manager who can schedule doctor’s appointments, arrange transportation, and help Participants get their medicine.

• Participants can add their caregivers to their care team to help them make decisions regarding their care and understand the goals of their care plans.

• Participants have the right to leave FIDA at any time and for any reason. If they decide to do so, they will **continue** to receive all of their Medicaid benefits through the MLTC program and all of their Medicare benefits through Original Medicare, or a Medicare Advantage Plan, and a Part D Plan.
FIDA Highlights

- The Participant Ombudsman program, known as the Independent Consumer Advocacy Network (ICAN) serves FIDA, MLTC, and Medicaid Managed Care enrollees who receive LTSS. ICAN can be reached by calling 1-844-614-8800 or online at: www.icannys.org.

- The IDT approach is participant-focused.

- FIDA's integrated Grievance and Appeals process is the first in the nation.

- A provider training portal has been established to reduce the burden on Providers and Plans. As of May 8, 2015, more than 10,200 Providers have registered for the core provider training module on the portal.

- DOH has developed a Participant-friendly website for FIDA: www.health.ny.gov/health_care/medicaid/redesign/fida/

Why Should an Individual Join FIDA?

- Receive full Medicare and Medicaid coverage, long term care, Part D and Medicaid drugs, and additional benefits from a single, integrated, Managed Care Plan. In other words, FIDA covers all the benefits that the individual may receive through their MLTC Plan, Original Medicare, or their Medicare Advantage Plan, and their Part D Plan.

- FIDA covers additional services, which are not currently available through MLTC Plans, for example:
  - Home and Community support services
  - Mobile mental health treatment
  - Peer mentoring
  - Positive behavioral interventions and support
  - Substance abuse services
  - Wellness counseling
Why Should Home Health Providers Participate in FIDA?

- **Home Health** and personal care services are covered under FIDA.
- FIDA will allow you to **collaborate** with other Providers as part of a care team to develop a single, customized care plan to address all of the Participant’s specific needs.
- FIDA will **save you time**, as the FIDA Care Manager will document your Participant’s care plan, and any changes to it; help your Participant schedule appointments and arrange for transportation; and keep you informed about any services or care your Participant receives.
- FIDA may help **decrease avoidable hospitalizations** by offering you more opportunities to speak with your Participant and the other members of the care team to make sure they understand and follow the goals of their care plans.
- FIDA will **streamline** the administrative claims processing, since there is **one** billing process and one payer (the FIDA Plan) for both Medicare and Medicaid services.
- A Frequently Asked Questions document for Home Health Providers was released and is available on the FIDA MRT website: [www.health.ny.gov/health_care/medicaid/redesign/faq_for_home_health_providers.htm](http://www.health.ny.gov/health_care/medicaid/redesign/faq_for_home_health_providers.htm)

Balancing Incentive Program (BIP)

- The overarching goal for BIP is to rebalance the portion of NYS Medicaid LTSS expenditures so that Home and Community Based expenditures comprise at least 50% of NYS’ total LTSS expenditures.
- **$598.7 million** was allocated to increase access to community based LTSS and support the Office for People With Developmental Disabilities (OPWDD) and Office of Mental Health (OMH) Transformation agreements.
- BIP requires three structural changes:
  - No Wrong Door/Single Entry Point (NWD/SEP) network
  - Core Standardized Assessment (CSA) instruments
  - Conflict Free Case Management (CFCM) standards
BIP Goals

Rebalancing the delivery of LTSS towards community based care.

Promoting enhanced consumer choice.

Improving access to and expanding community LTSS.

Providing essential services in the least-restrictive setting.

BIP Progress

• In federal fiscal year 2009, the NYS rebalancing percentage was 46.7%, which made NYS eligible for BIP.

• As of March 31, 2015:
  • BIP Goal = 50%; NYS = 58.7%.

• As of April 1, 2015, the CMS quarterly report reflects:
  • NYS has completed 81% of the required deliverables.
  • CMS milestones for the percentage of completion are not weighted for complexity.
BIP Next Steps

• In March, CMS announced it would entertain state-specific requests to extend the timeframe for investment of the BIP grant award through September 30, 2017.

• Extensions should be focused on existing activities that require additional time to complete.

• Any proposed activities/uses of funding should align with the goals of the program.

• This change is providing opportunity for agencies to rethink the design of BIP initiatives and re-engineer for improvement, make optimal decisions, rather than decisions forced by short time constraints and request additional funds.

• DOH is working on its request to submit to CMS. When finalized, DOH will make the plan available on the MRT website.
Contact Us:

FIDA MRT Website:  
www.health.ny.gov/health_care/medicaid/redesign/mrt_101.htm

FIDA e-mail: Fida@health.ny.gov

MLTC MRT website:  
www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm

CFEEC e-mail: CF.Evaluation.Center@health.ny.gov

BIP MRT website:  
www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm

BIP e-mail: BIP@health.ny.gov