

The following reflects the public comments presented in response to the posting of the 1915c Nursing Home Transition and Diversion Medicaid Waiver (control #0444.R01). Responses were due to NYSDOH by December 1, 2017.

One commenter presented a discrepancy on page 154 in the last paragraph of the application stating that “the RRDC will review the 24-hour provider report and issue a status response within 48 hours but on page 157 it says the RRDC will do this within 24 hours.”

Response: NYSDOH recognizes the discrepancy and will amend the application.

One commenter presented that “the UAS is not effective in terms of appropriately establishing level of care requirements for populations that have cognitive needs... The state should have created an “alternative route” as they have done in the TBI waiver so that if a person is deemed ineligible due to an UAS score, they can provide documentation that they do in fact have a need appropriate for NHTD services. “

Response: NYSDOH disputes the statement that the UAS is “not effective in terms of appropriately establishing level of care.” CMS approved the UAS-NY as the assessment tool for level of care for the NHTD waiver via technical amendment effective April 1, 2014 and has not required an alternate route process.

One commenter presented that simply meeting the diagnostic criteria (no matter the cause) should establish the level of care requirement since the NHTD waiver is not disability specific.”

Response: Section B-1 of the waiver application states that in order to be eligible: “The applicant must be at least aged 18 at the time of applying for services. Once enrolled in the program there is no maximum age limit to receive services. If the individual is between the ages of 18-64, he/she must have a physical disability for a primary diagnosis.”

The individual must be a Medicaid beneficiary with Medicaid coverage that supports community based long term care.

The individual must be assessed to need nursing home level of care (LOC) as established by the currently approved patient assessment instrument (UAS-NY).

The individual must choose to participate in the waiver and be able to identify a residence in which he/she will be residing when receiving waiver services. Residential settings of four or more unrelated individuals are excluded. Waiver participants at the time of the approval of the waiver application residing in a setting of four or more unrelated individuals will be grandfathered in until the individual moves. The services and supports available through the waiver and other sources must be sufficient to maintain the individual's health and welfare in the community.

The criteria for physical disability is established in the Program Manual as: Documentation from the individual's physician, hospital summaries or nursing home summaries verifying physical disability (age 18-64).

Individuals age 65 or older must require nursing home level of care.

One commenter presented that as the state readies to transition the waivers into the managed care setting, reducing administrative requirements and unfunded mandates should be a priority.

For example, even though service plans are required only annually, service providers are still required to complete ISRs every six months.

Response: CMS Technical Guidelines state: “In order to assure participant health and welfare and the effective delivery of waiver services, active, continuous monitoring of the service plan is an essential component of the waiver.... The state may specify a minimum monitoring schedule and/or provide that monitoring schedule.”

In this circumstance, NYSDOH has chosen the development and review of ISRs as a monitoring tool for plan implementation and participant progress.

“In addition, the requirement that supervisors meet with every client for whom they provide supervision is not only unnecessary, it flies in the face of how most supervision is provided in the healthcare setting.”

Response: The provision of health care services generally requires direct client contact that includes observation and discussion with the service recipient. The requirement that a supervisor have this minimal contact is a quality assurance measure.

“Given the fact that some waiver participants require 24-hour supervision/oversight and the challenges associated with providing services in a home and community based setting, some flexibility of the service caps should be developed. For example, if a PBIS or ILST worker is with a participant and for some reason, HCSS staff fail to show up, staff are required to stay to ensure health and safety of the participant. On rare occasions, it might take a few hours for the HCSS provider agency to get another staff member to the participant’s home to relieve them. In such cases, the hours will count against the participants hour cap or may exceed the weekly allotted amount, which would not be appropriate. Some mechanism (i.e. the RRDC being able to approve emergency exceptions to the caps) would ameliorate such issues. “

Answer: PBIS and ILST staff are not a “back-up” or “substitute” for HCSS staff and as such should not bill for the provision of a service while waiting for staff. CMS used 372 reporting data to assess participant utilization and subsequently established service caps. Data supports that the imposed service limits are sufficient to meet the needs of the population.

“The state should ensure that all the major issues associated with the waiver transition plan are resolved before transitioning the NHTD waiver into managed care. Making these changes to the current application will make the transition smoother and less chaotic for the participants and families whom are impacted.

Response: All issues presented in this comment are related to the transition of waiver services to managed care and will be addressed through the ongoing Waiver Transition Workgroup.

One commenter presented concerns regarding service limits: “Both the TBI and NHTD waiver applications indicate a limitation of 4 hours per week for PBIS and ILST services.”

Response: CMS used 372 reporting data to assess participant utilization and subsequently established service caps. Data supports that the imposed services limits are sufficient to meet the needs of the population.

The application states:

ILST: No additional hours are allowed to complete initial and reassessments. Not to exceed 220 hours annually/4 hours per day.

PBIS: The number of hours utilized to complete the initial behavioral assessment must be included in the service plan and may not exceed ten (10) hours per service plan period. Hours are not provided to write the plan. The service is limited to 240 hours annually not to exceed 8 hours per day.

One commenter presented: "One issue that I have with the NHTD enrollment process is that it is very difficult to transition a participant out of a nursing home into an apartment when environmental modifications are involved. Most apartment complexes don't allow any changes to be made to the apartment until the lease is signed and as per the waiver, the participant must be living in the apartment when the lease is signed. Therefore, this causes an issue when someone is in need of a ramp, etc. to safely live in a community apartment."

Response: As provided in the CMS Olmstead Letter #3, the state authorizes home accessibility modifications up to 180 consecutive days of admission in advance of the community transition of an institutionalized person. The pending application provides for environmental modifications to be initiated up to 30 days prior to the initial Notice of Decision (NOD)/Discharge from the facility and reimbursed after the NOD is issued. Housing is not a waiver service; therefore, the waiver application does not address execution of leases in relationship to waiver services.

One commenter presented: "Additionally, due to the many hurdles presented to me as a result of the complicated systems, completing an enrollment in 60 days is not always possible and I am requesting that you consider extending this time frame a bit."

Response: Timelines for submission of service plans is identified in the Program Manual, not the waiver application. Upon approval of the application, this language may be addressed in the Program Manual. Currently, in extenuating circumstances, RRDCs may extend the 60-day limit.

One commenter presented: "The January 2019 merger of these Waivers into Managed Long Term Care is ill-advised, and, at a minimum, premature. The combination of an increased minimum wage, improved job market, insufficient partial capitation rates and financial disincentives to serve high need individuals has led to the fleeing of service providers, decreased choice, cherry picking of consumers and approved home care hours not actually being covered. Unless and until these issues are fully addressed, the NHTD and TBI waivers should not be incorporated into Medicaid Managed Care. Furthermore, the elimination of the State-funded housing subsidy for new applicants without any program to fill this vital need is going to result in the needless institutionalization of many New Yorkers. The subsidy should be maintained."

Response: NYSDOH appreciates your comments related to the transition to Managed Care. The specific actions related to the transition will be more fully defined in the transition plan to be submitted to CMS. The comments provided are not specific to the content of the application.

"There has been a pattern of NHTD and TBI waiver applicants sitting in limbo for months, sometimes years, waiting for a written Notice of Decision on their applications. This is a denial of due process and causes people to remain needlessly warehoused in facilities. We ask that Appendix F (p.148) include a provision requiring the RRDC to advise applicants 60 days after their application that they may treat the failure to receive a written decision on their application as a denial from which they may appeal and receive a fair hearing."

Response: The comments presented will be considered as NYSDOH further defines its operational procedures in an amended program manual to be finalized upon CMS approval of the application. Please note that delays in determining eligibility are often due to participant error.

“Appendix F (p.151) states that the RRDC may take whatever steps are reasonable and prudent to protect a person from harm and provide prompt treatment must be taken. This must be done consistent with the individuals expressed wishes and desires unless such person has been adjudicated to lack capacity to make these decisions. We ask that this or similar language be added to respect the dignity and autonomy of those being served.”

Response: The application states: “A participant’s safety must always be the primary concern of the provider agency, SC and the RRDC. Whatever measures appear to be reasonable and prudent to ensure the protection of a person from further harm, injury, or abuse, and to provide prompt treatment or care, are taken. When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused a person shall be removed from direct contact and immediate proximity to, or responsibility for, the participant.”

The issues of concern are inherent throughout the contents of the application and supported by the program manual. This in no way limits participant autonomy.

One commenter presented: The NHTD plans to rely on the UAS-NY for determining eligibility, despite no evidence of its reliability and validity for such purpose, nor any working definition of nursing facility level of care. We are also aware of individuals who have been institutionalized for several years at NYS Medicaid expense, only to be determined to be ineligible because they (miraculously!) no longer need nursing facility level of care. Until the UAS-NY is deemed reliable and valid, and a clear working definition of nursing facility level of care is provided, the UAS-NY should not be used for eligibility determinations.”

Response: CMS approved the UAS-NY as the assessment tool for level of care for the NHTD waiver via technical amendment on effective April 1, 2014 and has not required an alternate route process. For documentation of the validity of the assessment instrument please see: https://www.health.ny.gov/health_care/managed_care/mltc/pdf/uas_comm_hlth_asses_data_val_tbi.pdf

One commenter presented that there is confusion regarding the wording in the application about the requirement that all ILSTs be supervised regardless of qualification and experience.

Response: The application states: “All agencies that employ two (2) or more ILST staff must provide supervision by an individual who fully meets the qualifications as an ILST provider. The supervisor is expected to meet any waiver participants prior to approving the training plan developed by an ILST under their supervision, have supervisory meetings with staff on at a monthly basis, and review and sign-off on all training plans. A supervisor may maintain an active caseload of waiver participants.”

There are no qualifications that eliminate the need for supervisor.

The commenter also indicated this same concept is demonstrated in the PBIS section.

Response: The requirements are different. The application states: “The two key positions in the PBIS service are the Program Director and the Behavioral Specialist. Each PBIS provider must employ a Program Director.

The Program Director is responsible for assessing the member and developing the PBIS plan for each member. The Program Director may perform the function of a Behavioral Specialist or supervise the Behavioral Specialist. The Behavioral Specialist is responsible for the development and/or implementation of the Detailed Plan under the direction of the Program Director.

If a provider has more than one individual who meets the qualifications for Program Director, each of these qualified individuals can develop PBIS plans.”

One commenter presented: “Since the initial writing of the application for TBI and NHTD waivers, there have been many new mental health and clinical degree classifications that seem equally appropriate for the waiver services. While the previous qualification guidelines presented an arduous task to find qualified candidates, the current qualifications add significant challenges to the process. Current qualifications create challenges in staff recruiting, seeking adjustments to qualifications. CIC and PBIS qualifications should both include Mental Health Practitioners.”

Response: The qualifications in the application were made to streamline and eliminate confusion related to staff qualifications and to prepare the provider community for transition to managed care. Qualifications are now consistent with those required by managed care plans.

One commenter presented: “NYSDOH should make the “grandfather exception” for staff qualifications permanent so the Department does not unintentionally push qualified staff out of the workforce.”

This statement is repeated throughout the comments for multiple services. NYSDOH should make the “grandfather exception” permanent.

Response: The qualifications in the application were made to streamline and eliminate confusion related to staff qualifications and to prepare the provider community for transition to managed care. Qualifications are now consistent with those required by managed care plans.

One commenter presented: “The conflict of interest (COI) corrective action plan (CAP) should be posted for public review and comment prior to DOH submitting the NHTD waiver renewal application to CMS.”

Response: The application states: “NYSDOH will issue written guidance on the COI requirements and the subsequent programmatic changes that must occur.” The Corrective Action Plan is a separate and distinct document that is approved through a separate CMS review, which was approved on June 27, 2017.

One commenter presented: “Data collection regarding implementing service caps should be collected, reviewed and unintentional consequences to participants identified prior to NYSDOH submitting the waiver renewal to CMS.

Response: CMS used 372 reporting data to assess participant utilization and subsequently established service caps. Data supports that the imposed services limits are sufficient to meet the needs of the population.

The commenter also presented: Additionally, the number of participants that will lose counseling services (CIC) when the two-year limit is up should be identified and shared with the NHTD stakeholder community.”

Response: The application states: “The efficacy of a treatment must be reviewed if successful intervention and significant progress has not occurred within two (2) years. At that time, alternative methods require consideration or continued services must be documented as a medical necessity. A transition plan will be implemented prior to the termination of services. Services may be extended in extraordinary cases with sufficient medical justification and upon review and approval of the RRDC.”

One commenter presented: The process for the use of UAS-NY for development of the detailed plan and service goals for ILST services and the PBIS assessment is not clearly defined.

Response: The UAS-NY assessment is a comprehensive functional assessment available at the time of service approval. Use of this information will expedite the initiation of services. The content of the detailed plan is not limited solely to the information provided in the UAS-NY.

One commenter presented: NYSDOH should clearly outline the process to implement the changes associated with cost reporting.

Response: Additional directives will be provided by NYSDOH upon approval of the application and providers will be offered training. NYSDOH anticipates the distribution of the Consolidated Fiscal Report (CFR) Manual which will provide additional direction to providers.