

Overview of Waiver Renewal WebEx Q and A
Date of Presentation: January 13, 2016

1915 (c) Comprehensive HCBS Waiver Application Questions

WAIVER PROCESSES

1. Where can I get a copy of the OPWDD 1915 (c) Comprehensive Home and Community Based (HCBS) Waiver Application?

The OPWDD 1915 (c) Comprehensive Home and Community Based (HCBS) Waiver Application can be found on our website at the following link:

<http://www.opwdd.ny.gov/node/6344>

2. Within the Renewal Application, what does highlighted text mean?

OPWDD has highlighted information throughout the Waiver Application to indicate the selection of a check box/circle.

3. What is the submission timeline of this proposed Waiver Renewal to the Centers for Medicare and Medicaid (CMS)?

OPWDD is currently in a period of public comment until March 4, 2016. In conclusion of the public comment period, OPWDD will prepare responses to public comment and evaluate any changes that should be made in the application. Following this assessment of public comment, OPWDD will submit the Renewal to CMS.

We hope to have an approved Waiver Renewal by April 1, 2016 in order to begin implementation of the proposed changes discussed during these presentations. We will keep people updated as the process of formal submission to CMS continues.

4. When will these potential changes go into effect?

This Renewal Application includes changes that were agreed to in earlier Technical Amendments and these elements of the Renewal were implemented in 2014 and 2015. The proposed elements of the Waiver that are new will be implemented following CMS approval and public notice.

5. How can comments be directed to CMS? And will CMS review comments submitted to OPWDD on the waiver application?

Stakeholders can email CMS directly at RONYdmch@cms.hhs.gov

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OPWDD is required to review the public comments and publish responses to them. In addition, any changes that are made to the waiver based on public comment is published, as well.

STATE PLAN SERVICES VS. WAIVER SERVICES

1. Will OPWDD continue to fully fund all HCBS Waiver services following the approval of the Waiver Renewal? For example, Respite.

Yes, the OPWDD 1915 (c) Comprehensive HCBS Waiver will continue to fund all services included in the HCBS Waiver today. On the first page of Appendix C of the HCBS Waiver Application (online document p. 43) there is a list of services that are available through the HCBS Waiver.

2. Is there guidance on what services are part of the HCBS waiver versus what services are State Plan?

On the first page of Appendix C of the HCBS Waiver Application (online document p. 43) there is a list of services that are available through the HCBS Waiver. The HCBS Waiver Services are: Day Habilitation, Live-in Caregiver, Pre-vocational Services, Residential Services, Respite, Supported Employment (SEMP), Community Transition Services (CTS), Fiscal Intermediary (FI), Individual Directed Goods and Services (IDGS), Support Brokerage, Assistive Technology (AT), Community Habilitation, Environmental Modifications (EMODS), Family Education and Training (FET), Intensive Behavioral Services (IBS), Pathway to Employment, and Plan of Care Support Services (PCSS). The other OPWDD services which are not a part of the HCBS Waiver and are Medicaid State Plan services are: Article 16 Clinics, Day Treatment facilities, Medicaid Service Coordination (MSC), and Intermediate Care Facilities (ICFs). There are sections of the OPWDD website that can provide more guidance at the following link: <http://www.opwdd.ny.gov/welcome-front-door/resource-booklet>.

3. How will the HCBS Waiver interact with the Community First Choice Option (CFCO) State Plan?

CFCO is a Home and Community Based State Plan option that will be implemented in NYS. OPWDD intends to submit a subsequent amendment to the waiver application in the future to reflect changes that will be needed as a result of CFCO implementation. There will be more information forthcoming on this State Plan and its impact in the future.

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HCBS WAIVER ELIGIBILITY

1. Are persons eligible to receive waiver services if they reside in a nursing home or rehabilitation setting?

No, when individuals opt to enroll in the HCBS Waiver, they are choosing to receive community-based rather than institutional services. Individuals cannot enroll in the HCBS Waiver if they live in an Intermediate Care Facility (ICF), Developmental Center (DC), or a Skilled Nursing Facility (SNF).

If someone lives in an institutional setting and wants to leave that facility and live in the community as an alternative, the individual can be enrolled into the HCBS Waiver after s/he transitions out of that skilled nursing facility.

Please note: to be eligible to enroll in the OPWDD Comprehensive HCBS Waiver, an individual is required to demonstrate an ICF level of care. In addition, an individual must demonstrate that s/he has a developmental or intellectual disability and live in an “allowable setting.” The allowable settings are described in statute, NYS SSL section 366(7-a (b)(iv)), regulations (NYCRR Part 635-10.3) and include the person’s own home or that of relatives, a supervised or supportive community residence, a certified individualized residential alternative (IRA), or a certified family care home. Individuals residing in settings certified by other state agencies or admitted to and residing in residential schools are not eligible for enrollment in the Waiver.

2. If a person lives in an IRA, can s/he move in to his/her own apartment and continue to receive Waiver services?

Yes, persons can live in their own apartments or family member’s homes and can continue to receive Waiver services. In fact, the majority of people served through the HCBS Waiver do not live not in a certified residence, such as an IRA.

3. Will people living in IRA's be able to receive Waiver services?

Yes, an IRA is an eligible setting for Waiver enrollment. (See response to Question #1 above.)

4. If a person previously received Waiver services but has not for some time, does s/he have to reapply for Waiver services? Meaning, how long is the Waiver enrollment period good for?

If there has been a significant lapse of Waiver services, the individual would need to reapply for enrollment in the Waiver. Reapplying for enrollment (including a current level of care

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for ICF level of care) assures that the individual continues to be eligible for, and in need of, HCBS waiver services.

5. If you are enrolled in Consumer-Directed Personal Assistance Program (CDPAP), can you qualify for Waiver services?

Yes, CDPAP is a consumer-directed personal assistance program State Plan option for individuals who self-direct their personal care services. An individual who is enrolled in CDPAP can also opt to receive HCBS Waiver services if his or her needs are not fully met by CDPAP services.

6. Can individuals continue to receive Family Support Services (FSS) while they are enrolled the Waiver?

In certain circumstances, yes. For example, Family Support Services funds family outreach and education for individuals who live at home. A person who is enrolled in the Waiver and lives with his or her family might benefit from outreach and education services funded by FSS.

7. Does the Renewal of the Waiver Application have any impact on the Waiver enrollment status for people already enrolled in the Waiver and receiving Waiver Services?

No, the OPWDD 1915 (c) Comprehensive Home and Community Based (HCBS) Waiver Application is a legal agreement with the Federal government that defines how NYS delivers and funds HCBS Waiver services. The Waiver Renewal does not affect an individual's current enrollment in the HCBS Waiver.

8. Can a court or another agency require an adult individual, living at home with a parent or caregiver, to accept HCBS Waiver services, if s/he demonstrates a need for Waiver services but does not want to receive such services?

Probably not. An individual chooses to enroll in the HCBS Waiver and receive Waiver services. However, an individual may have a legal guardian authorized by a court to make decisions about where the individual lives and what services he receives. In that case, the court appointed guardian could make that choice on behalf of the individual. If there is a dispute about the individual's ability to make such choices for him or herself, the individual may be advised to seek a remedy through the court that issued the guardianship order. The basic premise of receiving community supports and services is that the individual has a choice of receiving said services.

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9. Does the HCBS Waiver provide financial support for house maintenance, utilities, taxes, and such when parents support children with developmental disabilities in the home?

No, the HCBS Waiver does not allow Medicaid payments for housing costs for individuals enrolled in the Waiver. OPWDD may provide housing subsidies with State funding.

HCBS WAIVER PROVIDERS

1. Are HCBS Waiver providers certified by OPWDD to provide Waiver services to individuals?

Provider agencies must be approved by OPWDD to deliver Waiver services and are the only agencies that may deliver HCBS Waiver services in the OPWDD system. A provider agency must have an OPWDD Provider Agreement. The Provider Agreement identifies the types of Waiver services that a provider can provide. In addition, there are site-based services that require an operating certificate. OPWDD will soon implement changes that will require HCBS Waiver providers to have an Operating Certificate, issued under Mental Hygiene Law Article 16, instead of the OPWDD Provider Agreement. More information is available at this link: http://www.opwdd.ny.gov/opwdd_regulations_guidance/npa_materials

2. How are agencies informed by any proposed changes to service delivery included in the Waiver Renewal application?

Any changes included in the Renewal Application to the way HCBS Waiver services must be delivered are subject to CMS approval. Once approved, the changes will be implemented with appropriate public notice.

DAY HABILITATION

1. Can you explain the comment on slide 14 regarding the "sunset" of Individual Day Habilitation in September 2015?

Day Habilitation is a program that is currently in operation and that is not changing. There was, however, a change for a subset of Day Habilitation called "Individual Day Habilitation." Individual Day Habilitation was an hourly one-on-one service that had very low enrollment. Program changes were made to Community Habilitation that allowed for the provision of the same services as those that were provided in Individual Day Habilitation. Thus, Individual Day Habilitation was 'sunset' effective October 1, 2015. OPWDD worked carefully with those providers, individuals and families to ensure that all who were enrolled in Individual Day Habilitation either moved into a regular Group Day Habilitation program or

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moved into Community Habilitation. The transition depended on which program best met the needs of the individual.

2. How does the Waiver cover the cost of care for individuals (including retired seniors or medically frail individuals) who are not interested in receiving Day Habilitation?

There are several options for these individuals. Once enrolled in the Waiver, a person can opt to self-direct their services, allowing a very flexible package of services to be put together for the individual to enjoy retirement options outside of the certified setting. In addition, the Residential Habilitation provider can offer opportunities in the home. Moreover, Community Habilitation is an option for these individuals to enjoy community integration opportunities outside of certified settings. In some communities, there are Senior Programs that may also be available.

RESIDENTIAL HABILITATION

1. Does the Waiver Application address the payment of vacancies and retainer days?

Yes, there is extensive discussion about payment for those days. This topic is described in Addendum A, which is the rate setting language, starting on page 221.

2. Is there a possibility that Individualized Residential Alternatives (IRAs) will be closed?

No. There are no plans to close IRAs.

3. Can HCBS Waiver providers bill Residential Habilitation between the hours of 8am and 3pm for retired individuals?

Residential Habilitation is a service that is billed on a “per diem” basis. This means a provider bills a daily unit for each day where services were provided.

RESPITE QUESTIONS

1. Does the HCBS Renewal Application speak to an annual dollar cap on an individual's Respite?

No, an annual Respite cap is not addressed in the OPWDD Waiver application. There is a provision that limits the daily claim amount for Respite in the Rate Setting section (page 302 of the on-line document). This means that there is a limit on the amount of money that the

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Federal government is willing to pay for Respite services in a 24 hour period. However, when an individual requires additional respite during the 24 hour period, providers are held harmless because OPWDD is “covering” the balance that the Federal government is not willing to provide. We continue to work with CMS on a methodology that will no longer require implementation of the cap.

2. Currently an individual is not able to find agencies that offer one-on-one Respite for individuals.

We appreciate the comment. In addition, we understand how important Respite is to our population and how challenging it can be to provide. We believe that the fee methodology we are proposing for Respite will promote the provision of one-on-one Respite.

3. How will the proposed Respite fee methodology affect access to the one-on-one Respite service?

The methodology described would allow both a one-on-one and a group Respite. The goal of this proposed methodology is that the fees will incentivize service provision of one-on-one Respite services. Please note, that this is a request that OPWDD is presenting to CMS and, therefore, is subject to CMS approval. OPWDD Regional Offices will work with providers to ensure continuity of Respite service delivery when this fee methodology transition occurs.

4. Why are individuals who live independently and require 24/7 care (for protective oversight) not eligible for Respite services?

Respite is a unique waiver service because it is not a “direct” service to the individual. It is relief to the individual’s caregiver. If someone lives independently without an unpaid caregiver, then there is no one to relieve and OPWDD cannot authorize the Respite service.

SUPPORTED EMPLOYMENT

1. Will the prerequisite for Pathway to Employment or Supported Employment (SEMP) be changed?

No program changes have been made in this Waiver application to the pre-requisites for Pathway to Employment or SEMP. The language is the same as in Amendment 07 of this Waiver agreement.

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SELF-DIRECTION

- 1. Does the Waiver Renewal propose any changes to allow the utilization of self-directed staff outside of the typical Day Habilitation hours for people who live in certified residences?**

No, the rules are not changing in this application. When an individual lives in a Supervised IRA, Supportive IRA or Family Care Home, CMS requires that OPWDD applies consistent rules throughout all of these settings. The residential provider is responsible for the habilitative and community integration needs of people on weekday evenings and anytime on weekends. (This was implemented in previous applications-Amendment 07.)

- 2. How can self-direction be provided between the hours of 8am to 3pm? More specifically, outside of the home if an individual wants to retire.**

Self-directed services can be provided anytime for people who live in their own homes, but cannot be provided in a certified setting. That is, a person who lives in a certified residence can only receive self-directed services provided outside of the residential setting during weekday, day-time hours. (Note there are exceptions for employment-related services.)

- 3. How will the Waiver Renewal affect children who currently self-direct their services and live in a non-certified residence?**

The self-direction services described in this Waiver application are based on changes that occurred in 2014. Based on this Renewal Application there will not be any changes in the self-direction plans for Individuals.

- 4. CMS has not used Bureau of Labor statistics for setting rates of professional providers in self-direction services. So why is this methodology being used in NY?**

The methodology using Bureau of Labor statistics was approved by CMS. That is not changing in this Renewal Application. A change that is happening outside of the Waiver is the Independent Practitioner Service for Individuals with Developmental Disabilities (IPSIDD). IPSIDD is a Medicaid State Plan service that is currently under development.

Additional information regarding IPSIDD is available at:

http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_services/service_changes

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5. Can you provide clarification regarding Fair Hearings for service needs that exceed the level of the Personal Resource Account (PRA)?

A participant has a right to a Medicaid Fair Hearing on a denial, termination or reduction of a self-direction budget, as long as the budget amount the person is requesting does not exceed the target value. A request to exceed the budget target amount is not an issue governed by Fair Hearing requirements.

6. For self-direction services, does OPWDD consider a young adult who has stopped receiving educational services as “eligible?” For example, an 18 year old may elect to cease participation in school services although s/he would be eligible for educational services through his/her 21st birthday.

OPWDD will consider that a young adult is eligible for educational services until such time that he or she has “aged out,” graduated or has left high school after completing the compulsory years of education. A young adult may self-direct services and the full PRA is available once he or she has “aged out,” graduated or completed the compulsory years of education.

FISCAL INTERMEDIARY

1. How are any quality issues with Fiscal Intermediaries (FIs) addressed?

All Waiver providers, including FIs, are subject to review by OPWDD.

2. Will there be some form of medical loss ratio applied to Fiscal Intermediaries (FIs)?

No, a medical loss ratio relates to health insurers and relates to proportion of premium revenues spent on operating/administrative costs and service costs. Funds paid to FIs are not health insurance premiums. FIs bill Medicaid directly for a monthly fee to cover operating/administrative costs. The FI bills Medicaid and pays for the self-directed services that an individual utilized based on actual service documentation and billing.

3. As a provider, I am interested in expanding my Waiver services to include Fiscal Intermediary (FI) services. How does my agency accomplish this?

There are processes in place for providers who are interested in expanding the types of services that they currently provide. With the growth of interest in self direction, it is

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anticipated that there will be a need for additional FIs. More information is available at this link:

http://www.opwdd.ny.gov/opwdd_services_supports/service_providers/how_to_become_a_service_provider

4. Fiscal Intermediaries should be analyzed regarding their costs of doing business in regards of evaluating services.

We thank you for your recommendation. FI do report their costs in the Consolidated Fiscal Report (CFR), and OPWDD will evaluate providers' surplus-loss for FI services.

NYS TRANSITION PLAN/HCBS SETTINGS TRANSITION PLAN

1. What is the status of the NYS Transition Plan?

Work is underway by the Department of Health (DOH) and other state agencies that deliver HCBS services to revise the New York State Transition Plan that was initially submitted to CMS in March 2015. The following link is on the DOH Medicaid Redesign Team (MRT) home page for the NYS Statewide Transition Plan:

https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm. An initial publication and public comment period for the State Transition Plan (STP) occurred in February/March 2015 before submission of the initial STP. In September 2015, CMS responded to New York State's initial Transition Plan requesting further information and detail including timelines and milestones. NYS is revising its Plan.

Additional information relative to the OPWDD HCBS Settings Transition Plan, which is a component of the larger New York State Transition Plan, can be found on our website at: http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/transition-plan. Resources can also be accessed on the OPWDD HCBS Settings Toolkit at: http://www.opwdd.ny.gov/opwdd_services_supports/HCBS/hcbs-settings-toolkit

2. What will happen if the HCBS standards are not met at the time of full implementation in 2019?

Settings subject to heightened scrutiny (i.e., settings CMS presumes are institutional and/or isolating) will be required to submit an evidence package for public input and for submission to CMS for approval. For more information, see the October 2015 Provider Communication Memo regarding Heightened Scrutiny at the following link:

<http://www.opwdd.ny.gov/node/6252>

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For settings that are not subject to heightened scrutiny, OPWDD's Division of Quality Improvement will monitor compliance through its ongoing survey and inspection activities. Settings that fail to comply will be subject to the full array of OPWDD enforcement remedies including plans of corrective action, fines, etc.

3. What are the OPWDD policies that are being put into place regarding the relationship between HCBS Settings and Olmstead in sheltered workshops?

OPWDD continues a dialogue with the Centers for Medicare and Medicaid (CMS) related to the HCBS Settings Transition and how this regulation is implemented in NYS. As more is learned and as OPWDD implements the Federal regulation, we will keep people informed. OPWDD is devoting significant resources to the transition activities to bring services into alignment with the Federal HCBS Settings regulations by the 2019 deadline. Additional information regarding employment services is available at:

http://www.opwdd.ny.gov/opwdd_services_supports/employment_for_people_with_disabilities

4. What are the housing options available for individuals and what are the restrictions in terms of inclusion in the community?

People who receive HCBS Waiver services must have the opportunity to experience community life just like anyone in the community. There are certain provisions of the HCBS Settings regulations that apply particularly to certified, provider controlled housing (e.g., IRAs or CRs). There are particular assurances regarding provider controlled housing that the State and providers will meet by the end of the HCBS transition period. The work regarding these assurances is underway.

5. What protections are in place to ensure that the OPWDD community is safe from individuals who have a criminal record that are being placed in community based settings with other individuals?

The provisions of the Waiver Application do not address the specific requirements for individuals with a forensic history. Throughout the Waiver in the various Appendices (C, G and H), there are protections for everyone regarding health and safety. The language details incident reporting and quality oversight. In addition, the Waiver provides elaborate descriptions of the overall systems of assurances that are in place related to health and safety, and adequate supports for all individuals (specifically in Appendices G and H).

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WAIVER QUALITY IMPROVEMENT

1. How are you collecting data for the various performance measures?

There are quality measures throughout the Application that assess how OPWDD and its providers are performing. Each Appendix contains a quality improvement section which includes charts describing the measures throughout the Application. Those charts identify the data source and frequency of data collection and analysis. One example of the data sources is National Quality Indicator interviews and Division of Quality Improvement (DQI) surveys. In addition, fiscal interviews are conducted by OPWDD which compare information gathered via billing and claiming reviews or other Medicaid billing analyses. The structure of data gathering is elaborate and staff are continuously evaluating the effectiveness and efficiency of this process. The results of these measures are reported annually to the Federal government.

2. How will Division of Quality Improvement (DQI) and the Bureau of Program Certification (BPC) Protocols be affected by changes in the Waiver Renewal Application? And how can stakeholders evaluate the performance measures in the OPWDD HCBS Waiver for correction throughout the five year waiver period?

OPWDD has a Bureau of Program Certification and a Division of Quality Improvement which has various protocols regarding the review of Waiver services which are described in the application. The proposed changes that were discussed during the presentation did not impact any changes to the performance metrics. However, there is a continuous OPWDD process to review protocols in order to update the Waiver as necessary. If through engagement with stakeholders, it is discovered that there is a need to make a change, staff can submit an Amendment of the Waiver to make that change. Those protocols are an important source of data for the quality measure that we record annually to CMS.

RATE SETTING

1. Would any change in the rates that are detailed in Addendum A require CMS approval of a Waiver amendment?

Yes. There are four changes to the rate setting methodology that will require CMS approval to implement. These items are:

- Respite fees and a transition period to the new fee methodology
- Interim funding methodology for High Needs people who are new to services
- A technical change to Specialized Funding for people leaving institutional settings
- Technical change regarding funding for services that are taken over by another not-for-profit provider.

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These elements were outlined in the January WebEx presentations that can be found at this site:

http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/HCBS_waiver_services

2. Is there any rate setting guidance available?

There are relatively few changes in the funding methodology in the Waiver Renewal. The Rate Setting language is technical and complex, and does require a detailed understanding of provider Cost Reporting requirements. If a Stakeholder has a concern about the funding for a particular service, this can certainly be the subject of a comment and need not include references to the particular technical rate setting description in the Waiver Renewal.

3. If the rates are retroactive to 10/14, will agencies have to pay back monies due to lower rate structures?

There are no retroactive changes to rates going back to 10/1/14 that would negatively affect HCBS Waiver providers.

SPECIAL POPULATIONS FUNDING-TEMPLATE FUNDING

1. When will the Special Needs Funding (Template Funding) for people who leave institutions or nursing home settings be available?

Specialized funding is an existing program. OPWDD has proposed a technical change to implement a different date for the Template Funding regarding the flow of Federal funds. If an individual is currently seeking to transition from an institution, these funds are available. For individuals who are receiving specialized funding now, they will continue to receive specialized funding. More information regarding this topic can be found on our website at the following link: <http://www.opwdd.ny.gov/node/3654>

HIGH-COST NEEDS FUNDING PROPOSAL

1. Will “interim funding” for high cost individuals be a one-time expenditure or a designated time frame of payments?

Information regarding this proposal can be found on pages 305-306 of the online document. This proposed interim funding would be available until such time as the provider’s costs for delivering services to that person are available in its Consolidated Fiscal Reporting (CFR).

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An agency's Residential Habilitation and Day Habilitation reimbursement rates are based, in part, on the prior CFR cost reporting. If the new individual is very different from the individuals the provider is currently serving, then the provider's cost history would not reflect this disparity. This interim rate would be in effect until the costs of serving this new individual are a part of the provider's cost history and can be used to update rates. Once these costs are available, the interim rates would no longer be in effect and the provider would just have one rate which would include the service provision to the new higher cost individual.

2. Why is OPWDD being more restrictive in self-direction when it comes to high needs people?

The methodology for self-direction is not changing with this waiver renewal; it was approved by CMS in Amendment 07. OPWDD will be re-evaluating Personal Resource Accounts (PRAs) in the future based on new and better assessment systems. Please note, we do allow special funding for people leaving institutions who choose to self-direct services. This provision existed prior to the Renewal.

3. How does a provider become eligible to deliver services to high needs individuals?

Individuals' needs and person-centered planning drive the decision-making regarding service authorization and the selection of the provider that will serve the person. A qualified provider is one that can deliver high quality services to meet a particular person's needs.

4. How will you determine eligibility for high cost funding for individuals who have no history of being institutionalized?

OPWDD is proposing that a clinical assessment of the individual's needs be completed to evaluate the unique staffing needs of the person and the available staffing that an agency has based on its current reimbursement. The request for a higher reimbursement rate would be reviewed, authorized and approved by OPWDD. The reimbursement is not long term; it would last until such time as the provider's cost reporting reflects the actual cost of serving that new individual along with the other individuals the agency serves.

5. Will Day Habilitation be eligible for High Needs funding for people with high needs who live with their families?

If approved by CMS, high needs funding would be available for people who are new to Day Habilitation services and live with their families. This is a request to CMS, and there will be negotiations regarding the parameters of this proposal that may change how this proposal is ultimately implemented.

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- 6. How are the providers paid for services to individuals with high staffing needs if the person does not qualify for specialized funding or the newly proposed interim funding for individuals with high staffing needs?**

Individuals who are already served by a provider (i.e., not new to services) and who do not have a history of institutional placement, may have changing service needs. The rate methodology for Residential Habilitation and Day Habilitation reflects these changes through a regular review of cost reporting and updating of rates.

- 7. If an individual had one-on-one supports throughout his/her educational career due to high needs, how will agencies meet his/her needs in adult community programs safely without additional support?**

Educational supports and Home and Community Based supports are very different. The goal of the HCBS Waiver is to assist individuals with developmental disabilities gain independence. During the transition from the educational system to available adult services, each individual would be assessed to determine his or her unique strengths, needs and preferences for services in adulthood using a person-centered planning process. In some cases, it may be determined that a person who received one-on-one supports throughout his/her educational career would also require the same level of support in adult life whereas, in other cases, this may not be the determination. In addition, the types of services individuals are requesting to access and the resources that are available in their communities may impact the determination.

Questions Outside of HCBS Waiver Program Operations

FIDA-IDD/MANAGED CARE

- 1. Is the FIDA-IDD a program or demonstration?**

The Fully Integrated Duals Advantage program for Individuals with Developmental Disabilities (FIDA-IDD) is a national demonstration project. This is a three-year demonstration that is being implemented by the State, the Federal Government and a Plan (chosen through a competitive application process). It will be operational in 2016, and will operate in the downstate area. NYS is working with CMS for an anticipated start date of April 1, 2016.

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2. Who is the Downstate FIDA-IDD provider?

The FIDA-IDD plan's name is Partners Health Plan (PHP). PHP is a not-for-profit entity that operates in a nine-county Downstate area. During the application process, of all the applicants, PHP was the only applicant who successfully completed the Medicare and Medicaid readiness review and the Model of Care reviews. PHP is formed by a consortium of Developmental Disability providers with vast experience.

3. How and where will public comment be required on DISCOs and Managed Care opportunities for the developmentally disabled population in NY?

Public comment requirements depend on the Federal authority under which a State seeks Federal approval to operate managed care. For example, a State could opt to provide Managed Care through a Medicaid 1915b application or a section 1115 authority. In either case, there is a public process related to the applications.

4. Will the OPWDD HCBS Waiver eventually transition to Managed Care?

The HCBS Waiver must describe how people enrolled in the HCBS Waiver receive service coordination. The HCBS Waiver application allows for service coordination to be provided through MSC, Plan of Care Support Services (PCSS) and through the FIDA-IDD. The Waiver Application does not address any other form of Managed Care, and it does not provide for any further transition to Managed Care. If NYS makes a decision in the future to implement other Managed Care Models, then changes would be made in the Waiver. The Commissioner's Transformation Panel has studied these models and the Panel's recommendations are available on OPWDD's website.

5. Will enrollment in the FIDA-IDD become mandatory for eligible individuals?

No, there is no plan for individuals who are eligible for the FIDA-IDD to be mandated to enroll. For those individuals who meet the criteria, enrollment is voluntary. In order to enroll, the person must have both Medicare and Medicaid coverage.

6. In the future, will there be alternatives to the FIDA-IDD for Managed Care and are these alternatives addressed in this Application?

In this Waiver Application there are provisions to allow people who are enrolled in the HCBS Waiver to opt to receive services through the FIDA-IDD if they meet the FIDA-IDD eligibility criteria. FIDA-IDD is the only Managed Care organization that is referenced in the HCBS Waiver. Following a public comment period ending January 22, 2016, the OPWDD Commissioner's Transformation Panel published its report including the topic of alternatives that would be available in the future for implementing Managed Care. Implementation of

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any changes regarding Managed Care would require a future amendment to the HCBS Waiver. More information regarding the Transformation Panel and the public comment period that was held can be found at the following link:

http://www.opwdd.ny.gov/opwdd_about/commissioners_page/transformation-panel/panel_report.

7. Can someone enroll in FIDA-IDD if they are in a residential placement?

Yes, if a person lives in an IRA, Community Residence or Family Care Home, he or she may opt to receive the coordination of services through the FIDA-IDD. If a person who lives in a certified residential setting opts into the FIDA-IDD Plan, the plan will pay the residential provider the Medicaid rate for residential habilitation.

8. If one chooses FIDA-IDD, how can you opt out and how does the grievance process work for FIDA-IDD participants?

For individuals who opt to enroll in the FIDA-IDD, there are processes for grievances and appeals in place which are described in detail in Appendix F of the HCBS Waiver Renewal Application. The FIDA-IDD is a voluntary program which individuals can opt out of at any time.

9. What would be the advantage to the individual to enroll in the FIDA-IDD?

The FIDA-IDD offers a comprehensive benefit package that includes health care, dental, and various long-term services and supports. All those services are brought together in a single package which provides convenience in accessing the continuum of comprehensive services.

10. Are providers obligated to encourage individuals to enroll in the FIDA-IDD (Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities) Plan?

There is no obligation for providers to encourage individuals to enroll. The State will be providing information about the plan to individuals who qualify (individuals enrolled in both Medicare and Medicaid). Information regarding the FIDA-IDD option will be available beginning in March 2016.

11. When a person enrolls in the FIDA-IDD, what role does the current provider play aside from assisting the person with that transition?

There are specific continuity of care options. For example, if someone who lives in an IRA opts to enroll in FIDA-IDD, the FIDA-IDD will pay the Residential Habilitation provider the

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Medicaid rate as long as it is described in the person's care plan. For other services, there are shorter continuity of care periods. For at least 90 days, the plan will pay the Medicaid rate to the provider while working with the person related to what services that person wants to continue after the first 90 days.

12. How do payment rates change if individuals in IRAs voluntarily join the FIDA-IDD?

The FIDA-IDD plan will be paying the Medicaid residential rate to residential providers. Therefore, if a person who lives in an IRA chooses to enroll in the FIDA-IDD, then the residential provider would receive the Medicaid rate payment. This person must meet FIDA-IDD eligibility requirements which include OPWDD eligibility and enrollment in both Medicare and Medicaid. In addition, FIDA-IDD enrollees must be 21 years of age or over and live in the counties where FIDA-IDD is an available option.

13. If someone chooses to enroll in the FIDA-IDD, can s/he continue to receive Day Habilitation?

Yes, individuals can continue to receive Day Habilitation if they choose to enroll in the FIDA-IDD. Any individual who opts into the FIDA-IDD will continue to have the opportunity to enroll in any HCBS waiver service except Plan of Care Support Services (PCSS). PCSS is not applicable for FIDA-IDD enrollees because they will be receiving their care coordination services through the FIDA-IDD Plan.

14. Will Maximus be administering the Coordinated Assessment System (CAS) as it replaces the DDP-2?

There are current discussions underway regarding the implementation of the CAS assessment tool. There will be more information forthcoming about Maximus' role in regards to the CAS in the near future.

MEDICAID SERVICE COORDINATION

1. What is the future of Medicaid Service Coordination (MSC)?

Medicaid Service Coordination (MSC) is a Medicaid State Plan service, it is not an HCBS Waiver service. MSC is described in the Waiver because people who are enrolled in the HCBS Waiver in Fee-For-Service (FFS) receive their services coordinated through MSC. Nothing in this Waiver application governs the MSC program directly.

If individuals opt into the FIDA-IDD on a voluntary basis then they are opting out of the MSC service. FIDA-IDD is a relatively small plan operating in a nine-county Downstate area. MSC will continue to operate on a state-wide basis and will be the vehicle for providing service

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coordination for people who do not enroll in the FIDA-IDD or do not choose to receive Plan of Care Support Services.

2. Can an individual work as a Medicaid Service Coordinator (MSC) and a Care Coordinator in Managed Care?

There is nothing that precludes a person from working part time as an MSC or Care Coordinator. However, there would need to be a clear separation. People would need to have the time during their work schedule to serve individuals in both systems.

3. Will the role of MSCs be removed and transition to the responsibility of caregivers?

There is no intent to eliminate the responsibility of the Medicaid Service Coordination provider in this Waiver Application. The Medicaid Service Coordinator continues to be responsible for service coordination and the provision of services to the individuals on their case load. Of course, the coordination of services includes the participation of the individual's family.

COORDINATED ASSESSMENT SYSTEM (CAS)

1. When and how will the results of the CAS validation be made available?

The Coordinated Assessment System (CAS) is a new assessment system that OPWDD has been developing with the Department of Health (DOH). There will be public announcements regarding the CAS in 2016, regarding the timeline and process of implementation. A WebEx Session titled "Overview of CAS Implementation" was held on Wednesday February 10th. A Q&A from this WebEx will be issued soon.

2. Will the CAS be completed by only Front Door staff? Will there be any medical/nursing staff input included in this assessment if the individual is medically compromised?

Based on the needs of the person, family members and different types of professionals may need to be involved in completion of the CAS. For example, for someone with medical needs, the CAS assessment must address the clinical and medical needs of a person and this would require that nursing staff who are familiar with the individual participate in the assessment. The CAS is not described in this Waiver application because it is not a current Front Door process. However, there will be more information forthcoming on how the CAS will impact Front Door staff and medical/nursing staff in the near future.

3. Is there an opportunity for providers to have input on the CAS to reflect in more detail than currently proposed given the diverse medical complexities of individuals?

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The CAS is a comprehensive assessment tool. There are no plans to expand input at this juncture into the tool's development. Stakeholders will be involved in application of acuity measures in the months ahead. CAS is an elaborate system of assessment which will be described in more detail in the near future.

INTERMEDIATE CARE FACILITIES (ICFS) QUESTIONS

1. How are those with high needs funding already in Intermediate Care Facilities (ICFs) going to be addressed?

ICF methodology is cost-based and recognizes the staffing needs of the individuals served. The DOH is currently working on an ICF rate methodology with CMS. ICFs are outside the scope of the HCBS Waiver. The HCBS Waiver Services are an alternative to ICF services and, thus, ICF services are not discussed in the Waiver application itself.

2. Is NYS eliminating ICF services?

Individuals can continue to request ICF services if they require services provided in an ICF. Enrollment in the HCBS Waiver is an alternative to residing in an ICF. Note that the Waiver Application governs HCBS waiver services only. There are discussions of other services in the application, however, language is not included that specifically describes other Medicaid funded services outside the Waiver. Services outside of the Waiver are Article 16 Clinics, day treatment programs, ICFs and Medicaid Service Coordination. All are OPWDD services, but not HCBS waiver services. ICFs are not governed by the Waiver Application.

3. How can people find out more about ICF services?

The CMS website provides comprehensive information regarding ICF services at the following link: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/ICFIID.html>

MEDICAID TRANSPORTATION

1. Can you describe OPWDD's exploration regarding on-demand transportation?

Transportation is a very popular topic among our stakeholders. OPWDD has constructed a workgroup to explore the possibilities of how to make transportation easily accessible to our individuals. There are multiple exciting ideas nationally regarding on-demand transportation and how that can become a reality. The workgroup that has been started is

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collaborating across agencies to explore those options. This topic is not reflected in the current Waiver Application but could influence a technical change in a future amendment of this waiver application.

2. Is the most recent correspondence from DOH describing the Medicaid Provider enrollment requirements in regards to providers who transport individuals described in the Waiver Renewal?

Medicaid transportation is not an HCBS Waiver service, it is a Medicaid State Plan service. There was correspondence sent out recently to OPWDD providers from DOH to advise providers that the DOH will be making changes related to certain enrollment requirements for providers that deliver transportation. OPWDD and DOH are currently involved in discussions regarding this topic and there will be clarification forthcoming in the near future.