LeadingAge New York

Draft Regulatory Reform Concepts to Support the Success of the Delivery System Reform Incentive Payment (DSRIP) Program

The following series of concepts relate to waivers of regulations as well as changes in policies and practices that would facilitate DSRIP objectives and collaborations.

General

- **Provision of direct access to timely eligibility and plan status through eMedNY.** Unfortunately, providers have already encountered confusion about the status of Medicaid eligibility and managed long term care (MLTC) enrollment status. Misinformation or lack of current information about a beneficiary's status can result in unnecessary transitions for the consumer, non-payment for the provision of services, and other negative outcomes. Basic and up-to-date information should be available to providers to ensure continuity of care, which is critical for efficient service delivery that is essential in a DSRIP environment.

Home Care

- **Expedite the processing of Certificate of Need (CON) and other applications for home health services.** Similar to the effort made to process adult care facility and assisted living applications, home health CON and other applications must be processed more quickly to meet the increasing demands on these services as we serve more people more complex needs in the community. We recommend establishing an expedited, streamlined process with clear and posted timeframes for processing and action on:
    - Home care (CHHA, LHCSA and LTHHP) establishment or conversion applications;
    - Applications to serve new geographic areas and/or add new services to the operating certificate;
    - Applications for MLTC-provider services agreements; and
    - Care management administrative services agreements.
- **Ensure continuity of telehealth services.** The Department of Health (DOH) should issue guidance to ensure home telehealth continuity amid the transition to managed care including the following:
    - Provide for continuity of the home telehealth program authorized by Section 3614.3-c of the Public Health Law and associated reimbursements to home care agencies; and
    - Incorporate the home telehealth program in the MLTC scope of benefits and premium calculations.
- **Implement the Advanced Home Health Aide (AHHA) model.** Presuming that legislation will be enacted to develop an AHHA, expedited implementation would strengthen the ability of home care agencies to maintain people in the community, and to flag issues early to prevent a possible hospitalization or Emergency Room visit.
- **Increase the reimbursement for physician house calls to increase access to community-based assessments.** It should be made financially feasible for physicians to do house calls for a certain

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segment of the population; which again, could prevent the need for acute or emergency care in some situations.

The below issues relate in large part to the ability to continue to operate in a rapidly evolving environment. The need for home health providers to be able to respond to consumer needs quickly and nimbly is only heightened in a DSRIP environment, and thus smooth operations are critical:

- **Eliminate duplication.** Efforts should be made to identify instances when duplicative assessments or services are being provided to a beneficiary who is enrolled in an MLTC plan and also receiving home care services, and determine how best to eliminate the duplication. This would result in a more rationalized and efficient health care delivery system for Medicaid-eligible and dual-eligible individuals.
- **Seek further clarification and guidance regarding the applicability of Federal standards when a beneficiary is enrolled in Medicaid managed care.** Providers need more clarity when providing Medicaid services through a managed care model. It would important to identify and clarify those areas under the Centers for Medicare & Medicaid Services (CMS) interpretation where certain services/functions can be provided by agencies *outside* of the federal Conditions of Participation.
- **Amend regulations governing premium establishment for MLTCs and Medicaid mainstream plans and payments to providers, to ensure adequate financing of the regulatory base, patient service needs, wage parity and other employment mandates.** The regulations should also include the direct pass-through of state "add-on" funding (such as healthcare workforce recruitment and retention funds of all types) to home care providers to ensure both funding adequacy and the delivery of funds according to intent.
- **Address the financing home care "public goods" (e.g., aide training, technology infrastructure, community health activities, etc.) that are not appropriate or fair for provider-plan rate negotiation, or recovery through standard episodic prices.** This financing should be made available to all home care providers, regardless of type. This is akin to the substantial public goods financing mechanisms the State discretely provides to hospitals and other health care providers.
- **Establish an exception to the 90 day time limitation for Medicaid billing** to address circumstances where untimely turnaround of written physician orders precludes providers (and plans) from qualifying for billing for medically necessary services provided.

Nursing Homes

- **Encourage facilities to bring on physician extenders by allowing them to keep the Medicare Part B offset funds that would normally be taken from the Medicaid rate.** Such staffing would support serving higher acuity residents and providing necessary treatments to avoid hospitalization and emergency room visits.

- **Allow nursing homes to offer enhanced services that could limit avoidable hospital use.** Nursing homes face reimbursement and other challenges to providing chemotherapy services, which leads to more lengthy hospital stays and readmissions. Similarly, if nursing homes were permitted to offer hyperbaric services for wound care and any other specialty services which can feasibly be provided in a nursing home, avoidable hospital use could be further reduced.
- **Allow Medicaid reimbursement for remote consultations with psychiatrists and other specialty physicians.** This would increase the ability of the facility to meet the specialized needs of their residents in an expeditious manner. This is likely to reduce avoidable hospital and emergency room use.
- **Consider use of deemed status.** When a nursing home is participating in a performing provider system (PPS) and the hospital is surveyed/certified by the Joint Commission, the nursing home should be eligible to elect Joint Commission certification in lieu of the traditional federal/state survey process. This would ensure uniformity of approach and a more holistic review of system operations.

Adult Care Facility (ACF)/Assisted Living

- **Expand the role of the nurse in ACFs and assisted living settings** to provide more proactive, preventative services that keep people from needing acute or emergency care. Many of these facilities have nurses that work in the building but are not able to perform duties within their training and scope of practice due to state policy.
- **Enable nurses to conduct assessments in ACF settings.** A change in statute is likely needed to enable nurses to conduct assessments. DOH would have to also change their policy that 911 must always be called when a resident has an incident. DOH could also **conduct a demonstration or otherwise explore other ways to provide timely in-house assessments**, perhaps through partnership with an MLTC, Fully Integrated Duals Advantage (FIDA) plan or health home. Such services are likely to prevent a significant number of ACF and assisted living residents from having to be sent to the hospital or emergency room.
- **Allow ACFs and assisted living facilities to utilize advanced home health aides.** Building on the home health recommendation above, this advanced aide should also be available for use in ACF and assisted living settings.
- **Update admission and retention standards for ACFs.** The social ACF model is somewhat outdated and needs to be updated. The current admission and retention standards provide a rather narrow band of eligibility, as people are staying in their own homes longer than ever. People are coming to ACFs frailer, and with more complex needs than before. We anticipate that trend will only grow, and the model should be updated accordingly.
- **Allow access to hospice services in the assisted living program (ALP).** Currently, DOH prohibits a Medicaid beneficiary from residing in the ALP and concurrently accessing the hospice benefit. This limits access to critical services and supports. We urge the Department to work with LeadingAge NY and other stakeholders to eliminate this barrier. Aside from the clear benefits to the beneficiary, doing so is also likely to reduce hospitalizations and emergency room visits for the dual-eligible resident population.

- **Provide more guidance so that ACFs and assisted living residences (ALRs) feel comfortable working with hospice recipients at end of life.** Separate from the specific Medicaid issue of the ALP, there remains difficulty in providing hospice services in an ACF and ALR setting. Many providers are fearful of being cited by DOH as the needs of a hospice resident do not fit within the ACF/assisted living regulatory framework. DOH worked with the provider community years ago to provide guidance, however it doesn't seem to be sufficient in some circumstances. DOH should work with the assisted living and hospice provider communities to develop more explicit guidance and safeguards to broaden access to these critical services in ACF and assisted living settings.

Adult Day Health Care

We are pleased to report that necessary regulatory reform was addressed for adult day health care, and **the last necessary step is to finalize and implement the new regulations for the unbundled services payment option**. Below are issues that have posed barriers under the current regulations, which will be resolved under the new regulations that are hopefully in the final stages of implementation.

Under current regulations:

- ADHC has an all-inclusive rate and individuals must receive all the services the ADHC offers based on the registrant's assessment.
- MLTC plans do not want to use ADHC in many instances because of the current regulations, which they feel requires them to pay for services that registrants do not need.
- MLTC plans say that under current regulations, ADHC duplicates what the MLTC does and thus they are paying twice for services. For example, the ADHC under current regulation must assess each registrant and conduct case management. So must the MLTC under their regulations.

The newly adopted regulations will:

- Allow ADHC programs to unbundle their services and payments and thus provide and charge the MLTC only for those services the MLTC decides the registrant needs and is willing to pay for.
- Allow an ADHC to utilize the MLTC plan's assessment of the individual.

Managed Long Term Care (MLTC) Plans

The below issues relate in large part to the ability to operate with maximum efficiency in a rapidly evolving environment, which is critical in a DSRIP context:

- **More timely MLTC rate adjustments.** While not specifically regulatory reform, timelier rate adjustments are critical for MLTC plans. As MLTCs quickly expand their member risk profiles to accommodate the push to implement managed care for an ever increasing and diverse population of enrollees, there is a two year lag between when current rates and when rates will be adjusted to reflect the current risk pool. This lag poses a significant challenge to the demands of current operations.

- **Clear guidance on new initiatives before they are implemented.** With so many new initiatives under way in managed care it is often the case that mandates are issued before clear guidance is available on how to comply with the mandates. Examples include the FIDA application process, and the funding of the wage parity requirement. MLTCs are encountering periods of confusion and even disruption as mandates are implemented before necessary guidance is available. The pace of implementation has to be tied to the ability to manage the information flow. Another symptom of this problem is found in state issued deadlines that are set and then postponed, making it challenging for MLTC to adequately plan.
- **Adequate funding of mandates is critical**. Related to the rate issue above, the state needs to ensure that plans are not subjected to unfunded or under-funded mandates. The clearest example of this is the wage parity requirement. While the most recent state budget includes additional funding to cover wage parity, it is coming late in the process and still falls short of the actual cost of the mandate.
- **Identify ways to streamline reporting and assessment requirements.** MLTCs are being burdened with increasing requirements. One example is the Uniform Assessment System (UAS-NY). In addition to the time and administrative burden, plans incurred significant costs to ramp up for the new assessment tool. Further, there are duplicative assessment requirements for those beneficiaries who are in MLTC plans and receive services from other programs that must utilize the UAS-NY or are performing another assessment (e.g., OASIS, MDS).
- **Revisit DSRIP attribution methodologies to reflect predominant care management responsibilities.** Enrollment in an MLTC plan should be expressly considered in the loyalty assignment methodology, since the care management provided by MLTCs is a better indicator of loyalty and continuity than other affiliations, such as the primary care provider. Consideration should be given to including MLTC enrollees in the long term care population subcategory grouping along with nursing home residents. With the nursing home population and benefit slated for transition to managed care, this approach makes even more sense.