

Transition time period

1. Is there any transition time established for this policy?

Plans and providers should work together to ensure an expeditious implementation of any policy changes necessary to ensure compliance with state and federal regulations pertaining to the delivery of specific home health services.

2. How should LHCSAs proceed in complying with this policy change? Should they immediately cease providing these services to clients they are serving under direct contract with a managed care plan?

LHCSAs and managed care plans should work together to identify those individuals who are appropriately cared for by LHCSAs. Those clients who may be identified as requiring services provided through a certified home health agency should be transitioned as appropriate while ensuring safe and necessary care.

3. What is the payment source for the services rendered by the LHCSA from the date of the issuance of the DAL until new contractual arrangements are made?

Providers and plans are expected to meet the payment responsibilities that have been established in their contractual agreements pertaining to the provision of care until such time that care to the appropriate provider type has been established.

4. Will plans be instructed to continue payment for services even though the DAL indicates that such services cannot be provided through a contract with a LHCSA? If plans are not given such instructions, what assurances will the Department give to LHCSAs that are delivering such services in the best interests of the patient?

The DAL provides guidance and clarification to managed care plans and home health providers regarding the provision of home health services to Medicare and/or Medicaid beneficiaries when these individuals are enrolled in a managed care plan or managed long term care plan. Providers and plans are expected to meet the payment responsibilities that have been established in their contractual agreements pertaining to the provision of care until such time that care to the appropriate provider type has been established.

5. Can there be a grandfathering of existing contracts and services being delivered?

Services being delivered under existing contracts that require changes to ensure compliance will not be grandfathered. Plans and providers should work together to ensure an expeditious

implementation of any contract changes necessary to ensure compliance with state and federal regulations pertaining to the delivery of specific home health services.

6. Can an implementation/transition time frame be established to allow all parties to determine how to handle and then implement the changes?

Plans and providers should work together to transition patients if necessary to the appropriate care provider while ensuring patient safety and ongoing care.

7. How much time will providers and plans have to come into compliance?

Providers and plans are expected to be in compliance with all state and federal laws and regulations pertaining to the authorization for and the delivery of services. However, since it is apparent that some confusion regarding the provision of home health services by qualified providers exists and some modification to current agreements must be executed, the Department anticipates that these changes will be effectuated by September 2, 2014.

Aid Continuing

8. If there is a change and aid continuing is in place pending a resolution, is the LHCSA expected to continue to service the client? What liability exists? What payment source exists?

Aid-continuing provisions remain unchanged as a result of this clarification. The Medicaid recipient for whom an aid-continuing directive has been issued must continue to receive that aid-continuing level of services until appropriately discontinued pursuant to Department regulations and policy. The provider who furnishes the services need not be the same provider, however. The recipient could be transitioned to a different Medicaid provider if the new provider agreed to admit the recipient and provide the aid-continuing level of services.

Service Area Boundaries

9. Will CHHA service boundaries apply in these contracts if the LHCSA is able to provide services in the county where the patient receives services?

Yes, service boundary limitations apply. Service area boundaries apply to both CHHAs and LHCSAs. Certified home health agencies and licensed home care services agencies are authorized to provide services in specified geographical service areas. The authorization limits the provision of services to that specified area.

10. In more rural areas of upstate New York, LHCSAs may be the only available service provider (i.e. there is no CHHA that is contracting for certain services with the managed care plan). How will access and continuity of care for patients be ensured if there is no CHHA servicing the area or willing and able to contract with the plan?

Please identify the specific area where access to certified home health agency services is not available. The Department has just completed an 18-month process of expanding the availability of certified home health agencies throughout the state as part of the Medicaid Redesign initiatives. Managed long term care plans are required to have contracts with at least 2 certified home health agencies where available in their network. If a MLTC plan cannot contract with 2 providers they must attest to the DOH that they will provide necessary services to their enrollees out of network and reimburse for that care. A LHCSA can not be substituted as a CHHA.

Assessments

11. Can LHCSAs providing personal care services continue to complete the nursing assessments needed to secure service authorization/reauthorizations from managed care plans?

Yes. Please refer to the DAL 14-03, Question 2 as it relates to the UAS-NY assessments and Question 4 as it relates to personal care. A LHCSA can not be substituted as a CHHA.

12. Are nursing medication pre-pours covered by the DAL?

Yes. The pre-filling of medication boxes must be performed by a registered professional nurse for individuals receiving home care services ordered by an authorized practitioner. As such, it is considered a skilled service. In December 2009, the Governor signed into existence Chapter 503 of the Laws of New York State which provides the following:

Notwithstanding any provision of law or regulation to the contrary, the commissioner of education, in consultation with the state board for nursing and the state board of pharmacy, shall promulgate guidelines which allow for the prefill of up to a fifteen day supply of medication prescribed by a physician or other authorized practitioner and provided to an individual by a registered professional nurse for individuals receiving home care services ordered by an authorized practitioner and provided under the supervision of a registered professional nurse.

Specific guidance was issued by the State Education Department in May 2010 regarding the pre-filling of medication container for up to fifteen days and can be found on the New York State Department of Education website at <http://www.op.nysed.gov/prof/nurse/nurse-prefillmedications.htm>

13. What if the only service the patient receives is medication pre-pours?

If an assessment of an individual's care needs indicates that the patient requires medication pre-pours and no other home health services, providers and plans may want to consider working with the patient's physician to determine if a customized patient medication package prepared by a pharmacist for a specific patient is an available and suitable option. The patient medication

package is designed to indicate the day and time, or period of time that the content within each container is to be taken. It is the responsibility of the dispenser to instruct the patient or caregiver on the use of the patient medication package. For more information as it relates to customized patient medication packaging please refer to:

<http://www.op.nysed.gov/title8/part29.htm> Title 8 NYCRR § 29.7(a)(15) Special provisions for the profession of pharmacy

Provider Types

14. What types of home health providers meet the Conditions of Participation for Medicare, as specified at 42 CFR 440.70(d)?

Both certified home health agencies and long term home health care program providers are qualified to participate as a home health agency under titles XVIII and XIX of the federal Social Security Act. As such, these provider types authorized by Article 36 of the Public Health Law must meet the Conditions of Participation (CoPs) for Medicare, as specified at 42 CFR 440.70(d).

Home Health Aide

15. How frequently do home health aides have to be supervised when a patient is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services and care is being provided through a certified home health agency?

When a patient is receiving home health aide services through a certified home health agency but not the skilled services described above, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. The visit must occur when the home health aide is present in the patient's home and providing patient care (42 CFR 484.36(d)(3))

16. Can home health aide services be provided for a Medicaid beneficiary patient who does not require skilled nursing care, physical or occupational therapy or speech-language pathology services through an entity that does not meet the Conditions of Participation for home health agencies?

Yes. Home health aide services can be provided by a state licensed agency that does not meet the Conditions of Participation if skilled services as described above are not part of the patient's assessed plan of care.

17. In New York State, most home health aides are employed by licensed home care services agencies that do not meet the conditions of participation for home health agencies. Home health aide services when provided by certified home health agencies as part of a patient plan of care are provided through contracts between certified home health agencies and the

licensed home care services agencies. As long term care patients receiving home health services are transitioned from fee- for- service to managed care, networks of providers have been established that include both the certified home health agencies and licensed home care services agencies.

18. Does a certified home health agency that has a contract with a managed care plan to provide home health services also have to have a discrete and separate contract with an agency for home health aide services if the certified home health agency does not provide these services directly?

No. Both providers can have contracts to provide services to beneficiaries enrolled in a specific managed care plan with the plan. The certified home health agency does not have to have a discrete contract with a licensed home care services agency that is part of the managed care plan network provided that the responsibilities of the certified home health agency regarding the patient care are not diminished and are clearly understood and delineated.