TOP FIVE ISSUES RECOMMENDED TO THE HOME & COMMUNITY BASED CARE REGULATORY WORKGROUP

ISSUE	CONSTRAINT	RECOMMENDATION
1. REGULATION • **Uniformity** – Provide, to the extent practicable, uniformity of regulation of home care services delivered under managed long term care plans (MLTCs) and mainstream managed care through contracts with home care agencies, regardless of provider type or plan type. • **Excessive/Incompatible Regulation** - Eliminate regulations not efficient or necessary in a managed care-home care delivery model; regulation must be compatible with managed care delivery model and goals. • **Applicability of the Federal Conditions of Participation/Federal Standards**- (a) Determine to which services and providers these regulations and standards must apply and clarify managed care plan requirements for use and payment of those services, and provide adequate premium to plans to support; (b) to the extent permissible under federal and state law limit applicability of these standards, and limit on a uniform basis, across providers and provider-types; (c) eliminate or workaround barriers potentially created by the federal 1915-c waivers (e.g., nursing home eligibility "floor," maximum patient slots, etc.) so that home care patient eligibility and program operations can function seamlessly under managed care. • **Sorting of Roles and Responsibilities** of the provider and managed care plan (e.g., patient responsibilities, MD orders, reporting major changes in patient conditions, supervision) so as to eliminate conflict, confusion, overlap, inefficiency, and to ensure clarity with regard to compliance.	Many state regulations, policies and procedures are currently written to be "program/provider-specific," which to an extent worked in a program-specific environment, but now are not compatible with a managed care delivery model where the home care agency is the subcontractor. These regulations, policies and procedures require flexibility or modification. The modification process requires a length of time that is problematic given the state's timetable for change. Enabling statute could expedite, but the Legislature is not now in session and its return is subject to the call of the Leaders or to a Special Session called by the Governor. Absent the Legislature, the home care/manage care community ***needs*** DOH to remedy via administrative authority/action. Some of the layers of regulation are federally established and would require either (a) a flexible federal interpretation, or (b) federal waiver. Federal regulations require that skilled services (e.g., nursing, PT, ST) provided to Medicaid recipients be provided by an agency that meets Conditions of Participations (COPs). Also, federal regulations require that, despite NYS implementation of Uniform Assessment System (UAS-NY), providers must still complete and report OASIS.	<u>It is requested that the workgroup</u>: Review regulatory areas to address these aforementioned issues, including but not limited to: requirements, forms and frequency for assessment and reassessment (including duplicative state and federal); responsibility/frequency for supervision; responsibility for medical orders and interface with the physician; LTHHCP specific issues like patient slot limits, patient budget and expenditure cap requirements, level of care eligibility vs. MLTC; monthly waiver service requirement; quality and statistical reporting; and other. Propose that these regulations be either: (a) changed to remove silos and provide for more seamless arrangements; or (b) allowed to be waived by the commissioner to address the problem/ incompatible areas; or (c) be superseded for managed care by adoption of an alternate, compatible set of regulations specific to the home care-managed care model. Recommend that (a) federal flexibility be sought through interpretations and clarifications (such as CMS's verbal affirmation to HCA that care management, assessment and supervision may be permitted to be carved out from COP requirements, in specified circumstances and upon satisfaction of certain criteria) and engage with CMS for this goal, (b) where interpretative flexibility is limited or not possible, requests should be made for requisite federal waivers, and (c) where neither "(a)" nor "(b)" are possible, that proposed rule changes be submitted to CMS and to the NY Congressional

ISSUE	CONSTRAINT	RECOMMENDATION
(Issue 1. REGULATION – continued)		Delegation. An example of a federal regulatory easement that is requested to be pursued is to permit the new NYS universal assessment system (see issue category #5, "UAS-NY) to be used for Medicaid patients in lieu of duplicating this assessment by also having to complete a federal OASIS assessment, and to limit the OASIS requirement to Medicare patients only. Recommend that regulations apply uniformly, to the extent practicable, and to both MLTC and mainstream managed care home care services. Recommend that written guidance be issued by DOH on regulatory issues, sufficient to adequately and clearly advise home care providers and plans of program requirements. Recommend to be convened a special expert panel of representatives of managed care, LHCSAs, CHHAs, LTHHCPs and associations to work with DOH to sort out roles and responsibilities; articulate in DALS, GIS etc. so everyone is provided the same directives. Recommend DOH clarification for the providers and health plans (which confront their own level of uncertainty), and maximization of the flexibility of, LTHHCPs ability to function and participate in the new managed care paradigm, as well as to function in the FFS environment under Medicaid, Medicare and private pay or private third-party coverage. Recommend that the aforementioned be resolved as quickly as possible. Any delays prior to acting, especially waiting until the March 2014 workgroup report date, will only see a further decline in participant choice, unnecessary costs and expenditures, and a decline in the numbers of home care agencies who have provided quality service. As an example, one LTHHCP is being forced to lay off 40% of its staff due to regulatory challenges affecting its ability to partner with managed care, others are facing closure.

ISSUE	CONSTRAINT	RECOMMENDATION
2. FINANCING The body of home care regulation modified, continued or otherwise left intact by the workgroup must be matched by adequate funding to support regulatory compliance and the delivery of appropriate services, as well as state and local wage mandates, imposed on health plans and providers.	The current Medicaid financing base does not reflect the cost of the current home care regulatory base and associated mandates. Nor are these costs accommodated within the new managed care payment construct or, to an extent, within episodic pricing. There is no mechanism for home care "public goods" (e.g., training, public health mandates, etc.) financing. Investment in home care regulation and financing must be prioritized within the Medicaid Global Cap provisions.	The workgroup is asked to recommend that adequate financing for home care regulation and mandates accompany its regulatory recommendations, and specifically that the premiums paid to managed care plans and in the rates and payments to providers be adequate to support regulations, wage parity mandates and service delivery. The workgroup should further address the issue of ensuring financing for those home care public goods not conducive to negotiation or standard episodic prices (i.e., akin to the various discrete public goods financing mechanisms the state provides for hospitals).
3. CONTRACTS AND PROGRAM APPROVALS • **Timeframe for Processing Program Approvals** The lengthy application processing and approval period, along with other obstacles required for providers/programs to restructure in order to function under the new managed care environment, must be addressed. • **Timeframe for Processing Contract Approvals** In addition, the timetable for review of contracts between home care providers, including LTHHCP and CHHAs, their subcontractors and managed care plans, must likewise be addressed. Currently contracts or applications to become a CHHA that have been held up have resulted in providers downsizing their home care staff and operations. The DOH indicated that LHCSA applications would be expedited. Currently it takes over 2 years for approval. LHCSA providers can wait 2 years to add a county or another service.	DOH staff limitations contribute to delays. Requirements for State Public Health and Health Planning Council review and approval contributes to timeframe. Unknown whether approval process will accommodate "all comers," or whether limitations will be imposed. Without a clear understanding of the contract review process, providers continue to struggle to stay afloat with all of this ambiguity. The number of contracts that are being executed between home care providers and managed care plans is numerous.	<u>The workgroup is asked to recommend that</u>: The contract review process be streamlined and expedited, including provider agreements and Care Management Administrative Services agreements. The approval process for LHCSA, CHHA or other home care program approval or conversion be streamlined and expedited. A clear timeframe be posted for the contract review process. Any deviations from the timeframe will be explained in writing to the applicants. Timely review and response to pending contracts. A clear timeframe be posted for reviewing and deciding on LHCSA or CHHA applications. Any deviations from the timeframe will be explained in writing to the applicants. A clear timeframe be posted for reviewing and deciding whether to add another county or service to an existing LHCSA license. Any deviations from the timeframe will be explained in writing to the applicants.

ISSUE	CONSTRAINT	RECOMMENDATION
4. HOME TELEHEALTH Home telehealth operates in NYS exclusively under home care, with existing and consistent standards (both statutory and pursuant to DOH administrative guidance). This system is functioning with existing and substantial state/home care provider resources already invested in hardware, software, in-home units and staff training, expertise and protocols.	Mandatory enrollment specifications of the commissioner currently do not carve out telehealth from the enrollment requirement (but could upon Commissioner's discretion). Telehealth is not currently an explicit or defined service under MLTC. No provisions have been put into place for addressing the telehealth "cliff" risked under mandatory enrollment by providing for the continuity of the home telehealth program, for its inclusion also within MLTC and for an MLTC inclusion process only when program features and rates are properly in place.	Legislation has been introduced by Senator Young (S4956) and Assemblyman Morelle (A7440) that: (a) ensures the continuity of the current home telehealth program; (b) also incorporates the program under the MLTC statute; (3) provides for inclusion within MLTC only upon the commissioner's determination that the appropriate rates and program features are in place for MLTC. It is recommended that the workgroup (a) support the above remedies; and (b) urge the Department to accomplish these proposals administratively if possible.
5. UNIFORM ASSESSMENT SYSTEM- NEW YORK (UAS-NY) • **Implementation Issues –** o Questions continue to arise with confusion regarding who is responsible for the assessment, the LTHHCP or the MLTCs, and generally who has what role in conducting some or all of the assessment; o MLTCs are contracting with CHHAs to perform the assessments but the CHHAs have not been engaged in this tool; o Determining Level of Care, including how to handle physician overrides in the LTHHCP; o How to pull reports; o Duplication of assessments (OASIS & UAS-NY); o No crosswalk to date with the SAAM, DMS-1 & OASIS C with the UAS-NY;	Currently depending on the program, what county you are operating in or whether you are involved in a pilot, providers are being asked to complete more than one assessment instrument, causing a diversion of vital clinical resources and without reimbursement for time/effort involved for these multiple processes. Currently trying to manage the staffing problems when providers' clinical field staff is in the office undergoing hours of training, and no reimbursement for pulling clinical nurses from the field to complete 15 hours-plus of training for the UAS-NY. Currently providers are still required to perform both the OASIS the UAS-NY on the same patient. MLTCs and providers will have 3 quarters of	<u>It is requested that the workgroup recommend:</u> DOH resolve the many outstanding issues and ensure this new assessment tool can be implemented successfully without additional anxiety for the participants. DOH provide written guidance to providers on which federal and state rules apply for conducting an assessment. That program specific webinars be conducted so questions can be addressed. Adherence to 11 OLTC/LCM 1 dated 8/25/2011 – "the department will convert all PCSP assessments to a uniform assessment system (UAS-NY). <u>Separate and additional training will be made available in advance of such conversion."</u> That the state obtain federal approval to utilize UAS-

ISSUE	CONSTRAINT	RECOMMENDATION
○ How to handle the loss of clinical time in the field, and how to handle the loss of revenue; ○ For the non-Medicaid patients do providers continue the DMS-1 to show LTHHCP eligibility. • **Multiple Requests for Program Specific Webinars (since May 2013) –** Continue to request program specific webinars. • **Practicality and Competency with UAS-NY –** The requirement to "go live" with a tool without a test environment has been an issue for providers. It is also a hardship for the frail, elderly patient to sit through hours of a provider trying to figure this out. While some providers are reporting that DOH may have released a testing environment, no confirmation or details on such have been made available. • **Applicability to New, Forthcoming Models of Delivery/Coverage –** What is the role of this tool in a dually capitated environment such as PACE, MAP, and the FIDA demonstration?	SAAM data and then will be asked to perform the UAS-NY for the fourth quarter.	NY for Medicaid patients, in lieu of repeating with an OASIS, and to limit the OASIS requirement to Medicare patients only. It is also requested that the workgroup address the larger policy questions regarding the intended use of UAS-NY under FIDA and other new models.