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

LeadingAge New York has developed concepts for waivers of regulations as well as changes in policies and practices that would facilitate DSRIP objectives and collaborations. Where applicable, LeadingAge New York has provided guidance as to how the desired outcome could be achieved through waiver of regulation, amendment of statute, or change of policy.

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.
  ***Statutory Reference**: This issue would require a DOH/eMedNY policy change.*

  For questions about this section, please contact Patrick Cucinelli at pcucinelli@leadingageny.org.

Below are concepts, organized by service line, for home care, adult care facility/assisted living, and nursing home providers.

Home Care

- **Expedite the processing of Certificate of Need (CON) and other applications for home health services.** Home health CON and other applications must be processed more quickly to meet the increasing demands on these services as we serve more people with more complex needs in the community. LeadingAge NY recommends establishing an expedited, streamlined process with clear and posted timeframes for processing and action on:
  - home care (CHHA, LHCSA and LTHHP) establishment applications; and,
  - applications to serve new geographic areas and/or add new services to the operating certificate.

  ***Statutory and Regulatory Reference**: NYS Public Health Law Article 36 – Section 3606 (2) and Title 10 NYCRR 760.5 Determinations of public need.*
- **Ensure continuity of telehealth services.** The Department of Health (DOH) should issue guidance to ensure home telehealth continuity amid the transition to managed care. Additionally, the initial investments needed to utilize home telehealth should be explicitly incorporated into the MLTC scope of benefits and premium calculations.
  ***Statutory and Regulatory Reference**: New York State Public Health Law Article 36 – Section 3614.3-c.*

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- **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.
  Reference*: This change would require the passage of legislation proposed last year. LeadingAge NY has been working with DOH and other stakeholders through the AHHA workgroup to review the role and educational requirements of the AHHA.*
- **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 segment of the population, which again, could prevent the need for acute or emergency care in some situations.
  Reference: *This change would require a budget increase and subsequent changes in eMedNY for Physician Billing or Rate Codes. In addition, several 1915(c) waivers provide this service and should see an update in the rate. For example, the Nursing Home Transition and Diversion Waiver pays $40… for a twenty minute home visit for "needed medical care provided by a physician, nurse practitioner or physician's assistant to waiver participants who are unable to leave their home."*

The issues below 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 efficiently is only heightened in a DSRIP environment; 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. The need for home health providers to be able to respond to consumer needs quickly and efficiently is only heightened in a DSRIP environment.
  Regulatory References: *Below are references to regulations that are duplicative of MLTC regulatory requirements:*
  - *Assessments, Certified Home Health Agency (CHHA): Title 10 NYCRR Part 763.3 (State regulation) and 42 CFR 484. 55 (federal regulation).*
  - *Plan of Care: Title 18 NYCRR section 540, Title 10 NYCRR 763.6 (State regulation), 42 CFR 484.18 (federal regulation)*
  - *Physician Orders: Title 10 NYCRR 766.4, Title 10 NYCRR 763.7 (State regulation)*

- **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 is 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.
Action Required: *This does not point to a particular regulation or statute, but rather a goal for DOH and CMS to work together in partnership with the provider community, in the context of rapid and substantial to change.*

Amend statute/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.

Reference: *New York, Soc. Serv. § 364(j)(18)(b)*

- **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.
Action Required: *Hospital public goods financing is made available through the Health Care Reform Act (HCRA) and appears in statute in New York State Public Health Law, Section 2807. Financing would need to be addressed in the budget, and could be addressed in this section of law.*

- **Establish an exception to the 90 day time limitation for Medicaid billing** to address circumstances where untimely turn-around of written physician orders precludes providers (and plans) from qualifying for billing for medically necessary services provided.
Regulatory References: *Title 18 NYCRR, Section 540.6*

For questions about this section, please contact Cheryl Udell at cudell@leadingageny.org.

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.
Regulatory References: *Title 18 NYCRR, Section 540.6(4)*

- **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.
Regulatory References: *Title 18 NYCRR, Section 505.9. Various references in the residential health care section are made regarding allowed and covered services. The above mentioned services are not specifically prohibited, but there is no language specifically allowing them.*

- **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.
Regulatory References: *Title 18 NYCRR, Section 505.9 - Residential health care. Various references in the residential health care section are made regarding allowed and covered services. As above, this is not specifically prohibited, but there is no language specifically allowing it.*

- **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. Doing so would ensure uniformity of approach and a more holistic review of system operations.
Action Required: *This would require a change in State and Federal policy.*

- **Allow a Nursing Home to admit someone without requiring a PRI, to enable more rapid admission.** In certain parts of the State, it takes time to arrange for a PRI and Screen to be done, which can delay someone's admission to a nursing home. This is particularly along the borders to other states, where facilities commonly accept people from out of state, or repatriate a resident in a nursing home in another state. While an assessment of appropriateness is still conducted, arranging for the appropriately trained person to conduct a PRI can stall an admission. Waiving this requirement would enable nursing homes to more rapidly accept people out of the hospital, or bring them back from other states.
Regulatory Reference: *Title 10 NYCRR, 415.26 and 400.11*

For questions about this section, please contact Patrick Cucinelli at pcucinelli@leadingageny.org.

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.
Action required: *LeadingAge NY's request is for DOH to enable (but not require) nurses to perform duties that home health aides perform in the community, which LeadingAge NY*

believes requires simply a change in State policy. LeadingAge NY also suggests that Licensed Home Care Services Agencies (LHCSAs) that are a component of an Assisted Living Program (ALP) should be able to perform the duties that a LHCSA can do in the community, which includes nursing. Again, this would require a reinterpretation of 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.
  Statutory Reference: *Amendment of New York State Education, Law Section 6503 would be required for an ACF to provide the nursing assessment directly. A demonstration could be enacted through legislation, however such services could probably be provided in a cooperative manner through providers with input from DOH to clarify roles and responsibilities.*

- **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.
  Reference*: As above, this change would require the passage of legislation proposed last year; LeadingAge NY has been working with DOH and other stakeholders through the AHHA workgroup to determine key aspects of the change over the past year. We would want to ensure that this option was available not just in the community, but also in ACF 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.
  Regulatory Reference*: Title 18 NYCRR, Section 487.4 (Adult Home) or 488.4 (Enriched Housing Program). The waiver could also be temporary, for a period of time post-discharge from a rehabilitative or hospital stay, as well, to get a person back to the adult home or enriched housing program level of care.*

- **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.

Action required: *This will require a policy change, with clarification of roles, responsibilities and payment.*

- **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.
  Action required: *This will require further clarification of existing policy, with specific and explicit direction about what is allowed. Another way to approach this would be an explicit waiver of retention standards (Title 18 NYCRR, Section 487.4 (Adult Home) or 488.4 (Enriched Housing Program) in these circumstances. Given the vague nature of existing direction, there remains hesitancy for hospice services to be provided in ACF settings.*

  For questions about this section, please contact Diane Darbyshire at ddarbyshire@leadingageny.org.

Managed Long Term Care (MLTC) Plans

The issues below 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.
  Statutory Reference: *New York State Social Services Law, Article 5, Title 11, § 364(j)(18)(b)*

- **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.

Action Required: *This does not point to a particular regulation or statute, but rather a goal for DOH and CMS to work together in partnership with the provider community, in the context of rapid and substantial change.*

- **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.
  Statutory Reference: *New York State Social Services Law, Article 5, Title 11, §364(j)(18)(b)*

- **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).
  Statutory Reference: *New York State Social Services Law, Article 5, Title 11, §364(j)(5)*

- **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. MLTC enrollees in the long term care population subcategory should be an attribution factor.
- With the nursing home population and benefit slated for the transition to managed care, this approach makes even more sense.
  Action Required: *This does not require any change in regulation or statute, but rather, DOH and CMS reviewing the processes to ensure consistency and logic to enable the most effective performance for both the MLTC and the DSRIP Performing Provider System.*

For questions about this section, please contact Patrick Cucinelli at pcucinelli@leadingageny.org.

Adult Day Health Care

LeadingAge NY and the Adult Day Health Care Council are pleased to report that necessary regulatory reforms have been addressed for Adult Day Health Care (ADHC), in the new regulations for the unbundled services payment option. Specifically, the new regulations 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. They also allow an ADHC to utilize the MLTC plan's assessment of the individual, eliminating the duplicative assessment issue noted above.

This approach can be a model for regulatory reform in other areas, to enable more efficient service delivery and eliminate duplicative requirements in a managed care environment.

For questions about this section, please contact Christine Fitzpatrick at cfitzpatrick@leadingageny.org.

We hope this is helpful to the Department as reforms are considered for DSRIP purposes and overall efficiency of the system. If you have about this document, please contact Diane Darbyshire at ddarbyshire@leadingageny.org or Dan Heim at dheim@leadingageny.org, 518-867-8383.