HCA, LeadingAge New York, HCP

Initial Priorities for Home Care Regulatory Reform

The Home Care Association of New York State (HCA), LeadingAge New York and the New York State Association of Health Care Providers (HCP) respectfully submit the following, joint home care regulatory reform and other priorities for consideration by the Home and Community Based Care Regulatory Workgroup.

We ask expeditious implementation of these reforms for the providers and health plans striving to adapt to and fulfill the State's Medicaid Redesign mandates and goals, and ultimately on behalf of the patients dependent upon their care.

These "initial" recommendations are in accordance with the State Health Department's request that we provide you with select, key areas to begin the next phase of Workgroup discussion and action. In addition to these recommendations, the Associations continue to work on refining and identifying additional issues as they arise and will share those with the group. Each Association may have other issues that are priorities for their members and will share those particular issues as well under separate cover.

Questions relating to this set of reform priorities may be addressed to: Al Cardillo of HCA at acardillo@hcanys.org; Christy Johnston at HCP at johnston@nyshcp.org, and Cheryl Udell of LeadingAge New York at cudell@leadingageny.org.

For all the requests and recommendations provided, the Associations will assist the Workgroup and the Department in whatever efforts are needed to be undertaken in order to move forward in these and other priority areas.

I. Excessive/Incompatible Regulation

The underlying regulatory structure for the managed care-home care delivery model should provide for efficiency and quality aligned with the goals and structure of this new model.

The Associations urge that the Workgroup recommend the removal or modification of regulations and procedures related to Medicaid programs in Social Services regulations (NYCRR Title 18—Sections 505.14-Personal Care Services, 505.21-LTHHCP, AIDS Home Care Program Services and 505.23-Home Health Services), and Health regulations that address minimum standards (NYCRR Title 10—Sections 763-CHHA, LTHHCP, AIDS Home Care Programs and 766-LHCSA) that are excessive, duplicative, inefficient or otherwise incompatible in the delivery of home care under managed care.

Per the request from the Department and Workgroup in early September, the following are a few specific areas that we recommend are addressed at this time. Public Health Law Section 4403-f 7(a)(i) grants authority for waiver of regulations to "promote the efficient delivery of appropriate, quality, cost-effective services" provided under MLTC. This will provide an expeditious and efficient avenue for State action in many such areas.

This list is not exhaustive, but serves to provide some immediate next steps.

1. Physician orders—A lack of distinct responsibility/liability between health plan and provider for physician orders and for general communication with physician offices regarding the care of the patient.

Providers should only be responsible for physician orders if they are case managing the patient. This would require changes in the minimum standards.

2. Assessments—Conflict has been created by providers' regulatory responsibilities to provide care per the provider's professional assessment of patient need versus the limitations imposed on type and scope of service by the health plan.

3. LTHHCP features—Incompatible regulatory features of the LTHHCPs exist and must be reconciled. For example, nursing home eligibility threshold, slot limits, and LTHHCP-specific admission and authorization procedures.

4. Initiate an immediate, and ongoing, development of a clarification/guidance document that outlines the applicability of Federal standards (42 CFR Part 484), including the Conditions of Participation (CoPs), in the context of the provision of Medicaid services through a managed care model. In providing such clarification, the Workgroup is asked to identify and clarify those areas under CMS interpretation where certain services/functions can be provided by agencies outside of CoPs.

5. Having Workgroup members and respective State Associations work together to review methodically and identify specific regulations and procedures to propose for Departmental waiver. The results of the waiver would serve as the basis for more permanent regulatory change.

The Associations would facilitate an aggressive meeting schedule with Workgroup members, or their designee, to conduct the analysis and present initial proposals for priority changes earmarked for the waiver by the end of November that would provide immediate and substantial relief, and would continue monthly meetings identifying additional regulations and procedures to be earmarked for remedy through the waiver or otherwise.

II. Adequate Financing & Timely Payments

Adequate funding, for both premiums and provider payments, must be made available to support regulatory compliance, the delivery of needed services, and State and local wage mandates imposed on health plans and providers.

The Associations urge that:

1. The Workgroup recommend that the regulations governing premium establishment for MLTCs and MCOs, and the payments to providers, be amended 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.

2. The Workgroup is asked to address provisions for financing for those home care "public goods" (e.g., aide training, technology infrastructure, community health activities, and other) that are not appropriate or fair for provider-plan rate negotiation, or recovery through standard episodic prices. These provisions should be made available to all home care providers, regardless of provider type. This request for home care public goods financing is akin to the substantial public goods financing mechanisms the State discretely provides to hospitals and other health care settings.

In addition to adequate payment, timely payment is of the utmost importance to ensure cash flow and payment for services rendered. The Associations urge that:

3. The Workgroup recommend that the Department reinforce adherence to existing prompt payment requirements and work with the Department to identify other ways to expedite payment in dispute

resolution circumstances, including requiring that partial payments for claims be processed according to prompt payment requirements as provided for in State Insurance Law.

4. The Workgroup explore ways to address system-wide efficiencies through:

    a. Establishment of uniform billing codes.
    b. Policies that establish timeframes for the provision of written authorization for services, payment assurances for services provided with a verbal authorization, and provisions to address situations in which there are gaps in authorizations but not services.
    c. Provision of direct access to eMedNY to verify eligibility and plan status to all providers even if they have not been Medicaid providers in the past.
    d. Establishment of electronic funds transfer requirements for payment; similar to EFT systems that exist for the Medicaid program.

5. The Workgroup recommend the Department establish an exception code 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.

6. The Workgroup recommend the establishment of a technical advisory group to address IT challenges associated with the transition, including provider and plan billing, clearinghouse, EHR, and other system compatibility issues and the cost of securing necessary IT to facilitate the ease of transaction.

The Associations are also interested in identifying ways to facilitate clear and accessible points of contact and communication between providers and plans with regard to resolving issues. A system that provides key contacts for both plans and providers would be a step toward reducing the resources expended trying to track down and connect with the appropriate contact.

III. Streamline and Expedite Contracting & Establishment Activities

The Associations urge that the Workgroup recommend that an expedited, streamlined process with clear and posted timeframes for processing and action be established for:

1. Approval of home care establishment or conversion applications,

2. Applications for service to new geographic areas and/or the addition of new services to the operating certificate,

3. Applications for MLTC-provider services agreements, and

4. Care management administrative services agreements.

While these recommendations apply globally, there is an urgency to ensure that applications that were submitted in response to the MRT recommendations and the shift to managed care be processed in an expedited manner.

IV. Telehealth Continuity and Transition

The Associations urge that:

The Workgroup recommend that the Departmental guidance issued to provide for home telehealth continuity amid the transition to managed care be amended to include the following:

1. Provide for continuity of the current section 3614.3-c home telehealth program and reimbursement provisions to home care agencies.

2. Incorporate the home telehealth program under the MLTC service and payment spectrum.

3. Provide for the startup of home telehealth services for MLTC patients upon the Commissioner's determination that the appropriate rates and program features are in place for MLTC.

The Associations will assist the Workgroup and the Department in the examination of areas for new opportunity, flexibility, innovation and efficiency in the home telehealth program and recommend corresponding amendments to accomplish these program enhancements. While some of the telehealth issues may resolve through the FIDA demonstration, the need is immediate and statewide, which would require a more comprehensive resolution.

V. Clear & Reasonable Roles and Responsibilities

The need for clear, reasonable and efficient roles and responsibilities for providers and plans is urgent for all parties, especially for the patients.

The Associations urge:

> The development of a checklist of the standard items that must be considered in service delivery, management and quality assurance, and the identification of the responsible party for each. These should be incorporated in the contracts between providers and plans. This will help establish a better understanding among providers and plans regarding who is responsible for what in relation to the delivery of services under this new paradigm.