OVERVIEW OF PRESENTATION

- Unbundled Services Payment Option (USPO) update and codes
- HCBS Settings Rule review and update
- Capital reimbursement for off-site rental agreements
- Other issues/Q&A
USPO BACKGROUND/TIMING OF CHANGE

- Response to Medicaid Redesign Team (MRT) Proposal #90 - expansion of mandatory enrollment in managed long term care (MLTC). Concept developed by ADHCC task force
- Billing codes effective May 2017?

WHY THE USPO?

- Issue – Both ADHC and social adult day care are covered services under MLTC. MLTC plans decide whether their members receive ADHC or social adult day care and how often and in which programs these services are rendered
- MLTC plans have made it clear since 2010 that they would not pay for what they considered a duplication of services and wanted to pay for only those ADHC services they believed their members needed
- Plans began to split care plan between SADC and ADHC
WHY THE USPO, CONT.

- Issue - Under old regulations, services/payments couldn’t be unbundled. ADHC must provide all its services, based on a registrant’s assessment, and utilizing an all-inclusive rate
- As MRT #90 was rolled out, many MLTC plans chose a combination of social adult day and home care over ADHC or
- Registrant visits were split between ADHC and social adult day causing displacement of registrants
- Many members opened social adult day programs to adjust to MLTC referral patterns
- ADHC programs have always provided the services that social adult day care programs provide PLUS ADHC provides skilled services using different types of staff in a highly regulated physical environment

KEY CONCEPTS/PROVISIONS OF UNBUNDLED SERVICES

- Use of the USPO is voluntary on the part of programs
- If a program elects the USPO, it remains a certified LTC program in NYS and all individuals who attend the ADHC, regardless of payer source are registrants
- ADHC program doesn’t become, or referred to, as a SADC program
KEY CONCEPTS/PROVISIONS OF UNBUNDLED SERVICES

- Regulations do not change ADHC basic eligibility requirements for ANY registrants who are admitted.

- 425.1 (b) Registrant is defined as a person:
  (1) who is not a resident of a residential health care facility, is functionally impaired and not homebound, and requires supervision, monitoring, preventive, diagnostic, therapeutic, rehabilitative or palliative care or services but does not require continuous 24-hour-a-day inpatient care and services, except that where reference is made to the requirements of Part 415 of this Subchapter, the term resident as used in Part 415 shall mean registrant.

KEY CONCEPTS/PROVISIONS OF UNBUNDLED SERVICES

- A program that elects the USPO must have all the services of an ADHC outlined in Part 425.5 available to all registrants.

- A program that elects the USPO, may provide less than the full range of ADHC services outlined in Part 425.5 to registrants referred by MLTCs and negotiate the payment from the MLTC accordingly.

- Enroll in ADHC earlier and stay longer.

- Creates flexibility in services provided and paid; i.e. laundry service.
WHAT THE REGULATIONS DO AND DON'T DO

- Programs that select the USPO will be able to adjust their staffing based on the mix of registrants they serve on any given day.
- Operators that currently run social adult day care programs in a nearby space, will NOT be permitted to “graft” that space on to their current ADHC space. These operators must apply to incorporate this space through the CON process.

- Election of the USPO will not increase an ADHC’s capacity.
- Election of the USPO does not change the number of individuals you can serve on any given day. Current provision remains:
- 425.6(d) The operator may admit, on any given day, up to ten percent over the approved capacity for that program. The average annual capacity, however, may not exceed the approved capacity of the operator’s program.
WHAT THE REGULATIONS DO AND DON’T DO

- Election of the USPO does NOT change:
  - requirement for an ADHC care plan, which must be coordinated with the MLTC
  - requirements for general records
  - program evaluation
  - policies and procedures
  - confidentiality of records
  - food and nutrition
  - pharmaceutical services
  - medical services
  - services for registrants with AIDS
  - ADHC care planning requirement
  - requirement that each registrant must receive a meal, snack and planned activities

REIMBURSEMENT/CODES UNDER THE USPO

- Rates between MLTC and the ADHC program are negotiated
- All programs/sponsors must price their services according to market demands
- Three-tiered package approach
THREE LEVELS: BASIC, STANDARD, INTENSIVE

- S5102 U01 Basic Level
  - Personal care, supervision and monitoring, socialization, meals, therapeutic recreation and activities
- S5102 U02 Standard Level
  - All services in basic level and all ADHC core services listed under 425.5
- S5102 U03 Intensive Level
  - All services in basic and standard levels. Plus, intensive skilled services including, but not limited to tube feeds, wound care, Hoyer lifts, TB screening and ongoing follow-up, palliative care

HOME AND COMMUNITY-BASED SETTINGS RULE


- HCBS setting MUST:
  - The setting is integrated in and supports full access to the greater community;
  - Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources;
  - Is selected by the individual from among setting options;
  - Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
  - Optimizes autonomy and independence in making life choices; and
  - Facilitates choice regarding services and who provides them.
ADHC PRESUMED INSTITUTIONAL

- Settings located in a publicly or privately-owned facility that provides inpatient treatment;
- On the grounds of, or immediately adjacent to, a public institution;
- Has the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

- Heightened scrutiny is the process by which NYS will collect evidence to overturn the presumption of institution
  - On-site surveys
  - Registrant and caregiver interviews
  - Photographs of physical location
  - Statements from members of the community
  - Regulations/statutes

CMS GUIDANCE YIELDS MORE QUESTIONS AND CONCERNS

- “One size fits all” approach doesn’t work for frail elderly or medically compromised population
- The State can submit, and CMS will consider, documentation showing that the HCVS setting is not operationally interrelated with the facility setting, such as:
  - Interconnectedness between the facility and the setting in question, including administrative or financial interconnectedness, does not exist or is minimal
  - To the extent any facility staff are assigned occasionally or on a limited basis to support or back up the HCBS staff, the facility staff are cross-trained to meet the same qualifications as the HCBS staff
  - Participants in the setting in question do not have to rely primarily on transportation or other services provided by the facility setting, to the exclusion of other options
  - The proposed HCBS setting and facility have separate entrances and signage
WHAT HAVE WE DONE?

- Proactive approach with DOH, Governor's office
- Public comments
- Strong, timely reactions to CMS guidance
- Four trips to DC to lobby NY Congressional Delegation
- Engaged with LeadingAge, NADSA, other state associations
- CMS delays HCBS implementation to 2022; NY STP must be approved by March 2019
- Litigation not out of the question

CAPITAL REIMBURSEMENT FOR OFF-SITE, LEASED SPACE

- ADHCC and GT has been working closely with DOH to resolve a problem that arose approximately a year ago regarding capital reimbursement
  - In 2016, ADHC programs that historically received capital reimbursement for off-site leases, were, without notice, denied those funds by DOH
  - DOH expressed concern that the agency is not permitted to provide reimbursement for the leased property due to long-standing regulations regarding nursing home capital reimbursement
  - GT laid out an argument for DOH that the agency has regulatory authority to reimburse ADHC programs based on regulations authorizing a calculation/reimbursement for “initial allowed facility cost”
  - DOH staff has indicated receptivity to this argument
CAPITAL REIMBURSEMENT, CONT.

- Next Steps:
  - DOH Counsel’s Office is reviewing the analysis
  - DOH staff is reviewing interplay between the application of the 65% cap on ADHC rates and capital reimbursement calculations (within the cap or in addition to?)
  - DOH and ADHCC to strategize in May regarding possible solutions to the immediate problem
  - Goal is to achieve reimbursement while respecting DOH’s general objection to leases for off-site programs

QUESTIONS?

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