HCA
HOME CARE ASSOCIATION OF NEW YORK STATE

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To: Jason Helgerson, New York State Medicaid Director and Greg Allen, Director of the Division of Program Development and Management, NYS Office of Health Insurance Programs

From: HCA and LeadingAge New York

Subject: New CHHAs and Safety Net Designations, Non-Medicaid Providers and Safety Net Status, and Attribution Methodology

Date: August 18, 2014

Thank you for the opportunity to meet with you and your staff on July 31, 2014 regarding Safety Net concerns. We understand that DSRIP is an extremely complicated initiative with many complex variables and many players. Your staff clearly indicated a willingness to work with providers as we navigate this new territory together, which is appreciated. In this spirit, we want to bring to your attention outstanding Safety Net issues, as well as some recommendations regarding the attribution methodology.

New CHHAs and Safety Net Provider Designation

We had raised concerns at that meeting that, as a practical matter, new Certified Home Health Agencies (CHHAs) do not have the historic data requested by the Department to show that they meet the Safety Net criteria. While we appreciate that DOH is willing to review the data CHHAs *can* provide to date, we recommend that CHHAs be reviewed separately for the purposes of the Safety Net designation, for a variety of reasons:

- The CHHA need methodology was opened up to address the increased demand as a result of the changing healthcare landscape in New York. According to the Request for Applications (RFA) issued in 2012, the state sought to develop new CHHAs and enable existing CHHAs to change their service delivery and practices. The RFA states "The expansion of home health providers in NYS will increase patient choice, improve access, improve continuity of care, improve the quality of home health services and enhance the efficiency of providing home health services to home health patients regardless of payer source." Essentially, the State promoted the CHHA expansion to serve a safety net function in response to the major reforms in Medicaid (including the Medicaid Redesign Team initiatives) and Medicare. It is incongruous to now determine that they don't meet the safety net definition because of their lack of experience.

- Such new CHHAs haven't been operational for long enough to be able to show the requested track record of being a Safety Net provider, simply because of the *point in time* at which the Safety Net designation analysis is being conducted.
- Some new CHHAs came about as a transition from a Long Term Home Health Care Program (LTHHCP) that was made in response to state policy initiatives (as the RFA contemplates). Particularly downstate, LTHHCPs were mandated by state policies to transition out the bulk of their caseloads to managed care. Based on historical data, these LTHHCPs (now essentially transitioned to CHHAs) would have clearly met the Safety Net definition, but the sponsoring organizations were compelled to convert to CHHAs because the mandatory enrollment policy and contracting provisions jeopardized LTHHCP viability. These providers should be supported in their adaptation to this ever changing environment, rather than be shut out of the DSRIP Safety Net provider designation because of the timing of the initiative.
- Existing CHHAs which substantially served the long term care Medicaid population through their LTHHCPs face a similar situation to that above. Most of these organizations were structured such that the CHHA substantially provided the post-acute/rehabilitative care under Medicare, and the LTHHCP provided the substantial Medicaid long term care. With the transition of LTHHCP cases to managed care, the provider, now as a standalone CHHA, cannot show that it meets the safety net Medicaid proportion, even though this has long been the provider's overall record and commitment to community.
- Since most of the new CHHAs actually do have demonstrated experience as Safety Net providers in other services lines, including the LTHHCP, perhaps they could be evaluated by this additional data, along with a binding commitment to achieve the Safety Net definition by a realistic date-certain, thereby enabling their participation in a DSRIP PPS as a Safety Net provider.

Non-Medicaid Providers and Safety Net Status

DOH has taken the position that a safety net provider must be a Medicaid provider (with a Medicaid provider number) and those without a Medicaid provider number cannot file a Safety Net appeal. Unfortunately, this distinction was only recently made clear. In addition, some providers that do not have a Medicaid provider number but have a longstanding track record of service to a substantial Medicaid and dual eligible population could play an integral part in any DSRIP PPS. We urge that these providers be considered for Safety Net designation.

An example is a Licensed Home Care Services Agency (LHCSA) whose primary business is contracting with CHHAs and managed care plans to provide personal care services, but does not act as a separate biller to Medicaid, and thus does not have a Medicaid provider number. The

LHCSA services are vital to the consumer's successful management in the community, and are essentially Medicaid-covered services in these subcontracting relationships. We ask your consideration that these entities whose Medicaid and dual patients comprise more than 35% of their patient base be considered Safety Net providers eligible to file an appeal.

Another example is an adult care facility (ACF) that, while not a Medicaid provider, may serve dual-eligibles. ACFs are responsible to provide, arrange for or coordinate the entirety of a resident's care. They are responsible for personal care, assistance with medications, care management, supervision, monitoring, nutritious meals, and other services integral to the successful management of a resident's health care needs. Some ACFs are committed to serving a low-income population, which is extremely difficult to do, financially. The ACF annual census can provide a way to verify the safety net provider status of a facility, as it identifies the number of Supplemental Security Income (SSI) recipients served. SSI eligibility is a good proxy for Medicaid eligibility. ACFs should be able to qualify for the Safety Net designation as well, if otherwise meeting the criteria.

Attribution Methodology

We participated in the Aug. 1 *Attribution and Valuation* webinar, which walked through the very complex methodologies for how individuals will be attributed to specific PPSs. We appreciate that the Department took into consideration the importance of nursing homes in the process; however we are concerned about the omission of other key providers that comprise PPSs.

Home care will be integral to the success of DSRIP projects. Home care is essential to successfully managing people in the community and avoiding hospital and emergency room use. In addition, there are many Medicaid and dual-eligible individuals that receive long term home care services, including personal care. These individuals are seen most frequently by their home care or personal care provider. Home care is also providing care management services under contract with managed care entities. There are populations that consistently receive services from a particular home care provider, and those services are critical to their successful management in the community. Thus, it is vital that this factor be considered in attributing an individual to a particular PPS.

The Department should also add assisted living programs (ALPs) to the attribution hierarchy. Like nursing homes residents, ALP residents receive the majority of their services from the ALP. The ALP is the most frequent service provider to that resident, and this service relationship is at times more consistent than other provider relationships the individual may have.

Lastly, adult day health care programs (ADHCs) should also be added to the attribution hierarchy. Similar to the aforementioned services, ADHC participants typically attend the

program several times a week. During these visits an individual may receive a range of services including nursing, personal care, case management and maintenance and restorative therapies. As a result of the types of services and the time spent during a visit (minimum five hours), the consumer relationship with the ADHC is likely more consistent than that of any other relationship with service providers. It makes sense that participation in an ADHC would also be a factor in attribution.

Next Steps

Again, we appreciate your willingness to have a dialogue with us about the roles of our members in DSRIP. We respectively request a more detailed discussion with you regarding the attribution and valuation methodology, to ensure our members' inclusion and roles in the process and calculation. With regard to the Safety Net issues, we note that the appeal process concludes on August 27, and thus respectfully request the Department respond to those concerns as quickly as possible.