BUDGET BILL BRINGS CHANGES FOR LHCSAS AND FIS

Home Care Alert
April 2, 2018

The New York State budget bill was issued late on Friday and it contains a number of important provisions that will affect fiscal intermediaries and home care agencies. The key provisions of the budget bill are summarized here.

Limits on LHCSA Contracts

The Executive Budget proposed to limit each MLTC to contracting with only 10 LHCSAs. This proposal was not adopted in the final budget bill that was published on Friday. However, the budget bill does restrict how many contracts with LHCSAs MLTCs will have. The restrictions, as explained below, are based on geographic area and the year at issue. The bill empowers the Commissioner of Health to "establish a methodology to limit the number of" LHCSAs with which MLTCs contract. While the Commissioner will have broad discretion to determine how many LHCSAs each MLTC may contract with, the methodology must comply with the following rules:

For MLTCs operating in New York City and/or the counties of Nassau, Suffolk and Westchester, a MLTC will be limited to contracting with the number of LHCSAs based on how many enrollees the MLTC has. Effective October 1, 2018, the MLTC will be permitted to have 1 LHCSA contract for every 75 members enrolled in the plan within "such region." Note, "region" is not defined so it is not clear whether the MLTC is required to consider the total number of their enrollees within New York City only, or whether "region" includes New York City and the surrounding counties. *To illustrate how this will work, if a MLTC plan has 10,000 enrollees, the number of enrollees would be divided by 75, allowing the MLTC to have 133 LHCSA contracts. As the example illustrates, the larger the number of MLTCs' enrollees, the more LHCSA contracts that the MLTC may have.*

Effective October 1, 2019, one MLTC contract per 100 members enrolled in the plan within such region.

For MLTCs operating in counties outside New York City and the counties of Nassau, Suffolk, and Westchester, such MLTCs may enter into contracts with LHCSAs based on the following methodology:

Effective October 1, 2018 one MLTC contract per 45 members enrolled in the plan within such region. Thus, assuming the MLTC has 10,000 enrollees, that number will be divided by 45. Such MLTC will be permitted to have 222 contracts with

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LHCSAs.

Effective October 1, 2019, one contract per 60 members enrolled in the plan within such region.

The budget bill does allow some exception to the above rules. For example, if application of the above standards would require an enrollee to transfer to a new LHCSA, and the enrollee does not want to be transferred, then the MLTC may choose to continue contracting with the enrollee's current LHCSA. Such contract would not count towards the above limits for 3 months. Also, MLTCs will be permitted to enter into contracts with LHCSAs where necessary to maintain network adequacy standards, notwithstanding the above limits.

The Commissioner may require MLTCs to provide proof of compliance with these requirements on an annual basis.

LHCSA Moratorium

Effective April 1, 2018, a two-year moratorium will be implemented on the processing and approval of LHCSA applications that have not received establishment approval or contingent establishment approval by the Public Health and Health Planning Council (PHHPC). The moratorium will not apply to:

- an application seeking licensure of a LHCSA that is submitted with an application for approval as an ALP;
- an application seeking approval to transfer ownership for an existing LHCSA that has been licensed and operating for a minimum of five years for the purpose of consolidating ownership of two or more LHCSAs; and
- an application submitted pursuant to community need, as determined by the PHHPC.

LHCSA Registration

The budget bill states that no LHCSA may continue to operate after January 1, 2019 unless it has registered with the Commissioner of Health. The Commissioner will publish the standards for registration, as well as any deadlines to submit an application for registration.

A LHCSA that fails to submit a registration by the deadline (to be established by the Commissioner) shall be required to pay a fee of $500 for each month (or part of the month) that the LHCSA is in default. A LHCSA that fails to register one year cannot register the following year unless it pays late fees.

The DOH will post on its public website a list of all LHCSAs and their registration status.

The DOH will institute proceedings to revoke the license of any LHCSA that fails to register for two annual registration periods, whether or not such periods are consecutive.

Advertising by FIs

The budget bill also states that a fiscal intermediary ("FI") will not be permitted to publish any advertisement that is false or misleading. For purposes of this law, an advertisement is any material produced in any medium that can "reasonably be interpreted as intended to market" the FI's services to medical assistance recipients. The law does not specify what would make an advertisement false or misleading.

FIs will be required to submit all ads prior to distribution to the DOH for authorization. Distribution of the ad will not be permitted until the DOH provides authorization. Authorizations will be granted by the DOH within 30 days of submission.

If the DOH notifies the FI that the advertisement disseminated by the FI was false or misleading, the FI will have 30 days to disseminate or remove the advertisement.

If the DOH determines that the FI has disseminated two advertisements that are either false or misleading, or that were not previously approved by the DOH, the FI will be prohibited from providing FI services and any authorization granted to the FI to provide FI services will be immediately revoked, suspended, limited or annulled. The DOH will maintain a list of all FIs that are not compliant and will provide the list to MLTCs.

Cost Reporting

The Commissioner may require FIs and LHCSAs to report on the costs incurred by the provider in rendering services to Medicaid beneficiaries. The DOH "may" specify the frequency and format of such reports, determine the type and amount of information to be submitted, and require the submission of supporting documentation. However, the DOH must provide no less than 90 days' notice before any such report is due. If a report is incomplete or inaccurate, the provider must re-submit the complete or corrected report within 30 days from the date the provider receives notice from the DOH that the report is incomplete or inaccurate.

Attorney General Reports

The budget bill requires the New York Attorney General to make an annual report to the temporary president of the Senate, Speaker of the Assembly, Chair of the Senate Finance Committee, chair of the Assembly Ways and Means Committee, Chair of the Senate Health Committee, and the Chair of the Assembly Health Committee by April 15 of each year on the amounts of monies recovered by the Medicaid Fraud Control Unit under the False Claims Act for the preceding calendar year.

If you have any questions about the budget bill and how it will affect your agency's operations, please contact any one of the attorneys in our Home Care Group.