HCANJ
Health Care Association of New Jersey

Health Care Update

Vol. 21, No. 1 February 2015

Medicaid Eligibility Reform - The Solution is "Pending"

Welcome to 2015 and another year of action and advocacy from your HCANJ leaders and staff. While our primary mission of a more fair and effective reimbursement and regulatory system remains, New Jersey had some media attention over the holidays highlighting another challenge we face - Medicaid eligibility delays or "pendings." The articles on nj.com (*http://www.nj.com/healthfit/index.ssf/2014/12/medicaid_backlog.html#incart_river*) and The Philadelphia Inquirer (*http://articles.philly.com/2014-12-30/news/57499330_1_state-computer-systems-state-audit-backlog*) illustrated the very dysfunctional Medicaid application and eligibility process. In response, we authored an Op/Ed detailing that these challenges are nothing new for us in long term care, and are even more pressing for our providers who cannot cost-shift or discharge.

Jon Dolan
President/CEO

As those in long term care know, the long term care Medicaid eligibility process is a system filled with delays, inefficiencies, and inaccuracies and it represents a real crisis for families and facilities. The county Medicaid offices add a layer of bureaucracy that, combined with the complexity of asset transfers, income verifications and cost share calculations, makes it near impossible to receive an approval in the required 45-day time frame. The elected and bureaucratic Garden State leaders must act immediately to address this crisis.

An administrator's daily life is filled with improving care and dealing with everything from census to survey. "Medicaid Pendings" has become a monstrous problem, particularly as it pertains to cash flow. It causes huge delays, inconvenience, and repeated inaccuracies that lead to serious delays of hundreds of thousands to millions of dollars in reimbursements payments to our providers.

In our Op/Ed we pointed out the aspects of the problem and offered to work with the State in order to provide creative and immediate solutions to address it properly. As we begin 2015, I want our members to know that your leaders and member committees placed the advocacy for these solutions to the crisis at the top of our agenda.

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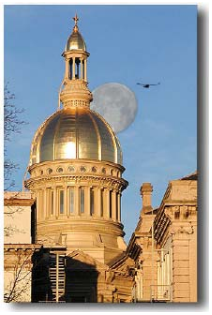

News from the State House

Commercial driver license relief measure advances; health care facility generator legislation hits Governor's desk

The last "State House Update" reported about the introduction of legislation to alleviate the requirement that drivers of facility buses must possess a commercial driver license. HCANJ is happy to say that this legislation, Assembly Bill 3951 and Senate Bill 2596, is now just one Senate vote away from the Governor's desk.

This legislation would exempt certain vehicles owned or leased by certain health care facilities or used to transport people with developmental disabilities from a statute known as "Angelie's Law." This law prohibits persons without a valid commercial driver license from operating most autobuses. It includes some exceptions and HCANJ requested the legislation to also exclude buses used by facilities to transport residents to social events, shopping excursions and medical appointments.

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As a Membership service, classified advertisements of 75 words or less for positions available can be placed without charge by HCANJ members for two consecutive months.

For further information contact Pattie Tucker by phone at 609-890-8700 or via e-mail at pattie@hcanj.org.

The Solution is "Pending"

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The first challenge is to assist and encourage our state leaders to overcome the initial failure to design and deliver a comprehensive computer system to link the counties and state with application data, eligibility process information and case management tools. This is a critical component; and, in this day and age we must be able to find a way to quickly and effectively implement the Consolidated Assistance Support System (CASS)or provide something else that will work for New Jersey.. New Jersey should survey other states with efficient systems to evaluate whether or not their vendors can meet our needs.

Unlike other providers, we must take in and care for residents and cannot deny, discharge, or cost-shift away them from Medicaid. Waiting for payment combined with the chronic shortfall of over $30 per patient day while payroll must be met and vendors be paid, makes this a crisis.

Our recommended legislative solution granting some speedy relief is to pass the "Uncompensated Pending Medicaid Beneficiary Payment Relief Act" into law. This will allow the state to pay fifty percent of all Medicaid pendings running over 90 days. That immediate relief will allow us to better survive the process delays and render the quality care to New Jersey's most needy.

With that system in place, DHS can then develop the right per-case and per-county metrics or benchmarks for monitoring cases over 90 days, and advance payments to each county or by caseload. Tracking all approvals under 45, 60 or 90 days is a good positive reinforcement detail. Likewise, the risk of counties arbitrarily denying, so as not to violate the 90 day period, creates a possibility that the state must track as well. Simply put, we need a great "naughty and nice" list and proper sanctions. I know of none that exist currently.

The state must also determine where the challenges may be due to inadequate resources or where process improvement is an issue. The very real issue of files accumulating on employees' desks or stacked in hallways to be lost again and again, forcing families and providers to resubmit and deal with receiving no responses is unacceptable. This doesn't have to mean hiring more state or county employees; many times staff numbers is not the issue. However, where analysis finds truly overburdened and hard-working employees doing all they can, more resources must be applied.

Finally, our sector and the state need to admit how detailed and complex our applications are versus the standard social service or Medicaid applicant. Calculating or evaluating third party liabilities, Medicare premiums, cost share, spousal support, and a lifetime of assets to be depleted is more difficult for the government and families to undertake. That is particularly true if the family support network is non-existent or non-cooperative.

(Continued on Page 3)

Upcoming Recognition Dates

JANUARY

National Glaucoma Awareness Month
National Volunteer Blood Donor Month
18 - 24
National Activity Professionals Week
25
National Intravenous Nurse Day

FEBRUARY

American Heart Month
AMD/Low Vision Awareness Month
National Cancer Prevention Month
National Senior Independence Month
6
Women's Heart Health Day
(National Wear Red Day)
2 - 6
Pride in Food Service Week
8 - 14
National Cardiovascular Professionals Week
14 - 21
Alzheimer's & Dementia Staff Education Week

The Solution is "Pending"

(from Page 2)

The solution to this is to bring in the government equivalent of the "Special Forces" to serve counties and families in need and facility their applications. Our Associate Memberconsultants are working with many of you and thousands of New Jersey families to help process applications and break the logjam. They assisted HCANJ in evaluating the pending problem, from county performance to the family perspective. After seeing the challenge for families and how much that is a key component of the pending problem, I believe the state needs a special unit or contract in a private /public partnership with such a team of special facilitators in order to fully break the logjam.

The idea is that when a particular county is judged by the aforementioned metric to be overburdened and too delayed, the basic application is still taken at their level but it and all information with it would be forwarded to a special "Family Medicaid Facilitation Team" and an adjudications unit in Trenton. Then, when the county gets caught up with its cases, by alleviating its backlog and proving it can handle new applications, they could get back on track. Sound familiar? If we must deal with bans to admissions when quality suffers in a facility, should the county be held to similar quality standards when their mistakes and delays make quality customer service impossible? Moving forward, special/contracted Family Medicaid facilitators could be permanently assigned to each county, swoop in and scoop up the new or tough cases and move through quickly to resolve them.

While this has been a long update, please know an even more detailed plan for what I have described will be presented to the state. We appreciate their continued recognition of the problem and will attempt to assist them by providing our proposed creative solutions to eliminate pendings.

HCANJ CLASSIFIEDS

REGIONAL ACTIVITES DIRECTOR Chelsea Senior Living is seeking a Regional Activities Director to oversee and coordinate Alzheimer's and Assisted Living programming throughout NY, NJ and PA. Strong background working with seniors and activities programming is a must. Multi facility oversight experience a plus. Please send resumes to *cacrecruiter@yahoo.com.*

CLINICAL CORNER

Livanta New Contractor for Medicare

On August 1, 2014, Livanta LLC began work as the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for your state. In their new role, Livanta is responsible for case review for Medicare beneficiaries. To learn more about Livanta, we invite you to visit our website at www.BFCCQIOArea1.com.

Hospitals, critical access hospitals, home health agencies, and long term care providers are required to sign a Memorandum of Agreement (MOA) with Livanta. If you are one of those provider types and have not yet submitted the MOA, please do so as soon as possible. We also encourage hospice and rehabilitation providers to sign an MOA as well. You can download the MOA form at *www.bfccqioarea1.com/provider.html*.

Prior to the transition, Livanta received provider contact information from CMS. If you need to verify or update your contact information, please reach out to Area 1 Communications Lead, Laura Dugan, by phone at 717-450-5781 or by email at ldugan@livanta.com.

Quality Improvement Organizations
Sharing Knowledge, Improving Health Care.
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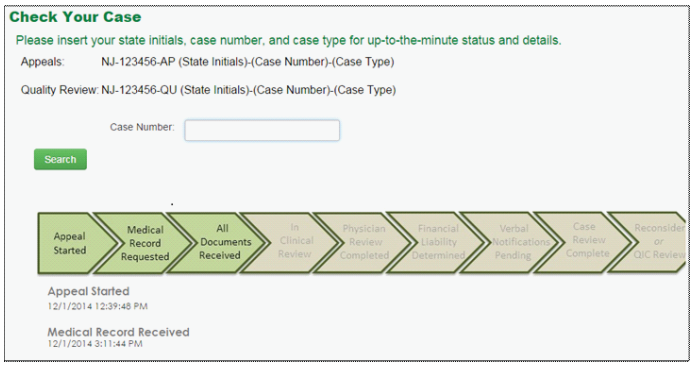
LIVANTA

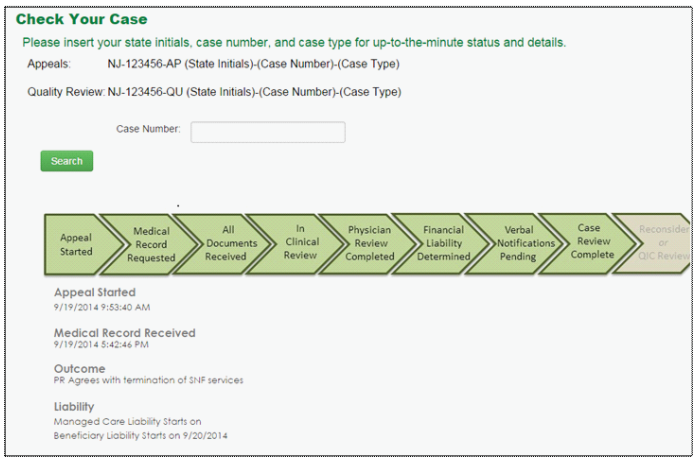
Introducing Arrow!

Livanta, the Beneficiary and Family Centered Care QIO for the west, is pleased to announce a new online tool for providers. Arrow, which is available through the home page of the Livanta QIO website at ***www.BFCCQIOArea1.com***, gives providers the opportunity to check on case status by simply inputting the case number, as directed.



Arrow provides a snapshot of the current status of your case through easy-to-follow graphics and additional written details. Green arrows indicate completed steps. Gray arrows indicate steps that have yet to be completed.

As the case progresses, steps are marked completed in real-time, and additional details on the case outcome and liability will display. Only high-level information is shared – no provider or patient information will be made available through the website.



Livanta encourages all providers to use this new tool to check on the status of their cases by visiting www.BFCCQIOArea1.com. While visiting the website, be sure to review the Provider Frequently Asked Questions, which have been recently updated and categorized to make it easy for you to find the answers you need.

For more information, contact: Laura Dugan, Communications Lead – Area 1, 717-450-5781, ldugan@livanta.com.

State House Update

(From Page 1)

The quick advance began with the Assembly Transportation Committee release of the proposal on December 11. On December 15, the bill passed the full General Assembly by a vote of 76 to 0. On January 13 the proposal cleared the Senate Transportation Committee. HCANJ thanks Assembly Speaker Vincent Prieto and Senate Transportation Committee Chairman Nicholas Sacco for sponsoring the proposal and moving it forward so quickly.

Legislation requiring certain health care facilities—including nursing and assisted living facilities—to either be generator-ready or have an onsite generator installed within three years also took a major step forward recently, landing on the Governor's desk following Assembly passage on December 15. HCANJ backs the proposal, Senate Bill 854, because it is a reasonable alternative to the many generator-related bills introduced in the aftermath of Super Storm Sandy. These are not the kind of generators that you purchase at Home Depot or Lowe's and facilities need the three years afforded to secure permits and local approval and to complete installation and inspections. Making low-cost New Jersey Economic Development loans available also helps capital-strapped facilities become better prepared for the next big power outage. Assemblywoman Annette Quijano and Senator Joe Vitale deserve the credit for advancing this legislation.

In other legislative action, HCANJ was pleased by the Assembly Human Services Committee's release of legislation increasing the personal needs allowance for nursing facility Medicaid beneficiaries to at least $50. Sponsored by Assemblywomen Cleopatra Tucker, Assembly Bill 3084, cleared the committee on January 15. It was second referenced to the Assembly Appropriations Committee.

Another HCANJ supported measure moving forward is Assembly Bill 1102, which moves oversight of "dementia care homes" from the Department of Community Affairs to the more appropriate requirement for licensure by the Department of Health. The measure, Assembly Bill 1102, passed the General Assembly on December 15. Assemblywoman Valerie Vainieri Huttle is the prime sponsor. The bill is now before the Senate Health, Human Services and Senior Citizens Committee for further consideration.

HCANJ will be seeking amendments to another recently introduced proposal, Assembly Bill 3949, which requires full pay for certain health care and public safety workers placed in isolation or quarantine. Otherwise known as the "Ebola legislation," the legislation needs to be reworded to ensure that it applies only to workers involved directly in the care of infected patients, either at the health care facility at which they are employed or as part of facility sanctioned medical support. As currently worded, the bill would apply to workers placed in isolation or quarantined due to their contracting an illness not in the coarse of their employment, for example, while visiting relatives in a country where a particularly communicable illness is prevalent.

MARK YOUR CALENDAR!

43rd Annual
HCANJ 20-Hour Symposium
& Mini Expo

March 17 - 19, 2015

Resorts Hotel & Casino
Atlantic City, New Jersey

Registration information is available online at:
http://www.hcanj.org/201520hr

For further information,
please call Michelle Palko -
(609) 890-8700.

CDC 2014 Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities

http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

Decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza. All long-term care (LTC) facility residents who have confirmed or suspected influenza should receive antiviral treatment immediately. Antiviral treatment works best when started within the first two days of symptoms. However, these medications can still help when given after 48 hours to those who are very sick, such as hospitalized individuals or those with a progressive illness.

Drug Choice - Two influenza antiviral drugs are currently recommended for use:

- **Oseltamivir (Tamiflu),** available as a capsule or suspension
- **Zanamivir (Relenza),** available as an inhaled powder using a disk inhaler device
  Note: Some long-term care residents may have difficulty using the inhaled device
- Amantadine and Rimantadine are NOT recommended for use because of high levels of antiviral resistance among circulating influenza A viruses

Duration of Treatment or Chemoprophylaxis

- *Treatment:* Recommended duration for antiviral treatment is twice daily for five days; longer treatment courses for patients who remain severely ill after five days of treatment, can be considered
- *Chemoprophylaxis:*
  Recommended duration is once daily for seven days (after last known exposure)

** For control of outbreaks in institutional settings (e.g., LTC facilities and hospitals), the CDC recommends antiviral chemoprophylaxis for a minimum of two weeks, and continuing up to 1 week after the last known case was identified

Dosing Considerations for Renal Impairment:

- **Oseltamivir (Tamiflu)**
  Influenza treatment
  CrCl > 60 ml/min: 75 mg PO twice daily for five days
  CrCl > 30-60 ml/min: 30 mg PO twice daily for five days
  CrCl > 10-30 ml/min: 30 mg PO once daily for five days
  CrCl <= 10 ml/min, not undergoing dialysis: Oseltamivir is not recommended
  Influenza prophylaxis
  CrCl > 60 ml/min: 75 mg PO once daily
  CrCl > 30-60 ml/min: 30 mg PO once daily
  CrCl > 10-30 ml/min: 30 mg PO every other day
  CrCl <= 10 ml/min, not undergoing dialysis: Oseltamivir is not recommended
- **Zanamivir (Relenza)**
  No recommended dosage adjustment of inhaled five-day course of treatment in patients with mild, moderate, or severe renal impairment

Considerations for Antiviral Use When Antiviral Supplies Are Limited

- When antiviral supplies are limited, recommendations for antiviral treatment and chemoprophylaxis might differ according to disease incidence, severity of illness, and likelihood for influenza-related complications
- Conservation of antiviral supplies to prioritize use for those with higher risk for complications or severe illness may be necessary; updated information on the most recent guidance for antiviral use from CDC and local public health officials should be sought during widespread illness or a pandemic, and medications should be reserved as much as possible for use in patients who are severely ill or at higher risk for complications

Dec 18, 2014

Influenza Outbreak Management

This guide reviews the two recommended influenza antiviral drugs, treatment, and dosing, as well as strategies when antiviral supplies are limited.

The influenza season is in full swing, with many states experiencing significant regional and even widespread reports of confirmed influenza and influenza-like-symptoms. The Centers for Disease Control and Prevention (CDC) has provided a guideline "Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities," which instructs all long-term care facility residents who have confirmed or suspected influenza to receive antiviral treatment immediately.

Antiviral treatment works best when started within the first two days of symptoms. However, these medications can still help when given after 48 hours to those who are very sick, such as hospitalized individuals or those with a progressive illness.

When at least two patients are ill within 72 hours of each other and at least one resident has laboratory-confirmed influenza, the facility should promptly initiate antiviral chemoprophylaxis to all non-ill residents, regardless of whether they received influenza vaccination during the previous fall. Priority should be given to residents living in the same unit or floor as an ill resident. However, since staff and residents may spread influenza to residents on other units, floors, or buildings of the same facility, all non-ill residents are recommended to receive antiviral chemoprophylaxis to control influenza outbreaks. All eligible residents in the entire long-term care facility should receive antiviral chemoprophylaxis as soon as an influenza outbreak is determined.

Should you have any questions, please contact your consultant pharmacist and/or account manager.