

HANYS

LONG TERM HOME HEALTH CARE PROGRAM

LONG-TERM CARE REFORM SERIES

- New York's Long Term Home Health Care Program provides critical services to fragile, chronically ill elderly, and disabled individuals, enabling them to stay in their homes.
- HANYS is advocating to improve the program to enhance patient access, streamline administrative processes, improve care coordination, and ensure sufficient resources for service delivery.

H A N Y S



Healthcare Association
of New York State

ISSUES BRIEF #3
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Restructuring New York State's long-term care system should build on the strength of existing models of care, locally based community services, and the strong network of providers with a fundamental mission and proven history of providing high-quality, cost-effective health care. Recent state long-term care reform initiatives have included reducing institutional capacity and promoting the use of home- and community-based services. As the state looks to expand these services, it must ensure that a sufficient capacity of services and resources are available to meet the needs of consumers in community settings.

HANYS supports reforming the long-term care system to promote consumer-focused, community-centered care with timely access to needed quality services, supported by sufficient funding. Long-term care reform should maximize community resources, foster creativity, increase workforce flexibility, create more opportunities for making personal choices, and embrace patient-centered partnerships. Long-term care reform should bridge existing gaps between health care and services addressing housing, transportation, mental health, disabilities, and substance abuse to help keep people in community settings and support their independence.

New York's Long Term Home Health Care Program (LTHHCP), also known as the "Nursing Home Without Walls" program, has been an effective model of coordinated, community-based, long-term care for 30 years. New York State operates the LTHHCP under the authority of a federal Home and Community Based Services Medicaid waiver established by Section 1915(c) of the Social Security Act, which incorporates services not normally covered by Medicaid. LTHHCP participants must be eligible for a nursing home level of care, but can receive medical and social support services in their own homes. As a result, frail elderly and disabled individuals can remain in their homes and avoid unnecessary and expensive emergency room and hospital care, as well as long-term institutional care.

To meet the challenges of providing care in the 21st century, the LTHHCP must be updated. Many administrative processes act as barriers to care and services in a fast-paced health care environment for high-acuity patients. The authorizing statute enacted in 1977 and the regulatory structure subsequently adopted in 1978 have not changed significantly since the program's inception. The current federal waiver authorizing New York's LTHHCP will expire at the end of 2008, and the state has the opportunity to revisit the program's structure and make amendments to improve program efficiency, enhance accessibility, and support quality improvement.

LTHHCPs strive to address consumer choice, practice efficiencies of care, facilitate patient transitions, and provide quality care. Adopting current technologies, maximizing coordination with other providers, and collecting and reporting data on performance and outcomes as part of an integrated continuum of care are critical to the continued success of LTHHCPs. Changes are needed in state statute, regulation, and the federal waiver to support attainment of these goals.

HANYS RECOMMENDS:

- **Revise administrative processes** to extend authorization approval timeframes; streamline assessment and approval of patients; standardize program administration and monitor consistency with established standards; ensure equal access to care to institutional services for married couples; and enable flexibility in the calculation of budget caps.
- **Ensure care coordination** with minimal fragmentation of care for patients, particularly when both physical health and behavioral health services are needed.
- **Foster operational efficiencies** by creating a universal assessment for post-acute settings, developing program-specific quality measures, supporting the expansion of services such as the use of telehealth, and increasing flexibility in workforce training and utilization.

ADMINISTRATIVE PROCESSES

HANYS RECOMMENDS:

- Reauthorization should be required on a less frequent basis—every six or 12 months.
- Streamline the admission, assessment, and determination processes.
- Eliminate the redundant and costly requirement for local social service districts to conduct patient assessments that are also completed by LTHHCPs.
- Develop processes for monitoring consistency with established program standards at the county level in program administration, patient access, and service delivery.
- Develop measures of program efficacy and access.
- Ensure consistency in promoting rebalancing and rightsizing by allowing married couples utilizing home- and community-based long-term care services the same access to Medicaid benefits as individuals receiving care in an institution.
- Allow more flexibility in developing patient budgets.

Authorization Periods

Current regulations limit authorization for LTHHCP services to four months. Once services are in place, many participants become medically stable and are able to remain in the program for multiple years. The requirement to perform reassessments every four months solely for the purpose of reauthorization can be burdensome, redundant, and unnecessary—particularly in light of workforce shortages. Other long-term care waiver programs, such as the Care at Home Waiver, require reauthorization assessments every six months. Unless there is a change in the patient's condition, an annual or semi-annual assessment is sufficient for the purposes of reauthorization, especially considering the fact that federal Medicare rules require patient assessments every 60 days.

Program Standards

The local departments of social services (DSS) in each county have a number of roles in the administration of the state LTHHCP. In addition to determining Medicaid eligibility, local DSS staff approve or deny LTHHCP participation, conduct patient assessments, compute and approve patient budgets, authorize services, and provide case management to LTHHCP recipients.

Some functions performed by the local DSS, in particular patient assessment and case management, duplicate those provided by LTHHCP nurses and often impede access to needed LTHHCP services. The state has historically allowed local districts flexibility in the interpretation and application of program requirements, which has engendered wide variation in administration of the program at the county level.

Eliminating the redundant and costly requirements for DSS to conduct assessments already completed by LTHHCPs and provide case management will decrease the administrative burden on both entities, and result in more resources being available and appropriately directed to patient care. Moreover, DOH should establish statewide standards that ensure consistent administration of the program and facilitate patients' timely access to services.

Spousal Protections

When the Centers for Medicare and Medicaid Services (CMS) approved the Nursing Home Transition and Diversion Waiver in 2007, it changed its interpretation of spousal impoverishment budgeting that has been in place in New York State since the LTHHCP began several decades ago.

Although CMS is promoting a number of initiatives that support home- and community-based services, elimination of spousal impoverishment protections for waiver participants creates a perverse incentive that favors institutionalization. DOH estimates that 10% of LTHHCP participants, approximately 3,000 people, will be affected by CMS' new interpretation that could reduce the community spouse's monthly income to an amount significantly below the level allowed for spouses of institutionalized individuals.

To support home- and community-based services and reduce institutionalization, policies must encourage community living by allowing spouses to preserve sufficient income to manage the expenses inherent in maintaining a residence. The state should explore and work toward options to ensure spousal impoverishment protections, maintain a participant's eligibility, and protect the ability of participants to stay at home with a spouse.

Patient Budgeting

LTHHCP statute requires that total monthly expenditures for each person not exceed 75% of the average monthly Medicaid rate for nursing home care in the county. The current individual patient budget cap affects access to the program by some patients who could benefit from the case coordination and services that LTHHCPs provide. Additionally, the cap is based on an outdated nursing home rate. The LTHHCP should be updated to ensure that patients can appropriately access needed services and remain in the program as care needs change.

CARE COORDINATION

Care coordination and case management are integral parts of the approach to care provided by LTHHCPs to patients with multiple illnesses, including individuals with behavioral health disorders. LTHHCP provides comprehensive coordination necessary to implement plans of care to stabilize or improve the health status of patients, ensure quality of care, and reduce avoidable hospitalizations, emergency room visits, and nursing home admissions. Care coordination requires an interdisciplinary team of health professionals to oversee the management of, and referral for, medical and other health services.

Current policy restricts participation in complementary Medicaid programs that work together to coordinate care for each patient's needs. Individuals who participate in Comprehensive Medicaid Case Management programs through the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, or the Early Intervention program for children cannot receive their health care services from a LTHHCP, and have been forced to disenroll from the LTHHCP. This results in fragmented care with little coordination of the overall, daily health care needs of the patient. These complex patients are likely to deteriorate in the absence of care that is coordinated.

Providing "whole person care" is critical to maintaining these individuals in the community. The state should explore ways to facilitate integration of care and services provided by multiple systems to LTHHCP participants that promote coordination of comprehensive patient care.

HANYS RECOMMENDS:

- Ensure that the services needed by a patient enrolled in a waiver program can be obtained in the most coordinated fashion with minimal fragmentation, particularly when a patient needs both physical health and behavioral health services.

OPERATIONAL EFFICIENCIES

HANYS RECOMMENDS:

- Develop a scoring system for eligibility purposes based on OASIS data, eliminating the need for two separate assessment tools.
- Use OASIS data to document and monitor patient status on an ongoing basis.
- Develop an appropriate methodology using currently collected data to calculate program-specific quality measures to better reflect the ongoing status of LTHHCP participants.
- Incorporate a payment rate for telehealth as part of the LTHHCP.
- Expand opportunities for the direct care workforce to increase skills and salary through specialization of aide services in specific areas of growing need such as behavioral health and disease-specific knowledge.
- Address remedies to workforce issues as part of the state's overall long-term care reform agenda.

Assessment Tool

Currently, LTHHCPs must use two separate tools to assess patients who are eligible for both Medicare and Medicaid (“dual-eligible”). To reduce redundancy and paperwork, HANYS recommends that only the Medicare evaluation tool be used.

The Medicaid tool that has been used since the beginning of the program—the New York State Long Term Care Placement Form Medical Assessment Abstract (DMS-1)—has been used to make patient level of care determinations and for re-assessments every four months. The DMS-1 was developed as an assessment for residential long-term care placement, and does not reflect current assessment needs for home care.

The Medicare tool—the Outcome and Assessment Information Set (OASIS)—is completed as part of an initial assessment and every 60 days.

Using OASIS data collected to determine eligibility and document patient assessments would reduce the paperwork burden on clinicians and allow more time for direct patient care.

Quality Measures

Quality measures for LTHHCP providers should be based on outcomes appropriate for individuals receiving long-term care, such as preventing complications and sustaining functional abilities. The long-term goals of the LTHHCP are different from the short-term goals of the Medicare home health care benefit, as are the patients served and the expected outcomes.

As Medicare providers, LTHHCPs collect and report OASIS data that are used by CMS to evaluate home health agencies' performance on patient outcomes, based on a 60-day episode of care. Many of CMS' Home Health Quality Measures, such as stabilization measures, are appropriate for LTHHCPs, but the ongoing status of LTHHCP patients is not captured by the calculation methodology used by CMS. The CMS quality measure rates are only calculated at the end of a care episode, typically at death or discharge to a nursing home for LTHHCP patients, and do not reflect the fact that LTHHCPs reduce hospitalizations and reduce use of emergency services.

An appropriate methodology for calculating quality measures is needed as part of a continuous assessment process to capture trends that demonstrate longitudinal progress in avoiding negative outcomes and maintaining quality over time.

Telehealth

Many providers have found telehealth to be very effective in reducing emergency room and hospital utilization, easing workforce shortages, and increasing patient satisfaction. Telehealth should be incorporated into LTHHCPs as a service for which providers can receive payment.

Workforce

The availability of qualified personnel is critical to the viability of LTHHCPs. Recruitment and retention challenges are similar to those experienced by other health care providers. LTHHCPs are struggling to hire sufficient numbers of nurses, therapists, and home health aides. Increased flexibility in the training and use of available staff would enhance efficiency in utilization of this limited resource.

New York's LTHHCP provides critical support to fragile, chronically ill elders and disabled individuals, enabling them to stay in their own homes. Given New York State's goals of increasing the community-based options available to consumers and supporting sustainable, efficient, high-quality care that maximizes patient choice, the LTHHCP is an excellent venue to help meet the growing demand for long-term care.

Developing innovative approaches to improving a tested and reliable model can expand the community-based care delivery system. The waiver renewal this year presents an opportunity to make changes to the program that will improve access for patients, simplify administrative processes, enhance care coordination, and ensure sufficient resources for service delivery.

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