

An Overview of  
Medicaid Long-Term Care Programs  
in New York

**MEDICAID  
INSTITUTE**  
AT UNITED HOSPITAL FUND

Chapter 4

# Long-Term Home Health Care Program

PREPARED BY  
Alene Hokenstad and Meghan Shineman  
of the United Hospital Fund  
and Roger Auerbach of Auerbach Consulting, Inc.

April 2009

## Table of Contents

---

<b>Program Snapshot</b>		3
Enrollment and Spending		3
Program and Provider Capacity		4
Health Status and Demographics		6
<b>Rules, Regulations, and Administrative Structure</b>		6
Federal Coverage Requirements		6
Covered Services		7
Service Utilization		8
Eligibility — Medical and Financial		9
Access		11
Provider Requirements		13
Payment		13
Quality Monitoring		15
<b>Policy Implications</b>		16
The Individual Budget Cap		16
System Simplification		17
Variation in Local Department of Social Service Policy		18
Spousal Impoverishment Protections		18
Program Size		19
Lack of Transparency in Reporting Care Management Costs		19
Medicare Conditions of Participation		19
Financial Incentives		20
Standardized Needs Measurement		20
<b>References</b>		22
<b>Index of Figures</b>		
Figure 4.1	LTHHCP Enrollment and Spending	3
Figure 4.2	Share of Enrollment and Spending in New York City, by Program	4
Figure 4.3	LTHHCP Enrollment, by Organizational Sponsor	5
Figure 4.4	LTHHCP Spending, by Type of Service	8
Figure 4.5	LTHHCP Referrals, by Source	11
<b>Index of Tables</b>		
Table 4.1	Regional Distribution of LTHHCP Capacity	6
Table 4.2	LTHHCP: Covered Services	8
Table 4.3	LTHHCP: Individual Monthly Budget Caps	10
Table 4.4	LTHHCP Provider Payment Rates	14
Table 4.5	LTHHCP Revenue, by Payment Source	15

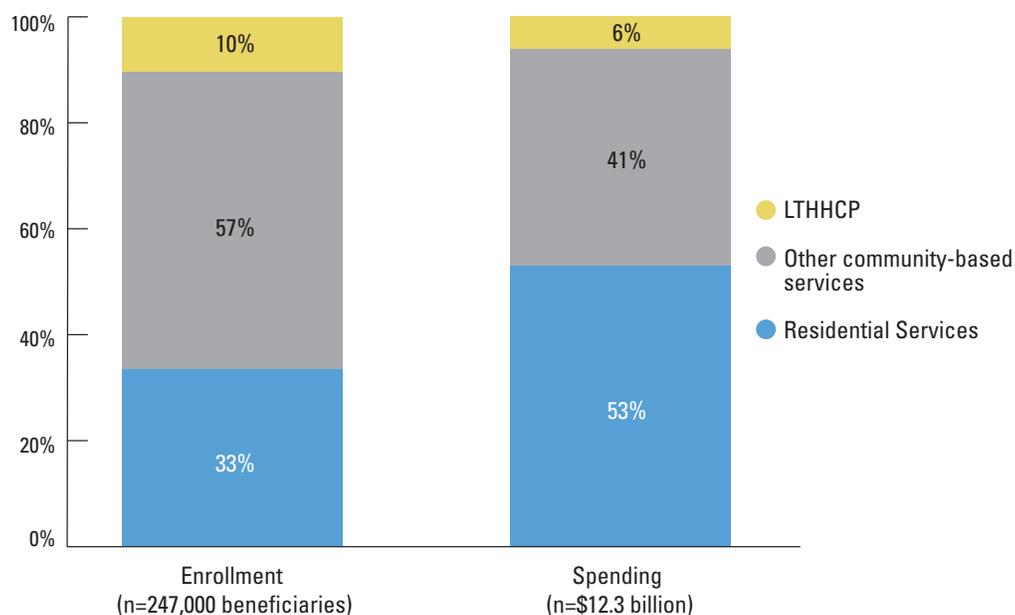
## Program Snapshot

In December 2007, approximately 24,000 New Yorkers were enrolled in the state's Long-Term Home Health Care Program (LTHHCP).<sup>1</sup> The program, also known as the Lombardi program or the Nursing Home without Walls program, was established in 1978 as one of the nation's first comprehensive community-based service programs for beneficiaries who require nursing home level of care. It is one of the largest waiver programs for aged and disabled Medicaid beneficiaries in the nation.<sup>2</sup>

## Enrollment and Spending

LTHHCP beneficiaries account for an estimated 10 percent of the state's Medicaid long-term care beneficiaries.

**Figure 4.1**  
**Percentage of LTHHCP Enrollment and Spending as a Share of All Medicaid LTC Programs, 2007**



Source: UHF analysis of September 2007 MARS data, 2007 LTHHCP census, and FFY 2007 CMS-64.

Note: Other community-based services include traditional PC, CHHA, CDPAP, ADHC, TBI, MMLTC, and PACE programs.

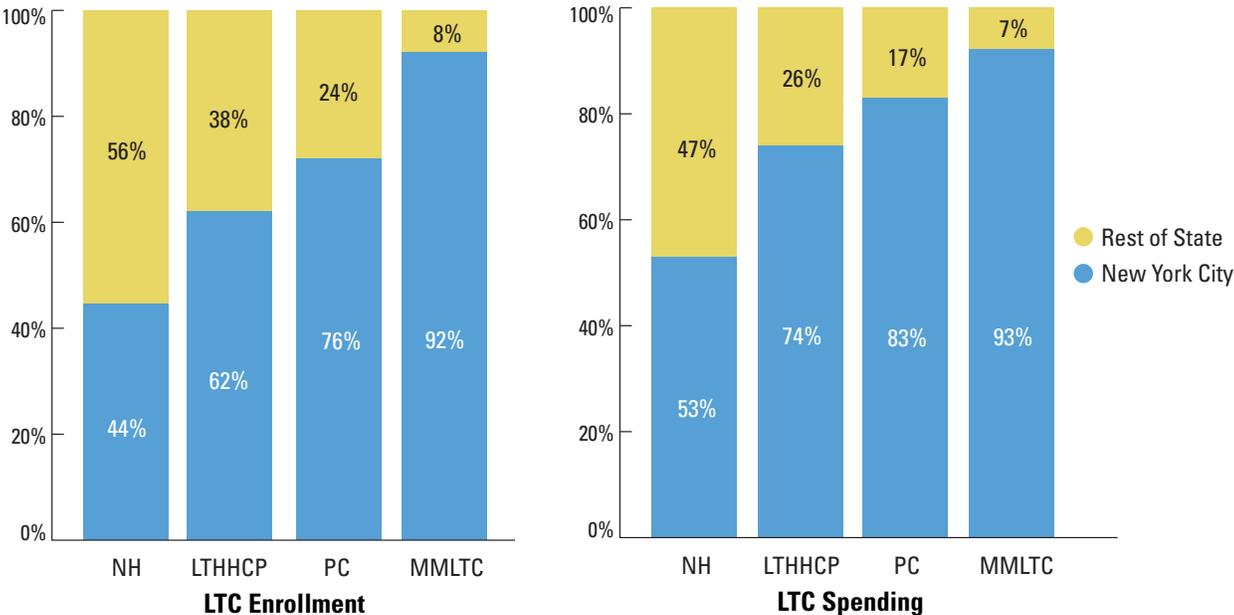
Medicaid spent an estimated \$700 million in FFY 2007 on the LTHHCP, approximately 6 percent of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities in the state.

<sup>1</sup> This program portrait is a chapter of *An Overview of Medicaid Long-Term Care Programs in New York* by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, the Medicaid Assisted Living Program, traditional personal care, certified home health agencies, consumer-directed personal care, adult day health care, the Long-Term Home Health Care Program, the traumatic brain injury waiver program, Medicaid managed long-term care, and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities or medically fragile children, such as the Care at Home Program. See the Technical Notes of the full report for a discussion of data sources and research methods.

<sup>2</sup> Every state except Arizona has at least one 1915(c) waiver program for aged or disabled Medicaid beneficiaries. Programs in five states (Illinois, Ohio, Oregon, Texas, and Washington) have more participants in a single waiver program than New York's LTHHCP.

**New York City vs. Rest of State:** The LTHHCP has larger percentages of program enrollment and spending in New York City than nursing homes do: 62 percent of its enrollment and 74 percent of its expenditures are in New York City.<sup>3</sup> The regional distribution of LTHHCP enrollment and spending is consistent with enrollment and spending patterns in other community-based programs. New York City programs tend to be larger than those in the rest of the state; because budget caps are based on regional nursing home rates, which are higher in the city than in other parts of the state, the amount of the individual budget cap is higher, which results in higher per-beneficiary spending.

**Figure 4.2**  
**Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007**



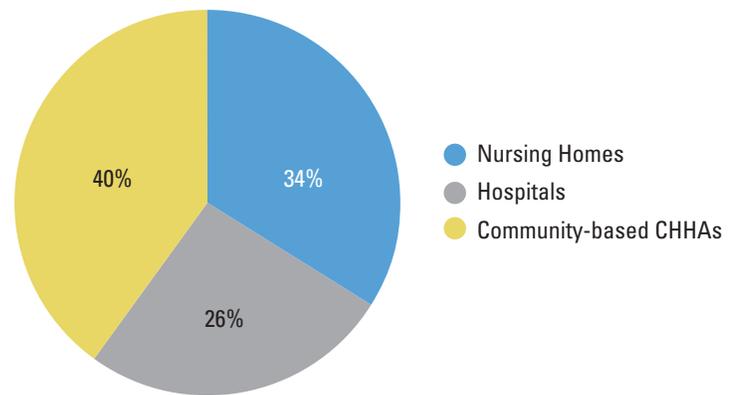
Sources: For nursing homes, LTHHCP, and personal care: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of September 2007 SDOH Managed Care enrollment data and SDOH Medicaid Managed Care Operating Report (MCOB) data, 12/31/07, provided by the MLTC/PACE Coalition.

### Program and Provider Capacity

There are 109 LTHHCP providers in the state. One-third (34 percent) of LTHHCP beneficiaries are enrolled in a program sponsored by a nursing home; one-fourth (26 percent) in a program sponsored by a hospital; and 40 percent in a program sponsored by a community-based (free-standing) certified home health care agency (CHHA). Because the state requires all providers to follow the Medicare conditions of participation for CMS surveillance purposes, all LTHHCP providers are technically treated as CHHAs.

<sup>3</sup> United Hospital Fund analysis of Medicaid Reference Statistics, FFY 2005-2007 (New York State Department of Health, Office of Health Insurance Programs, June 2008).

**Figure 4.3**  
**Percentage of LTHHCP Enrollment, by Organizational Sponsor, 2007**



Source: UHF analysis of 2007 LTHHCP census data (SDOH, Bureau of Licensure & Certification).

**Approved Slots:** Unlike most other community-based long-term care programs, LTHHCP providers are approved to provide services to a specified number of beneficiaries at any given point in time, sometimes referred to as “approved slots.” Applications for new providers and most new “slots” must be approved by the State Hospital Review and Planning Council, which generally approves the recommendations advanced by the Department of Health. To be eligible for new slots, the providers in the county must have an aggregate LTHHCP “occupancy rate” of greater than 85 percent for more than one year.<sup>4</sup>

**Program Size and Occupancy Rates:** Both provider size and occupancy rates (the difference between approved slots and actual enrollment) vary widely by region. On average, LTHHCP providers in NYC have 402 enrollees and an occupancy rate of 87 percent; in the rest of the state, they average 101 enrollees and have an occupancy rate of 60 percent. (Lower occupancy may be related to staffing shortages and the way in which local departments of social services interpret state policies, which affect access to the program.) The Department of Health does not maintain a program-wide waiting list. However, individual providers in some counties maintain their own waiting lists.<sup>5</sup>

<sup>4</sup> Under these circumstances, the State Department of Health has the authority to increase capacity for an individual provider by up to 50 slots, as long as the additional program slots do not double the size of the program. This policy only applies to programs that already have more than 50 approved slots.

<sup>5</sup> Although all regions have more approved slots than enrollees, some of the individual providers have more beneficiaries enrolled than the number of approved slots. The practice of provider-maintained waiting lists is unusual; waiting lists in other states are generally maintained by state or local governments.

**Table 4.1**  
**Regional Distribution of LTHHCP Capacity, 2007**

Region	Number of Providers	Census	Average Enrollees per Program	Approved Slots	Occupancy Rates
New York City	40	16,067	402	18,407	87.3%
Rest of State	80	8,062	101	13,337	60.4%
Capital	11	1,244	113	1,880	66.2%
Central	13	801	62	1,813	44.2%
Long Island	19	1,477	78	2,345	63.0%
New Rochelle	22	2,509	114	3,735	67.2%
Western/Buffalo	10	950	95	1,812	52.4%
Western/Rochester	8	1,081	135	1,752	61.7%
New York State (Total)	109	24,129	221	31,744	76.0%

Source: United Hospital Fund analysis of 2007 LTHHCP census as reported by the New York State Department of Health, Bureau of Licensure and Certification.

Note: Subtotals may not match totals because some LTHHCP sponsors have programs in more than one region.

**Workforce:** LTHHCP providers typically employ nurses directly, but subcontract with licensed home care service agencies for services from home health aides and personal care aides. There is no independent, reliable source of data about turnover rates among such workers at the national, state, or local level.<sup>6</sup>

## Health Status and Demographics

In accordance with eligibility rules, LTHHCP enrollees must require a nursing home level of care. Although enrollment is open to individuals of all ages with physical disabilities, the majority (69 percent) of beneficiaries are frail elderly.<sup>7,8</sup> We were unable to obtain more specific information about the health status of LTHHCP beneficiaries.

## Rules, Regulations, and Administrative Structure

### Federal Coverage Requirements

The Long-Term Home Health Care Program is a state program enhanced by a Medicaid 1915(c) home and community-based services waiver. Section 1915(c) of the Social Security Act allows states to request a waiver of certain federal Medicaid requirements in order to provide a wider range of services to beneficiaries who would otherwise be in an institution,

<sup>6</sup> National and local estimates of turnover rates for direct care workers in the home care industry range from 40 to 50 percent. Workforce analysts report that in New York City the turnover rate in the LTHHCP is higher than it is in the personal care program, which they estimate ranges from 11 to 15 percent annually. They report that in the rest of the state, the turnover rate is comparable to or worse than the national average. New York City's rates are likely related to labor-management agreements and the city's Living Wage Law, both of which affect direct care wages in the personal care program. Personal care wages are standardized and approximately \$2 to \$3 more per hour than the wages paid by the licensed home care service programs with which the LTHHCP providers contract. See Chapter 3 of this report for more about the personal care program.

<sup>7</sup> UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008).

<sup>8</sup> The state has two LTHHCP providers that exclusively enroll medically fragile children, St Mary's Hospital and Elizabeth Seton Pediatric Center. According to the 2007 LTHHCP census, these two programs had a combined enrollment of 1,017 children in December 2007.

including services not generally covered by Medicaid (such as medical social work and home modifications). In addition, Medicaid generally requires that states provide services to all beneficiaries who meet eligibility requirements. Waiver programs allow states to limit services to specific populations or geographic areas.

The LTHHCP is limited to individuals who require a nursing home level of care; it is not limited to a specific geographic area. Federal approval requires that the program be cost-neutral — i.e., that it not cost more than nursing home care for the same population would cost.

**Federal Waiver Assurances:** Federal approval to operate waiver programs must be reauthorized every five years; the LTHHCP waiver is in the process of being reauthorized.<sup>9</sup> The federal re-approval process requires states to demonstrate their capacity to perform six specific functions or “assurances” (see inset box).

#### **Federal Waiver Renewal Assurances**

1. To ensure that level of care determinations are consistent with care provided in institutional settings (e.g., nursing homes and hospitals);
2. To actively monitor the adequacy of each beneficiary’s plan of care;
3. To ensure that waiver services are provided by qualified providers;
4. To proactively identify and respond to beneficiary abuse, neglect, and exploitation;
5. To ensure that oversight is properly exercised over all services and functions provided by the program; and
6. To provide adequate financial oversight, including program cost-neutrality in relationship to institutional care.

Source: Centers for Medicare & Medicaid Services, Interim Procedural Guidance.

## **Covered Services**

LTHHCP providers are responsible for care management and for providing (as required by beneficiary need) specified state plan services: nursing; personal care; home health aide services; physical, occupational, and speech therapies; and medical equipment and supplies.<sup>10</sup> They are also required to provide, as appropriate, the following waiver services: medical social services, audiology, respiratory therapy, and nutritional counseling. Additional waiver services may include a personal emergency response system, home maintenance, home improvement or adaptation, moving assistance, home-delivered and congregate meals, social day care, non-medical transportation, and respite care.

<sup>9</sup> Initial 1915(c) home and community-based service waivers are approved for a three-year period. The LTHHCP was due for reauthorization in 2008, but the Department of Health has been granted an extension.

<sup>10</sup> The term “personal care” encompasses three different levels of care: housekeeping services, personal care aide services (commonly referred to as home attendant services in other programs), and homemaking services. [See Glossary.]

LTHHCP providers are required to provide at least one of the following services directly and in its entirety: nursing, physical therapy, speech language pathology, occupational therapy, medical social services, or home health aide services. Other covered services may be provided either directly or through a subcontractor.

**Table 4.2**  
**Long-Term Home Health Care Program: Covered Services**

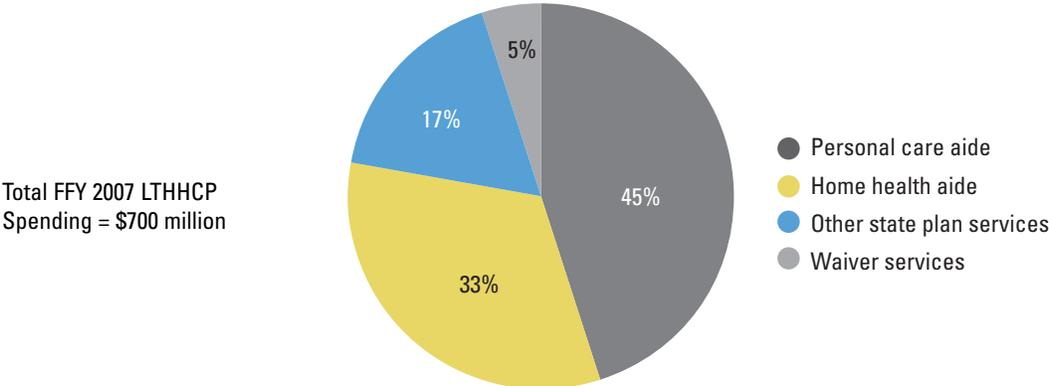
State Plan Services	Required Waiver Services	Optional Waiver Services
Nursing	Medical social services	Personal emergency response system
Physical therapy	Respiratory therapy	Home maintenance
Occupational therapy	Nutritional counseling	Respite care
Speech pathology	Audiology	Home improvement or adaptation
Home health care		Moving assistance
Personal care		Social day care
Homemaking		Non-medical transportation
Housekeeping		Congregate meals
Medical supplies and equipment		Home-delivered meals
		Telehealth*

Note: \*Currently outside of waiver. Some programs provide telehealth services as part of a state demonstration project.

### Service Utilization

As is the case in other long-term care programs, the majority of service use in the LTHHCP is attributable to direct care services—hands-on help with activities of daily living and instrumental activities of daily living. Nearly all LTHHCP beneficiaries receive direct care services (either personal care or home health aide services), and more than three-quarters of program spending (78 percent) is for direct care. [See Figure 4.4.]

**Figure 4.4**  
**Percentage of LTHHCP Medicaid Spending, by Type of Service, FFY 2007**



Source: UHF analysis of FFY 2007 CMS-64 and September 2007 MARS data.

Direct spending for waiver services accounts for a very small percentage of total program spending; some services (e.g., respite care) are used infrequently and others (e.g., home modification) are one-time expenditures.

Although most beneficiaries receive care management, its utilization and cost cannot be ascertained from available data. Unlike in most other programs, care management is not paid for discretely.

## Eligibility — Medical and Financial

Applicants must meet both medical and financial eligibility requirements.<sup>11</sup>

### Medical Eligibility

Medical eligibility is determined primarily by the level of functional disability. Eligibility is limited to beneficiaries who require nursing home level of care as measured by the Long-Term Care Placement Form (DMS-1). Eligibility also requires that the applicant can be safely and appropriately maintained in a home and community-based setting as indicated by the Home Assessment Abstract (HAA, or DSS 3139), and a physician's order.<sup>12</sup> Physician orders are required every 60 days, and program providers must conduct a comprehensive needs assessment (including the HAA) at least every 120 days.

**Individual Budget Cap:** The cost of care is an explicit consideration in determining medical eligibility for the LTHHCP. CMS requires that waiver program expenditures be cost-neutral in relation to institutional care. (The individual budget cap is the main way the state meets this requirement.) With some exceptions, New York statute requires that the annual service plan expenditures for each individual not exceed 75 percent of the average Medicaid payment rate for nursing home care in the same county (as indicated by the Summary of Service Requirements).<sup>13</sup> In practice, this means that applicants who require more than a maximum number of hours — more than 36 hours per week in New York City, roughly — of Medicaid-reimbursed direct care services (home health aide or personal care aide services) are not typically enrolled. It also means that beneficiaries may have to disenroll and seek services elsewhere if their needs increase above the threshold.

<sup>11</sup> For more information on Medicaid long-term care program eligibility, see Bogart 2007.

<sup>12</sup> The definition and interpretation of "Health and Safety" requirements has varied over time. New York requires LTHHCP providers to adhere to the Medicare conditions of participation, which require that "patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence." The state has additional regulations and directives, such as the requirement that beneficiaries be "self-directing" or have an informal caregiver (family member or friend) willing to direct care on their behalf. Variations in how the state, local departments of social services, and individual providers interpret and apply health and safety regulations likely affects access to the program and may explain some of the regional variation in enrollment patterns.

<sup>13</sup> The individual beneficiary budget is calculated on a monthly basis, but expenditures may be "annualized" to account for projected fluctuations in spending, such as a onetime expense for home modification. There are two spending cap categories tied to a now defunct distinction in nursing home level of care needs: health-related facility level of care (HRF) and skilled nursing facility level of care (SNF). A score of 60 to 179 on the DMS-1 denotes HRF and a score of 180 or more denotes SNF. Through a demonstration program, exceptions can be authorized for up to 100 percent of the average SNF/HRF budget cap for people with "special needs." The demonstration period was recently extended to March 31, 2012.

**Table 4.3**  
**Long-Term Home Health Care Program: Individual Monthly Budget Caps,**  
**by Region, 2007**

<b>Region</b>	<b>Average Monthly Nursing Home Payment Rates</b>	<b>Average Monthly LTHHCP Individual Budget Cap</b>
Capital	\$4,978	\$3,610
Central	\$4,853	\$3,560
Long Island	\$7,218	\$4,952
New Rochelle	\$6,248	\$4,221
Western/Buffalo	\$4,960	\$3,250
Western/Rochester	\$5,267	\$3,738
New York City	\$7,535	\$5,438

Sources: Average monthly nursing home payment rates based on UHF analysis of 2007 average regional daily reimbursement rates from SDOH website. Average LTHHCP individual budget cap based on UHF analysis of 2007 maximum allowable monthly expenditure cap per patient under the LTHHCP by level of care, by county.

**Exceptions to the Cap:** For certain conditions and needs (e.g., Alzheimer’s disease, decubitus ulcer, tube feeding), local departments of social services can increase an individual’s budget cap to 100 percent of the cost of nursing home care in the same county. The state limits such exceptions to 25 percent of a county’s total enrollees (15 percent in New York City); further exceptions are subject to Department of Health approval on an individual basis. We do not know how frequently exceptions are authorized. In addition, there is no individual cap requirement for the estimated 2,000 LTHHCP beneficiaries enrolled through the AIDS Home Care program.

**Family Care:** The availability of family help is not an official eligibility criterion for any of the state’s long-term care programs; however, it is often a consideration, and because of the individual budget cap requirement, it has particular relevance for the LTHHCP. For example, having a family caregiver available to supplement hours of care is likely to determine whether beneficiaries with extensive personal care needs can enroll in the program. We were not able to find a reliable measure of the extent that family care plays in the LTHHCP.

## Financial Eligibility

County governments determine financial eligibility for the LTHHCP, using general Medicaid eligibility criteria (income no greater than \$8,700 annually and personal savings no greater than \$13,050) and the additional “home equity limit” criterion that applies only to financial eligibility for long-term care (primary residence valued at no more than \$750,000).<sup>14</sup>

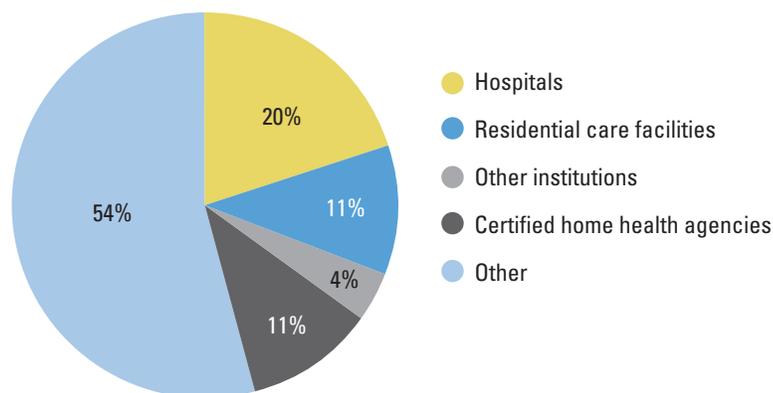
New York currently extends the same set of financial protections to spouses of LTHHCP beneficiaries that it extends to spouses of nursing home residents. These spousal impoverishment protections allow spouses to retain \$2,610 per month (\$31,320 annually) in income, and between \$74,820 and \$104,400 in assets.<sup>15</sup>

## Access

More than one-third (35 percent) of program admissions come from hospitals, residential care facilities, and other institutions; 11 percent come from CHHAs; and more than half (54 percent) from the community (physicians, self-referral, provider outreach, and other community-based programs).<sup>16</sup> We were not able to obtain good information about the relationship between program sponsorship and source of program referrals. As a result, we do not know what percentage of program admissions are “in-network” referrals from organizational sponsors (nursing homes, hospitals, and free-standing CHHAs).

**Beneficiary Needs Determination Process:** As with other long-term care programs, LTHHCP applicants generally apply directly to an individual program provider (as opposed to applying

**Figure 4.5**  
**Percentage of LTHHCP Referrals, by Source, 2004**



Source: UHF analysis of LTHHCP annual statistical reports, CY 2001-2004.

<sup>14</sup> Individuals whose income is higher than the rules allow may qualify for Medicaid through the Medically Needy program, which allows applicants with “excess income” (the amount above \$725 per month) attributable to medical expenses to “spend down” to the financial resource limit. See Chapter 1.

<sup>15</sup> See discussion of spousal impoverishment protections in Policy Implication section.

<sup>16</sup> United Hospital Fund analysis of LTHHCP annual statistical reports, CY 2001-2004.

through the local department of social services). The provider then sends a nurse to the applicant's home to conduct an initial eligibility determination. At this visit, the nurse assesses the applicant's care needs, which includes administering the DMS-1 and the HAA. These forms are the basis for the Summary of Service Requirements, with which the local department of social services computes and approves each individual's budget.

The provider forwards all three documents (sometimes referred to as the 120-day package) to the local department of social services, which makes an in-home visit to confirm eligibility. This visit (sometimes called a "joint visit") is required in the statute and regulations for the program. The local department of social services reviews each plan of care at least every 120 days.<sup>17</sup>

**Alternate Entry:** There is also an expedited enrollment process ("alternate entry") that allows providers, under specific circumstances, to provide services for up to 30 days prior to the joint visit. The provider is at risk for associated spending if the beneficiary is found to be ineligible. In practice, the local department of social services determines the extent to which beneficiaries can access the program this way. In some regions, including New York City, it is rarely used.

**Regional Differences in LDSS Policies:** There are other regional differences in policies of local department of social services that contribute to wide variation in access to the programs. For example, there are reported variations in how local departments interpret health and safety regulations, how they score assessments, and how they calculate budgets.

**OASIS:** To meet the Medicare conditions of participation, LTHHCP providers are required to complete the Outcome and Assessment Information Data Set (OASIS), a federally mandated assessment tool that must be re-administered every 60 days.

**Discharge Patterns:** We do not know very much about discharge patterns. The available data come from annual statistics submitted by program providers; because the information

<sup>17</sup> Some waiver services, such as home improvement and adaptation, are subject to an additional level of review and approval by the local department of social services.

is reported inconsistently, the data are not complete. It is unclear how many beneficiaries are discharged from the LTHHCP into other programs when their needs exceed the individual budget cap.

## Provider Requirements

The state's policy of requiring LTHHCP sponsors to meet the Medicare conditions of participation is unique; most states with similar programs for frail seniors do not have this requirement. The goals of this policy are to promote continuity of care and access to Medicare services and to claim Medicare revenue for LTHHCP beneficiaries who have both Medicaid and Medicare coverage (dually eligible). For example, because LTHHCP providers can bill Medicare directly, they are well positioned to expedite discharge from a hospital in order to transition dually eligible beneficiaries into the program.

Adhering to the Medicare conditions of participation, however, entails regulatory requirements that far exceed those of most other programs. For example, providers are required to supervise home health aides with an in-home visit every two weeks (versus once every three months in the personal care program); complete the OASIS clinical data set every 60 days (a similar assessment is due every 180 days in the personal care and Medicaid managed long-term care programs); and meet additional federal reporting requirements.

## Payment

The state's Medicaid program pays providers on a fee-for-service basis for each hour or visit. Rates are set prospectively, based on reported costs for the two years prior to the rate year, trended forward. LTHHCP sponsors are required to allocate administrative and general costs to each direct cost center.<sup>18</sup> The state department of health establishes a cost guideline for each category of service. If the provider fails to provide a justification to maintain the rate at the actual amount, the provider is paid at the cost guideline level. The Department of Health also holds each LTHHCP provider to a ceiling on administrative and general expenses (the final A&G allocation cap in 2007 was 25.48 percent). These expenses include recordkeeping, technology, corporate compliance, quality assurance, and training, as well as some care management costs (e.g., cost of initial needs assessments).

<sup>18</sup> Per Medicare accounting rules, program sponsors are required to allocate administrative and general costs across all cost centers.

**Table 4.4**  
**Average Medicaid Provider Payment Rates for LTHHCP Services, by Region, 2007**

Region	Average Visit or Hourly Rate			
	Nursing (per visit)	Therapy (per visit) (PT, SP, OT)	Home Health Aide (per hour)	Personal Care (per hour)
New York City	\$131	\$91	\$19	\$19
Rest of State	\$118	\$83	\$26	\$24
Capital	\$104	\$78	\$34	\$32
Central	\$100	\$71	\$31	\$28
Long Island	\$127	\$85	\$18	\$19
New Rochelle	\$130	\$84	\$24	\$22
Western/Buffalo	\$109	\$81	\$29	\$28
Western/Rochester	\$109	\$95	\$28	\$23
New York State (Average)	\$127	\$88	\$21	\$21

Source: United Hospital Fund analysis of 2007 Medicaid LTC reimbursement rate computation sheets for the LTHHCP.

Note: Differences in payment rates for different kinds of direct care workers (home health aides and personal care aides) do not necessarily reflect differences in the actual compensation that workers receive, which tends to be fairly similar. Estimated weighted averages based on estimated occupancy of program. These figures include administrative and general costs. Figures for personal care exclude housekeeping and homemakers.

**Medicare Revenue:** Medicare pays for post-acute home care services on an episodic basis (60-day episodes). Medicare revenue accounts for a small share (5 percent) of provider revenue statewide, ranging significantly by region, from 2 percent in New York City to 21 percent in the Finger Lakes region. This wide variation in payment source could suggest that some providers are better at maximizing Medicare revenue, but it more likely reflects differences in practice patterns and beneficiary populations. For example, a higher proportion of Medicare revenue could result from more appropriate opportunities to bill Medicare for post-acute services—such as more initial referrals from hospitals for dually-eligible individuals with post-acute care needs who are eligible for the Medicare home health benefit—or it could result from higher enrollment of medically fragile individuals who have more hospitalizations and therefore more Medicare-billable post-acute episodes. We do not have information about length of stay or hospitalization rates by level of need, factors that would shed greater light on the extent of different practice patterns.

**Table 4.5  
Percentage of LTHHCP Revenue, by Payment Source, by Region, 2004**

Region	Census, 2007	Payment Source (Percent of Total Revenue)		
		Medicare	Medicaid	Other
New York City	16,067	2.4%	84.7%	12.9%
Rest of State	8,062	11.8%	84.7%	3.5%
Capital	1,244	10.6%	87.8%	1.6%
Central	801	12.2%	86.5%	1.3%
Long Island	1,477	8.9%	87.8%	3.3%
New Rochelle	2,509	6.5%	92.6%	0.9%
Western/Buffalo	950	16.7%	78.2%	5.1%
Western/Rochester	1,081	20.9%	70.5%	8.6%
<b>New York State (Total)</b>	<b>24,129</b>	<b>5.0%</b>	<b>84.7%</b>	<b>10.3%</b>

Source: Home Care Association of New York State's analysis of cost reports/ regional source of payment data obtained from the Department of Health, Division of Home & Community Based Care.

Note: "Other" may include private pay and revenue from subcontracting relationships with other long-term care programs, such as Medicaid managed long-term care plans.

## Quality Monitoring

As noted above, the local department of social services reviews and approves care plans every 120 days, on behalf of the state department of health, who is accountable for performance. An on-site performance review by state surveyors is required no less than once every three years. There are no financial rewards for good performance.

Because the state requires all providers to follow the Medicare conditions of participation for CMS compliance purposes, all LTHHCP providers are technically treated as CHHAs and are subject to federal performance evaluation. The federal government evaluates CHHA performance on 42 outcome-based quality measures drawn from the OASIS, a set of demographic and clinical information submitted to CMS and the state Department of Health every 60 days. A subset of these measures is published on CMS's Home Health Compare website and the state's Home Health Profile website, launched in March 2008. There are concerns that the information reported for individual LTHHCP providers misrepresents their performance on key indicators, such as hospitalization rates and emergency room utilization, because the comparison group is primarily Medicare CHHA patients—a less chronically impaired population than the Medicaid long-term care beneficiaries typically enrolled in the LTHHCP.

## Policy Implications

The Long-Term Home Health Care Program plays a fundamental role in meeting the long-term care needs of 24,000 New Yorkers each month. Most of this population has multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities. Care for this group can be intensive and costly; associated Medicaid spending was roughly \$700 million in FFY 2007. This section of the report explores some of the challenges facing the LTHHCP and identifies critical issues for further research and discussion about how to improve the delivery of long-term care in New York.

### The Individual Budget Cap

The LTHHCP is the state's only long-term care program with a hard cap on individual spending per beneficiary.<sup>19</sup> Although the federal government requires that 1915(c) waiver programs be cost-neutral, the state has considerable latitude to determine how cost neutrality is achieved. For other 1915(c) waiver programs, such as the Traumatic Brain Injury and the Nursing Home Transition and Diversion waiver programs, New York has opted to achieve the required cost neutrality in the aggregate — i.e., at a program level rather than at an individual level.

The individual budget cap presents a potential barrier to access and continuity of care. Beneficiaries whose needs exceed the maximum allowable cost cannot enroll in the program, and beneficiaries whose needs increase over time may have to disenroll in order to receive more care, either in a nursing home or through other community-based programs. While the effect of this state policy on access to long-term care has not been fully determined, there is some evidence to suggest that it may be significant. For example, more than 60 percent of traditional personal care program beneficiaries in New York City receive more than 36 hours per week of direct care; Medicaid spending associated with this many hours of service would typically exceed the budget cap and would effectively prevent the beneficiary from enrolling in the LTHHCP.<sup>20</sup>

A long-term care reform agenda for New York should include a recommendation about whether to maintain the individual budget cap or to pursue other strategies, such as requiring cost neutrality at the program or individual provider level. This policy decision has greater financial implications than it did for other waiver programs because the

<sup>19</sup> The personal care program does not have a hard cap on spending, but beneficiaries receiving housekeeping services are limited to a maximum of 12 hours per week.

<sup>20</sup> United Hospital Fund analysis of data from the Brookdale Center for Healthy Aging & Longevity, Hunter College/CUNY.

LTHHCP operates on a much larger scale. It is also important to keep in mind that introducing this type of change is more logistically complicated. The LTHHCP does not have the same structural checks and balances on service utilization that exists in other programs. For example, in the LTHHCP, the state contracts with the same entity for care management and the provision of services; in the other waiver programs, the state contracts with different entities for services coordination and for service provision. This is not to suggest that the organizational structure is bad — more information is needed to determine the effect of different structural relationships on access, cost, and quality — but rather that an alternative to the individual budget cap is not as easily achieved. Given the way the program is structured, it is likely that alternatives to the budget cap depend on having more capacity to tie payment levels to a more standardized measure of need, similar to the case-mix index used to adjust nursing home payment levels.

## System Simplification

Since the LTHHCP was established in 1978, the state has introduced several other programs that are also limited to beneficiaries with nursing home level of care needs, including Medicaid managed long-term care (MMLTC). At the same time, a large number of beneficiaries with nursing home level of care access services through the traditional personal care program in New York City (Hokenstad et al. 2002). The three programs are similar in that most spending is attributable to direct care services. Yet they also have important differences. For example, both MMLTC and the LTHHCP provide care management — a service not provided in the personal care program. In addition, while there are modest differences in the services provided by MMLTC and the LTHHCP, the primary difference is in how the programs are paid. LTHHCP providers (like providers in other waiver programs) are paid on a fee-for-service basis; MMLTC plans receive a monthly premium for each beneficiary they enroll.

Given the apparent overlap in target populations, it is important to decide whether to maintain the three program options as they are, consolidate them, or further differentiate between them by changing eligibility criteria, payment caps, or financing methodologies. If the state opts for consolidation, it will be important to consider how to incorporate existing provider capacity. For example, the new requirement that MMLTC plans also become special needs plans (SNPs) under Medicare effectively excludes many current LTHHCP providers from transitioning into that role. In addition, differences in direct care worker wages present a practical barrier to voluntarily transferring beneficiaries from the personal care program into either the LTHHCP or MMLTC. And any solution should reflect regional

differences in the way in which beneficiaries access long-term care services. For example, if the state were to consolidate programs, it would likely have to develop a different strategy for counties where the LTHHCP is the primary way for beneficiaries to receive community-based long-term care.

In lieu of program consolidation, a long-term care reform agenda should include strategies to address the following issues in the LTHHCP.

## Variation in Local Department of Social Service Policy

Variation in the way local departments of social services interpret and implement state policies is widely cited (but poorly documented) as a significant barrier to access. There appears to be a need for more uniformity across the state with respect to consistent interpretation of health and safety regulations, level of need determinations, budget calculations, and access to the LTHHCP through the alternate entry process.

## Spousal Impoverishment Protections

Until recently, New York had a long-standing policy of extending spousal impoverishment protections for nursing home residents to beneficiaries in 1915(c) home and community-based waiver programs (Hartocollis 2009).<sup>21</sup> However, in response to CMS objections, the state eliminated spousal impoverishment protections for the Traumatic Brain Injury waiver program and agreed to forgo them for the new Nursing Home Transition and Diversion waiver program. As part of the 2009-10 Enacted State Budget, the state has agreed to remove them for the LTHHCP as well. For all three programs, the legislative language that eliminates the protections includes a provision that automatically restores them in the event that CMS withdraws its objections. The current status of the protections in the LTHHCP is unclear. CMS has granted the state an extension of the current waiver until July 14, 2009.

The Department of Health estimates that eliminating financial protections in the LTHHCP could affect as many as 4,000 married couples — more people than are enrolled in the NHTD and TBI waiver programs combined.<sup>22</sup> Because these beneficiaries have nursing home level of care needs, those who lose eligibility for the LTHHCP are likely to access long-term care services through other, potentially more expensive, programs. The impact would be more acutely felt outside New York City — particularly in counties with fewer

<sup>21</sup> There is disagreement about whether or not federal law gives states the authority to extend nursing home spousal impoverishment protections to 1915(c) home and community-based waiver programs for beneficiaries who qualify through the Medically Needy/Spend-Down Program. [See Chapter 1 for a discussion of the Medically Needy Program.]

<sup>22</sup> Based on an internal analysis conducted by the New York State Department of Health in 2007.

community-based program alternatives and therefore a greater probability that such beneficiaries would be placed in nursing homes. In order to promote the right care in the right setting at the right time, a long-term care reform agenda for New York State should include strategies that help to ensure that community-based care remains a financially viable alternative to nursing home care.

## Program Size

The typical LTHHCP provider has between 100 and 400 enrollees. Small scale operations may make it harder for smaller organizations to remain financially viable, keep pace with technological advancements, improve quality, and provide clinical specialization. Smaller programs are also more vulnerable to the effects of the recent workforce shortages and rising transportation costs. Better information will help assess where and to what extent smaller programs are needed in order to accommodate the needs of beneficiaries who live in rural or semi-rural areas, and where cost-efficiencies could be achieved through provider consolidation without diminishing access to appropriate care. To maintain small programs, New York will need a sound strategy for ensuring that providers have the capacity to keep pace with evidence-based practice.

## Lack of Transparency in Reporting Care Management Costs

Care management was conceived as a central element of the LTHHCP — one that distinguishes it from the personal care program. Unlike other community-based programs that provide care management, LTHHCP providers do not receive discrete payment for this service. Instead, its cost is incorporated into the payment rate for nursing or medical social services, and is included in the calculation of the administrative and general (A&G) costs. As a result, it is very difficult to determine how much and what type of care management (nursing or medical social services) beneficiaries are receiving, and how much Medicaid is paying for this service. A reform agenda should establish whether or not to reimburse or report care management as a distinct service.

## Medicare Conditions of Participation

Most states that operate programs like the LTHHCP for frail seniors and adults with disabilities do not require program sponsors to meet the Medicare conditions of participation. The historical goals of New York's policy have been to promote continuity of care for dually eligible beneficiaries, who have both Medicaid and Medicare coverage, and to access Medicare services and revenue. Adhering to Medicare's conditions of participation, however, necessitates costly regulatory requirements that far exceed those of most other long-term care programs. A long-term care reform agenda for New York should assess the clinical

relevance of these requirements, and determine the extent to which cost savings could be achieved either by eliminating the conditions of participation requirement or obtaining regulatory relief for CMS — for instance, scaling back nursing supervision requirements for medically stable enrollees. In light of the ongoing nursing shortage, a reform agenda should determine whether the opportunity to maximize Medicare outweighs the burden of additional regulatory requirements, or if other strategies for accessing Medicare revenue — such as the SNP requirement for new MMLTC plans — should be pursued instead. In addition, the conditions of participation requirements are a central feature of the state’s quality assurance strategy for the LTHHCP. If these requirements were eliminated, alternative quality assurance strategies for the LTHHCP would likely be required.

## Financial Incentives

LTHHCP providers are paid on a fee-for-service basis, and payment for A&G expenses is then applied as a proportion of each hour or unit of service provided. To the extent that A&G is a source of revenue for the program sponsor, there is a strong financial incentive to maximize the hours or units of service. Additional research could determine the extent to which different payment methodologies achieve different results. More generally, it is important to decide whether to explore different ways of financing the LTHHCP, including whether providers should receive a monthly payment and be allowed to pool funds in order to care for all enrollees — and if so, whether payment rates should account for wide variations in beneficiary needs.

Providers are also required to follow Medicare accounting rules, which require providers to allocate A&G costs across all cost centers. In practice, this means that A&G revenues can be allocated to cost centers that have no direct application to the operation of the LTHHCP. It is widely believed that some LTHHCP sponsors subsidize the operation of other health care programs and services — such as nursing homes or hospitals — using A&G revenue generated by the LTHHCP. Such cross-subsidization is not necessarily bad, but it does make it difficult to identify what Medicaid is paying for and at what price, and it may provide strong motivation for key parties to resist changing the way services are organized and financed. Regardless of how payment is structured, reform discussions should consider the extent to which underlying financial incentives affect current providers’ ability and capacity to change.

## Standardized Needs Measurement

In the current long-term care system, many concerns about quality cannot be fully addressed because of insufficient information. Each long-term care program in the state uses a different assessment tool to measure beneficiaries’ level of need. Therefore it is unclear

whether there are differences in health status or quality outcomes in the LTHHCP compared to other long-term care programs. More research would help determine which of the state's program models are most successful at managing care, for which populations, and at what cost to Medicaid.

The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool, which would standardize the definition of nursing home level of care across programs and settings, is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives: a more standardized basis for determining what resources are required to address a beneficiary's needs, regardless of geographic location, and supporting a more robust evaluation of quality outcomes across programs and settings. However, because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high policy priority and garnering sufficient resources and stakeholder cooperation.

There is broad consensus that the DMS-1, the form that New York uses to determine eligibility for the LTHHCP, is not the optimal tool for this job. It was originally developed for the purpose of determining nursing home eligibility and has two major limitations when applied in community settings: it does not fully measure functional limitations that result from cognitive impairments, and it does not assess all instrumental activities of daily life, such as the capacity to prepare meals. To address these limitations, the state has long allowed physicians to override the score for otherwise eligible applicants. CMS originally objected to this policy during the recent waiver renewal process, but subsequently agreed to allow its continued use with the understanding that it would be eliminated when the state completed development and implementation of the new assessment tool.

One tool under consideration for replacing the DMS-1 is the Semi-Annual Assessment of Members (SAAM), a chronic care version of the OASIS tool already in use in the MMLTC and PACE programs.<sup>23</sup> If the state adopted the SAAM for both the LTHHCP and the personal care program, it would then have both a standard measure of need and the ability to compare health status for two-thirds of all Medicaid long-term care beneficiaries receiving community-based services.

<sup>23</sup> The State Department of Health conducted an evaluation to determine the correlation in eligibility determinations using the SAAM in lieu of the DMS-1 in the MMLTC and PACE programs. They eventually decided, based on the outcomes of the evaluation, that the SAAM was an appropriate substitute.

## References

- Barone S. June 2006. *The Long Term Home Health Care Reference Manual: A Guide for Local District Staff and LTHHCP Providers*. Buffalo, New York: Center for Development of Human Services, Research Foundation of SUNY, Buffalo State College. Available at [http://www.health.state.ny.us/health\\_care/medicaid/reference/lthhcp/](http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/). Accessed January 6, 2009.
- Bogart VJ. October 2003, revised June 2007. *Financial Eligibility for Medicaid and the Medicaid Spend-Down Program in New York*. New York, NY: Evelyn Frank Legal Resources Program, Self-Help Community Services. Available at <http://onlineresources.wnyc.net/healthcare/docs/spenddownOUTLINE.pdf>. Accessed January 6, 2009.
- Hartocollis A. January 24, 2009. Change in Medicaid rules may pose stark choice for the chronically ill. *New York Times*, New York edition: A15. Available at: [http://www.nytimes.com/2009/01/24/nyregion/24spouse.html?\\_r=1&em](http://www.nytimes.com/2009/01/24/nyregion/24spouse.html?_r=1&em). Accessed February 5, 2009.
- Kitchener M, C Harrington, T Ng, and M O'Malley. December 2007. *Medicaid Home and Community-Based Service Programs: Data Update*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured. Available at <http://www.kff.org/medicaid/upload/7720.pdf>. Accessed January 6, 2009.
- Kitchener M, T Ng, N Miller, and C Harrington. 2005. Medicaid home and community-based services: national program trends. *Health Affairs* 24(1): 206-212. Available at <http://content.healthaffairs.org/cgi/content/full/24/1/206>. Accessed January 6, 2009.
- Seavey D, SL Dawson, C Rodat. September 2006. *Addressing New York City's Care Gap: Aligning Workforce Policy to Support Home-and Community-Based Care*. New York: Paraprofessional Healthcare Institute. Available at [http://www.directcareclearinghouse.org/l\\_art\\_det.jsp?res\\_id=217210](http://www.directcareclearinghouse.org/l_art_det.jsp?res_id=217210). Accessed January 6, 2009.