How state policies are dramatically changing the role and mission of New York’s model in-home long term care program and what it means for the survival of these essential front-line providers in the community

New York’s Long Term Home Health Care Program (LTHHCP) is now entering its 35th year at a time of major transition and reconfiguration of the program’s core role in the health care system, due in large part to major policy changes being implemented – right now – from last year’s budget. These changes come to a head in a phased-in approach beginning on April 1, 2012: a date that starts the process of completely altering the mission and prospects for survival of many of these front-line providers.

To imagine the serious impact of these imminent shifts, it is important to understand the LTHHCP – as it is today.
**The “Nursing Home Without Walls” today**

For decades, the LTHHCP, also known as the “Nursing Home Without Walls,” has made it possible for elderly, disabled and chronically ill patients to avoid unwanted or premature nursing-home placement by providing a range of health, assistive and social services at home as an alternative to care in the institutional setting.

Primary among the program’s essential roles is **care management**.

In fact, the legislation creating the “Nursing Home Without Walls” more than three decades ago actually refers to the LTHHCP in such terms, as a care-management program. At the heart of its patient-care structure are a nurse care manager and team of staff responsible for: clinical assessment; budgeting and coordination of services; patient and family outreach and education; communication with ordering physicians, local social services districts, and other stakeholders ... and, of course, the delivery of services in the home, from skilled nursing to home health aide, therapy, social work and other services.

Patients served in the program include the frail-elderly, individuals diagnosed with HIV/AIDS, persons with disabilities, pediatric patients, individuals with behavioral or mental health service needs, adults with chronic conditions, and others.

Not only does this program offer a home-based long term care option that patients prefer, but it is also cost-effective. Under Medicaid, program expenditures are capped, by statute, at 75% of the average nursing-home rate in each county where the program operates. Yet the “Nursing Home Without Walls” has historically achieved even greater savings. In fact, analyses by New York State’s Department of Health, New York’s Senate Health Committee, HCA, and others have found that patients in the LTHHCP are cared for at home at about 50% of the average Medicaid rate for nursing-home care, with some programs achieving an even greater rate of cost savings.

Approximately 107 state-certified LTHHCP providers serve 30,000 patients throughout the state. These locally-administered programs are each sponsored by a Certified Home Health Agency (CHHA), a hospital or a nursing home. Thus, these programs are not only vital to patients receiving services, but they are vital to entire organizational systems that rely on the LTHHCP as a central element of care transition, cost-savings and patient-centered long term care. Many LTHHCPs are sponsored by certified home health agencies with a venerated and, in many cases, century-old history of service. Sponsoring hospitals and nursing homes, meanwhile, value their Long Term Home Health Care Programs because the LTHHCP provides an important option within the organizational structure to offer long term care services for patients who do not need, or want, to be in an institution. For the state, these programs save Medicaid dollars and can further assist in cost-efficiency and programmatic reform goals under proposals advanced by HCA during last year’s legislative session and prior.

**HCA survey illustrates the clinical complexity of LTHHCP patients, care management role of program**

In 2010 to 2011, HCA conducted a detailed survey of our LTHHCP membership. The survey results provide a very detailed illustration of the clinical profiles of patients served in the program, referral and cost patterns, organizational profiles and other data underscoring the great importance of this program in caring for clinically complex patient populations.

As supported in the survey results, individual patients are often served by LTHHCPs for several years and, therefore, rely on this program’s expertise in long term care management. According to our survey, half of providers reported that the average patient length of stay is two to five years. Twenty-two percent of programs indicated that the average length of stay is longer than five years.

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Patients served by the LTHHCP are clinically complex, exhibiting multiple conditions, or co-morbidities. All LTHHCP respondents to HCA’s survey indicated that their average patient population exhibits at least two co-morbidities; 70% of LTHHCP respondents served patients with five or more co-morbidities.

These patients require extensive medication management as well, with some providers reporting that their patients, on average, take as many as 20 medications. Over 65% of LTHHCP survey respondents indicated that their patients take ten or more medications.

Other survey responses illustrate the care-management role of these front-line providers. Clearly, LTHHCPs are deeply seated in their role and mission to provide comprehensive care-management authority for their patients and to retain program oversight whenever possible throughout the many transitions of care – an important factor in the integration of LTHHCPs within larger health systems.

All survey respondents indicated that when other programs or providers are involved, their LTHHCP “always” remains the “primary coordinator of care.” Most answered “always” to the following statement: “When your LTHHCP patients are admitted to nursing homes (but there is anticipated return to the community for services), your LTHHCP retains the case on the program.” Meanwhile the majority “always” coordinate the patient’s visits to their primary or specialist physician, or with other ancillary service providers. Seventy-one percent of LTHHCP survey respondents had a Skilled Nursing Facility score over 200; however average patient expenditures were below the statutory budget cap which requires that program costs not exceed 75% of the nursing home rate.

**The “Nursing Home Without Walls“ Tomorrow: Changes on the Horizon**

On April 1, 2012, assuming CMS approval of a state Department of Health (DOH) managed care waiver, the Long Term Home Health Care Program as it is now known will be forced to function very differently in order to continue providing services to the chronically ill, persons with disabilities and the elderly. That is the start date for the state’s implementation of its “mandatory enrollment” requirement, under which community based long term care patients in Medicaid requiring more than 120 days of services must begin enrolling in a Managed Long Term Care (MLTC) plan or a newly termed Care Coordination Model (CCM), subject to state guidelines. (A CCM is literally an MLTC with a minor phase-in period.)

What does all of this mean for the LTHHCP?

For most LTHHCPs the new state requirement will effectively mean that, one by one, beginning in New York City, LTHHCP patients will be enrolled in an MLTC, CCM or other managed care plan. As the DOH requirements are now structured, these MLTCs and managed care plans will be under no obligation to contract back to the LTHHCPs to continue to serve their own long time patients. This risks dislocation of the patients and the program. HCA is advocating to change those requirements to maintain continuity of care. In addition, current DOH requirements do not ensure that managed care plans will allow LTHHCPs to continue their long-established, core functioning role of care management or provide the essential services that LTHHCP patients currently receive. As is evident from the foundation of the original LTHHCP law and resounded in HCA’s survey, care management is a major function of the LTHHCPs in providing services for patients whose in-home needs require care well beyond the 120-day threshold – in some cases, requiring care over many years. LTHHCPs will have to negotiate a care management role with willing managed care plans.

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To remain viable, LTHHCPs may choose to subcontract with an MLTC in an arrangement where the MLTC receives Medicaid payment directly from the state and then facilitates payment to the LTHHCP functioning as a service contractor.

Another option – though beyond the reach of most provider organizations – is for the LTHHCP to apply to become an MLTC or a CCM, or for LTHHCPs to group together to form an umbrella MLTC or CCM; but how efficiently achievable or viable are these options given the state’s guidelines and policy?

On November 15, 2011, the state published the CCM guidelines dictating the profile of non-MLTC organizations authorized to enroll community based long term care patients. These guidelines contain extensive capital and financial reserve requirements that are prohibitive to most provider based models.

Essentially, contrary to the Legislature’s intent and the urging of statewide provider and consumer organizations, these CCM guidelines were written by DOH to require organizations to be an insurance model, contrary to the design and function of the LTHHCP and the expertise of providers licensed to provide services through this program. Should an LTHHCP find that it is able to develop a plan congruent with the state’s CCM guidelines, the implementation timetable deployed by the Department for submitting an application and preparing for the April 1 start date is unrealistic and virtually impossible. The CCM guidelines were published on November 15, 2011 and implementation begins on April 1, 2012, offering little more than a few months to rework an entire organization operating under a more than thirty-year-old operational framework.

**Bottom Line:**
MLTCs and LTHHCPs both play an important care-management role, appropriate to the market dynamics, clinical features and home care service capacity needs in various regions of the state. However, the rapid pace of these state-mandated implementation changes has not taken into account these factors as the state pursues a single channel of enrollment for long term home care patients. For most LTHHCPs, the pace of this policy change threatens their very survival and the decades-long development of expertise in managing care for some of the most clinically complex patients. As it implements these changes, the Department of Health has yet to offer: an orderly transition plan; a reasonable and predictable implementation timetable; a well-defined delineation of compliance, administrative or reporting responsibilities; or, even, an articulation of the most basic rules governing certification, quality reporting, contractual arrangements, patient outreach responsibilities and continuity of care.

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**Solution: amend the budget to instill a more reasonable implementation plan**

As currently articulated, the implementation plan for the state's policy lacks the necessary guidance, consumer/provider safeguards or appropriate timetable to avoid disruption in the continuity of care or loss of the service infrastructure.

**HCA urges the Legislature and Executive to provide for a responsible transition to managed care which also maintains the state's landmark LTHHCP.**

HCA specifically urges that the budget be amended to incorporate language to include: (a) an adequate timetable and orderly progression for transition; (b) continuity of patient care and patient provider; (c) consumer and community options for models of care, including the LTHHCP; (d) contract parameters and safeguards for consumers, providers and managed care plans; (e) adequacy of premiums and service payment for managed care/home care enrollees; and (f) continuity of the telehealth program in Certified Home Health Agencies and LTHHCPs.

The Executive budget language mandates that long term care patients be offered the Consumer Directed Care Program; HCA urges that inclusion of the LTHHCP be a similarly mandated consumer option, as it is now under the fee-for-service system.

Nothing less than 35 years of care-management expertise, proven cost-savings, and the survival of entire community-rooted organizations are at stake. With a more orderly implementation plan, we can ensure continuity of care, provide an orderly transition to new settings of care, and secure the survival of long-established, clinically successful, community-based programs for providing cost-effective and compassionate care for patients in the home setting.