



# A BLUEPRINT FOR HOME CARE REFORM AND EFFICIENCY

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*Eleven concrete, implementable, and game-changer reforms and efficiency recommendations for New York State's Medicaid Home and Community-Based Care System – improving the system, cutting costs, and enhancing access for patients who need services.*

## THE CASE FOR REFORM AND EFFICIENCY

Reform of New York’s home care system is on the minds of policymakers and interested stakeholder organizations. There are many reasons why reform is needed:

- New York State faces a significant budget deficit and, therefore, must eliminate any inefficiencies that exist in the payment or program structure governing home care;
- The structure of the system must include payment incentives that help to drive inefficiency and inappropriate utilization out of the system;
- Providers need a stable and predictable payment system that pays for the costs of care yet incentivizes appropriate behavior;
- New York State’s home care providers are financially fragile and need stability and flexibility to structure programs and services that will meet the needs of patients and fulfill the integral role of home care in the evolving health care system.

Recognizing this imperative, many organizations have issued reports offering suggestions to reform the state’s home care system. Many of these suggestions, while well intended, are unrealistic and would undermine the core noninstitutional care infrastructure, holding the potential to waste invested resources, create senseless and expensive upheaval, dislocate patients and the providers who serve them and create dysfunction and added costs in the overall health system.

There is a better way to reform the state’s home care system – a way that taps the best of what New York State has to offer and builds on New York’s role as the national leader in home and community based care development, with effective and innovative models, a core provider infrastructure, and health professionals which, working together, *already* lower the cost of the Medicaid program.

The following document offers policymakers eleven far-reaching, game-changer reforms and efficiency recommendations to improve the state’s home care system. What’s more, these reforms were not constructed in an academic or theoretical vacuum or think-tank; they arise from a thoughtful, methodical policy process that has engaged the creative energy of those who know the home care system best – the home care leaders and clinicians in our state who have been working in this sector for years and who represent every facet of the home care provider infrastructure. In addition, each of these reform ideas is well developed, and, in most cases, legislative language is already prepared that would operationalize the changes that are recommended. In other words, the reforms and efficiencies contained in this report are “shovel ready.”

The time is now for meaningful, practical, creative and realistic reform. But for reform to work, it must take what is workable, innovative and good about New York’s home care system and build on it. This is imperative, given that home care’s role in the continuum of care and in the successful implementation of state, federal and health system reforms is pivotal and vital – and becoming ever more so. Home care can and needs to be a greater part of the solution to an affordable Medicaid program and a central part of a better plan to meet the overall health care needs of the state’s citizens. Home care is also where New York’s population of elderly and disabled individuals wants to be – aging and receiving vital services in place, in the comfort and security of their own homes.

To bring meaningful and realistic change, the following reform and efficiency ideas are recommended:

- 1** Enact Comprehensive Home Health Payment Reform – Across All Programs
- 2** Implement a Standardized, Consolidated Assessment for Home Care
- 3** Establish a Standard, Streamlined “No Wrong Door” Patient Entry into Home Care as Part of the New Assessment Tool, Eliminating Administrative Layers, Bureaucracy and Cost
- 4** Establish an Interim Measure to Eliminate Variation and Guide Utilization of Services
- 5** Expand and Ramp Up Care Management Capacity – Focusing on High Need/High Cost Patients
- 6** Focus and Better Manage Personal Care
- 7** Ramp Up and Expand Nursing Home Diversion
- 8** Maximize Federal Revenue Opportunities
- 9** Get Rid of Meaningless Regulations that Don’t Add Value to Patient Care and Add Unnecessary Cost to the System
- 10** Invest in the Home Health Workforce
- 11** Rid the System of Inefficiencies that Add Cost to the System

## *Proposal Overview*

Convert the current fee-for-service payment systems for home care into methods more aligned with state budget predictability, patient acuity, provider stability and efficiency, and flexibility in the provision and management of care.

## *Background and Detail*

The State Department of Health's current Medicaid reimbursement methodologies are unresponsive to home health provider cost requirements for the operation or delivery of services, intensity of patient need, incentives for agency efficiency or utilization control, patient access to care, staffing needs or flexibility in the delivery of services. The Department has twice proposed an episodic, prospective payment system (PPS) for Certified Home Health Agencies (CHHAs) but each time failed to address core issues associated with the design and implementation in order to ensure system stability, quality care and patient access. In response, the Legislature mandated that the Department of Health convene an advisory group to formulate such a system, but the discussions have thus far not produced resolution of the core methodological issues.

HCA proposes to:

- Convert the current CHHA fee-for-service payment methodology into an episodic PPS that is: constructed using an appropriate base; case sensitive (for acuity, complexity, intensity) and addresses further patient considerations; adequate to staffing and compensation; provides for capital, regulatory, quality innovation, system development and other necessary adjustments; pilot-tested and refined prior to live implementation; and appropriately transitioned.
- Convert the current fee-for-service payment methodology for Long Term Home Health Care Programs (LTHHCPs) into a case-payment system based on the results and efficacy of initial reimbursement pilots, including: a per diem approach similar to nursing homes and assisted living programs; a PPS designed specifically for long term populations; and/or other case payment reimbursement options. The converted payment system will offer significant savings, reforms and critical advantages to the state, LTHHCPs, the patients and the long term care system overall, including: more predictable and stable state expenditures and reimbursement; additional utilization control incentives; access to the LTHHCP for patients now unable to access the program – due to the logistics of the current fee-for-service rates and patient expenditure cap – and who are either institutionalized or enrolled in unmanaged services as a result; elimination of unnecessary costs and administrative burden for local districts and providers; elimination of the unnecessary and duplicative costs associated with the forced transfer and admission of patients to different settings due to the cap; and other benefits.
- Reform the payment system for personal care to reduce unexplained variability and control utilization.
- Establish a state structure authorizing “collaborative care models” (e.g., among home health, hospitals, physicians) for improved outcomes and cost-effectiveness, providing for alternative methods of reimbursement and regulation supporting these models and goals.
- Establish rural home health access financing under the Health Care Reform Act (HCRA) parallel to that existing for rural hospitals. Like rural hospitals, rural home health providers are especially challenged by the need to provide services in areas of sparse population, extreme resource limitations and other cost/system obstacles. Without sufficient rural home health infrastructure, only higher cost pathways will prevail.

# 2

## Implement a Standardized, Consolidated Assessment for Home Care

### *Background and Detail*

The basis for nearly all meaningful efficiency, service advancement, quality benchmarking, integration and other reform in home care and long term care is tied to the clinical assessment process and the need for more refined patient measures, standardization, consolidation/computerization of paperwork, and exchange of information across settings, among other improvements.

Providers and patients are buried in duplicative and in some cases antiquated state/federal assessment procedures, forms and criteria – the cost and brutal inefficiency and inadequacy of which are borne by all.

While the Department Health has begun work toward a uniform assessment, HCA proposes that the state (with input from the provider, consumer and worker communities) accelerate and proceed to establish a common data set and instrument for home care/long term care for determining an individual's needs, eligibility for services, identification of program options best matched to those needs and channeling of patients to those service options (see next section).

Along with providing a more precise and guiding measurement of patient needs and program options, the reformed process must eliminate paperwork, duplication and costly administration by consolidating/eliminating current formats and requirements, moving to electronic tools and building off of federally required instruments such as the Outcome and Assessment Information Set (OASIS).

### *Proposal Overview*

Establish a standardized, efficient and consolidated assessment/electronic data set for assessing the needs of individuals for home and community based care.

## Establish a Streamlined “No Wrong Door” Patient Entry into Care

### *Proposal Overview*

Provide for a streamlined, standardized patient entry into the home care system as a core function of the new assessment instrument, providing for more appropriate patient-program matching and eliminating consumer/provider confusion in the system, delays in access, duplication of effort, and administrative cost and burden.

### *Background and Detail*

The current methods of patient access into services vary from program to program, and from county to county. This combines with variations in service options, lack of public and professional education about options and other conflicts to create a difficult-to-navigate system where patients do not always end up with options most capable or suited to meeting their needs. The state and some localities have attempted various remedies including stepped up local social services department roles and single point of entry concepts (where in some areas all long term care referrals are funneled to the county or other entity for assessment and placement), but these strategies by-and-large backlog the system, are fertile for local bias and control, and require the expense of another layer of bureaucracy and staff.

HCA proposes that the standardized, common assessment instrument be constructed to also serve as the mechanism for identifying the option or options best matched to patient needs and for channeling patients to these options. This would represent the most efficient use of resources, expedite patient access and transitions to care and increase the prospects for patient enrollment in programs and services most suited to their needs.

This mechanism must also be used to replace expensive, human-intensive and double-layer processes of utilizing county-based or state-designated regional entities to perform assessments, and should consequently also halt and replace the state’s implementation of Long Term Care Assessment Center demonstrations.

# 4

## Establish an Interim Measure to Eliminate Variation and Guide Utilization of Services

### ***Background and Detail***

As the state proceeds to develop a new standardized, common assessment instrument for home care/long term care services along with changes in the payment process, an interim measure could be taken, until the transition to these new systems is accomplished, to further refine and standardize assessment and assignment of aide services in all programs – Personal Care, CHHAs, LTHHCPs and other. Such an instrument has already been developed, validated and successfully used for several years by a home care agency across a broad spectrum of its home care programs and services. While achieving standardization, the tool has also achieved a net reduction in assigned hours of care while maintaining or improving quality. Other agencies have implemented or are pursuing similar strategies.

HCA proposes that the state utilize such existing, successful models as the basis for broader implementation regionally (such as in New York City where such models are already being used by some agencies) or statewide.

### ***Proposal Overview***

Implement a tool (based on already successfully tested models) to further standardize and make consistent the method of assessing the need for and assigning hours of home care aide services across the continuum.

## Care Management – Expand the Capacity, Clinical Benefit and Cost-Effective Use of Home Health’s Care Management Models, Focusing on High Utilizers of Home Care Services

### ***Proposal Overview***

Direct those patients with intensive and/or complex care needs to models with robust, professional care management, including CHHAs, LTHHCPs and Managed Long Term Care programs (MLTCs), and further strengthen the care management capacity of these programs with new tools and approaches to care.

### ***Background and Detail***

Effective, expert management of patient care is critical to both health outcomes and cost exposure, particularly for patients with intensive and complex care needs and/or unstable conditions. This level of clinical management is essential in the care of the highest need/highest risk individuals, who, although comprising a proportionally small percentage of the population, exhibit the greatest needs and utilize the highest volume of services resulting in the highest associated costs.

There is currently no mechanism to appropriately and efficiently channel individuals into those home health programs which have strong and expert capacity for care management of chronic, complex and/or high risk, unstable conditions. There is also currently little activity by the state to eliminate obstacles to entering and/or remaining in these programs as well as to further strengthen these programs’ care management capabilities.

HCA proposes a mechanism, through the assessment and referral process (described in the assessment section of this document) and through a new high need patient initiative consisting of a state/provider partnership, to channel appropriate individuals to beneficial care management models in home health – CHHAs, LTHHCPs, MLTCs and (as a self-management model) the Consumer Directed Personal Assistance Program, or CDPAP– and to further bolster the care management capacity and benefits of these models by addressing access obstacles (e.g., eliminate inordinate procedures, replace the LTHHCP expenditure cap, etc.), strengthening components of the models and adding new features or approaches to management (e.g., collaborative care management combining home care, physicians and hospitals, integrating primary care and/or clinical nurse specialists, and including behavioral health services) that will support both clinical and cost control goals.

### ***Background and Detail***

New York's Personal Care Program, in particular the Home Attendant Program in New York City, serves a broad spectrum of needs from housekeeping to twenty-four-hour personal care, from patients with mild functional deficits, to patients most heavily impaired in activities of daily living (eating, dressing, transferring, etc.). Personal care does not include care management (like a CHHA or LTHHCP) beyond the local social services district casework function nor does it contain discrete utilization or cost controls (e.g., like the LTHHCP patient budget and expenditure cap or MLTC capitation). As a result of the breadth of the population, generic and safety-net nature of the program, limited patient management, and absence of cost/utilization control mechanisms, there is great and unexplained variance in services provided as well as enrollment/retention of patients whose care management needs would be better and more cost-effectively served in other more robust programs of care managed home care.

HCA proposes:

- A clinical review process for high need personal care recipients to determine appropriateness of services and the program options (personal care or more robust care managed home care models) that best meet the patient's needs.
- The establishment of performance standards for fulfillment of local districts' personal care responsibilities, with financial accountability.
- Implementation of the aide assessment standardization tool (as discussed elsewhere in this document) or other benchmarking system for more appropriately and consistently determining patients' need for personal care hours.
- Payment reform for personal care services reimbursement (see payment reform section).

### ***Proposal Overview***

Enact a series of reforms to better focus and manage the Personal Care Program, improving: the enrollment of appropriate patients into the program; the consistency and refinement of the assessment for and authorization of aide hours; the in-depth review of high needs cases; referral of recipients to care managed options (as described earlier) if more appropriate to their needs (respecting recipients' choice and process rights); and reimbursement adequacy and control.

### *Proposal Overview*

Maximize nursing home diversion and minimize premature and unnecessary institutionalization by enhancing and enforcing New York's principal diversion law established under the LTHHCP.

### *Background and Detail*

While ranges vary (some estimates have ranged from 15 to 70 percent), estimates are that a significant percentage of the individuals admitted to nursing homes for long term care could potentially be cared for at home instead, with substantial opportunity for cost-savings.

Under Social Services Law provisions for the LTHHCP, New York State has perhaps the strongest and strictest nursing home diversion statute in the nation. Section 367-c provides that, before a local social services official can authorize Medicaid payment for nursing home care for an individual, the official must ensure that such person is first assessed for and offered the LTHHCP as an alternative to institutionalization. Strictly enforced, the statute would prevent Medicaid expenditures for avoidable institutionalization. Despite the state's purported patient and policy goals of avoiding premature or unnecessary institutionalization, the state has lapsed on its enforcement of this diversion statute.

HCA proposes state Medicaid savings and greater patient centered care by maximizing nursing home diversion and minimizing premature and unnecessary institutionalization through upgraded, strict enforcement and financial accountability for abiding the state's nursing home diversion statute under the LTHHCP law.

In connection with this proposal, HCA recommends the expansion of nursing home right-sizing, for increased conversion of nursing home beds to LTHHCP and Assisted Living Program capacity.

### ***Background and Detail***

HCA proposes to increase state revenue through the Federal-State Medicare Shared Savings Partnership plan (originally conceived and proposed by HCA and subsequently enacted in the 2010-11 State Budget), by incorporating within the plan home care models and initiatives that reduce Medicare utilization. There are models currently operating throughout the state that have demonstrated improved patient outcomes, reduced hospitalizations and readmissions, reduced emergency room utilization and avoidance of other costly Medicare and/or Medicaid covered services. These models are tailor-made and already functioning candidates for inclusion in the Federal-State Partnership Plan for leveraging federal shared savings through this program. HCA is further engaged with the state hospital association (HANYS) and state medical society (MSSNY) on collaborative initiatives which could also be included to secure federal revenues under the Partnership Plan.

HCA also proposes that the state pursue enhanced federal Medicaid participation through the home and community based services and collaborative care management provisions of the Affordable Care Act (ACA) in a manner that would utilize or build upon the current home care infrastructure. ACA provisions which HCA recommends, and which HCA will partner with the state to pursue, include: Health Homes and an appropriate form of Long Term Care Rebalancing. While pursuing ACA's enhanced Medicaid shares, HCA cautions that the state avoid (or develop workarounds to) ACA "conditions" – such as "conflict-free" case management and "single point of entry" requirements – which would unravel the state's long-standing structures and policies for long term/community based services delivery.

### ***Proposal Overview***

Increase state revenue from federal sources through new state/federal health reform initiatives.

### ***Proposal Overview***

Provide for regulatory relief to reduce state and provider costs and to permit improved, more efficient functioning of the system.

### ***Background and Detail***

New York is the most, or among the most, heavily regulated states in the nation in relation to health care, Medicaid and a plethora of additional areas that saddle taxpayers and the health care sector with inordinate costs.

At a time when the state is considering curtailment or elimination of needed services, or reducing reimbursement to the point of forcing provider closures, the state must *first* consider whether all of its regulations are truly worth the cost.

HCA proposes that: (a) in conjunction with other proposed reforms, the role of local social services districts be streamlined or reduced in connection with the LTHHCP and other home care services; (b) state mandates that exceed federal regulations be identified and pared back to conform to federal obligations (unless the more restrictive state requirement is necessary due to a unique aspect of New York's home health system); (c) the state pursue federal Conditions of Participation waivers or other federal regulatory waivers or changes in cases where federal regulations result in unjustifiable costs; (d) the state enact HCA's regulatory relief legislative proposals to reactivate the Health Occupation Development and Workplace Demonstration Program and establish the Rural Home Health Flexibility Program; and (e) the state enact HCA's Medicaid efficiency proposals (referenced in section 11 of this plan); among other measures.

## ***Proposal and Background***

HCA proposes regulatory relief measures which will create opportunities for home health workforce development. Examples include the following:

- Several of the regulatory proposals referenced earlier will provide opportunities for modification in duty which could be aligned with increased training and/or job advancement.
- A legislative change also proposed by HCA would enable nurses and patients to orient and train home health aides and personal care workers to perform tasks which are ordinarily limited to nursing but which nurses routinely train patients' families to perform. In addition to the patient and fiscal benefits of this change, it would similarly provide for opportunities for increased training and/or job advancement for these individuals.

HCA proposes that HCRA funds provided pursuant to section 2807-v of the public health law and distributed pursuant to section 3614 of the public health law for recruitment, training and retention of direct care workers in home care be continued but that the manner of funding be changed so that funds are part of and cycle with the ratemaking process.

HCA proposes that HCRA funds provided pursuant to section 2807-l of the public health law for Health Workforce Retraining – which support the retraining of health care personnel with experience in one setting to work in a new, alternate setting – be amended to specifically include retraining for employment in home health care.

## ***Proposal Overview***

HCA proposes regulatory relief measures which will create opportunities for home health workforce development.

## *Proposal Overview*

HCA has developed and proposes an extensive series of additional changes to the statutes and regulations to yield significant savings to the Medicaid Program.

## *Background and Detail*

HCA has developed and proposes an extensive series of additional changes to the statutes and regulations to yield significant savings to the Medicaid Program, including but not limited to:

- Permit nurses and patients to direct home health aides and personal care workers to provide care currently limited to family members (as explained earlier);
- Establish LDSS performance standards for personal care and other aspects of home care;
- Modernize the Insurance Law coverage provisions for home care (which have not been updated since the early 1970s and bear no resemblance to the role played by home care in today's health care system), which would result in Medicaid avoidance;
- Reform the state's supervision and orientation regulations for home health aides and personal care workers;
- Enact efficiencies in medical transportation services for home care patients;
- Explore the elimination of restrictions on nurses' ability to function in certain settings, allowing nurses in these settings to perform duties consistent with their scope of practice rather than requiring outside nurses to perform the duties;
- Authorize new applications of telehealth for Medicaid recipients, aimed at reducing costs;
- Enact meaningful fair hearing reform.

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## CONCLUSION

The time is now for real reform to positively realign payment incentives and programmatic changes that make the delivery of care to patients more efficient. New York's home care providers are not only demanding it – they have been leaders of the movement to offer creative solutions for reform and change over the past two years. For New York's mission-driven providers, the imperative is now because providers can no longer sustain the "business as usual" budget-making approach that has resulted in an unprecedented level of home care reimbursement cuts, including over \$430 million in state budget actions just since April 2008. This comes on top of an additional \$65 million in new unfunded mandates aimed at home care during that same period.

The home health care system is extraordinarily financially fragile and is in danger of collapse in many parts of the state. Given the tremendous need for a strong and stable home care system to support the movement of patients from the acute care system, and the desire, ability and need for chronically ill patients to receive care at home, real reform and change is critically needed. HCA and its member organizations stand ready to work to enact meaningful policy change that will result in real reforms and efficiencies to improve patient care and reduce costs.



*The Home Care Association of New York State (HCA) is comprised of over 500 health care providers, organizations and individuals involved in the provision of home health care services to hundreds of thousands of patients and hundreds of thousands more family members each and every year.*

*HCA and its home health care provider members – including Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), Managed Long Term Care (MLTC) plans and Hospices – work to promote excellence and support high-quality, cost-effective home care and community services to the citizens of New York State. HCA providers cover the entire state, caring for patients who span the gamut from newborns and new mothers to centenarians, from post-surgical and other post-acute hospital discharges to countless New Yorkers whose every day goal is life at home and in the community instead of in a nursing home.*