A HOME AND COMMUNITY-BASED SERVICE SYSTEM REFORM BLUEPRINT

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INTRODUCTION

The state budget crisis has increasingly focused attention on the state's Medicaid-funded home and community-based service system. The current system is not sustainable in the face of likely continued budget cuts over the next few years. Many agencies are already operating at either breakeven or with a deficit.

Moreover, the current home and community-based service system is badly in need of reform. It is highly fragmented with overlapping layers and is confusing to everybody. The home care program with the most people with complex medical and behavioral health needs, Personal Care, has no resources for care management, while the programs with the most resources, the *Long-Term Home Care Program* and *Managed Long-Term Care*, are themselves highly duplicative in the services they cover. The core workforce of the system, home care aides, is split in two with one half much better compensated than the other. The system is inefficient and not currently structured to sustain budget cuts or to protect the most vulnerable of the consumers receiving care.

The proposal presented here is an attempt to rationalize and simplify the home and community-based service system. Under this proposal, clinically complex home care clients in New York City will be enrolled in a single, cost-effective program combining the best features of the *Long-Term Home Health Care Program* and *Managed Long-Term Care*. Wages will be equalized across programs for New York City home care workers and new opportunities will be opened for professional development for this large and neglected sector of the city's workforce. These changes will in turn support New York's eligibility for new programs funded by federal health reform for integrating Medicare and Medicaid financing and developing new service models for improving health outcomes for individuals with chronic illnesses and disabilities.

This proposal focuses on New York City, which represents at least 80% of the system's costs. At the same time, most of the critical issues discussed here apply to the rest of the State as well. There is a need for a Care Management Organization structure, as proposed here,

throughout the state. Aligning the home and community-based service system with federal health reform is a state-wide issue. Issues regarding direct care workers differ by region but they are fundamentally about adequate compensation, including full-time work, and creating opportunities for upgrading and playing a more vital role in service teams. In some areas of the State, increased use of consumer-directed services and allowing family members to provide paid assistance may be the most appropriate response to worker shortages.

The kind of transformation envisioned here will require executive leadership combined with the willingness of the key actors–consumers, providers, regulators, elected officials–to find enough common ground on which to grapple with the major issues and potential trade-offs.

CRITICAL ISSUES

This paper is based on the premise that the budget crisis presents an opportunity for reform of the home and community-based service system. If we do not choose to treat the crisis as an opportunity as well, we risk losing the capacity to address significant issues affecting the most vulnerable elderly and disabled consumers, and the workforce essential for their care. Any effort at reform must address four critical issues: 1) reducing and containing Medicaid costs; 2) simplifying the system; 3) improving quality outcomes by providing care management for consumers with complex needs; and 4) stabilizing the core workforce by establishing parity in wages for home care aides.

REDUCING AND CONTAINING MEDICAID COSTS

Budget cuts in home and community-based services have historically focused on two areas: 1) across-the-board decreases in rates of reimbursement to agencies; and 2) reducing service hours for the highest need/highest cost consumers, usually those receiving 12–24 hours of personal care a day in the *Human Resources Administration Home Care Services Program.* However, across-the-board rate decreases may severely weaken or even eliminate some of the

highest quality programs or those serving people with the most complex care needs while leaving other lower quality programs in better financial shape.

Reducing care for consumers receiving 12 or more hours of care who need intensive daily assistance will only cause harm to those consumers while achieving limited or no financial benefit. Medicaid home care costs will be cut, but those costs will only be transferred to the nursing home sector. This kind of cutback will result in a protracted legislative battle and a likely court case under the *Supreme Court's Olmstead* decision requiring care in the most integrated setting.

Addressing the need to reduce and contain state Medicaid costs requires both thoughtful reductions in benefits and maximization of federal funding. There are two major areas to look for costs to be cut:

1. Raising the eligibility threshold and reducing the number of eligible participants for Medicaid-funded home and community-based services. A modest adjustment in eligibility requiring a nursing home level of care is one of the most immediate and least harmful ways to cut costs since it affects those individuals least in need of services. Each of the major programs has a different mix of participants and each one uses a different assessment tool. It is impossible to make valid comparisons of service utilization and costs across programs or for different segments of the home care population today. A common assessment tool and a uniform application of a nursing home level of care eligibility standard are prerequisites for implementing this option.

2. Reducing home care service utilization where appropriate. The considerable pressure in the last decade to substantially reduce high cost personal care utilization resulted in many 2x12 hour shifts a day cases being converted to live-in or a 12–hour shift with family members living in the home providing care at night. Managing service utilization today requires a focus on mid-range use, such as

reducing a 10–hour case to 8–hours or an 8–hour case to a 6–hour or reducing days, where possible. Additional mechanisms for reducing overall utilization include concentrating service volume with specific agencies and aides in order to maximize clustering of services for individuals in apartment buildings and geographic areas, where appropriate, and establishing a chore service for individuals who primarily need assistance with household tasks and shopping.

Recent passage of federal health reform, the *Patient Protection and Affordable Care Act (PPACA*) also presents the state with a unique opportunity to increase the federal share of Medicaid spending and to share in any savings that accrue to Medicare as a result of Medicaid-funded services which reduce hospitalizations, lengths of stay and emergency room visits.[*] There are several programs created by the health reform legislation that would assist in State-level restructuring. These new programs should be fully examined and utilized as a part of reforming NYC's home and community-based service system (see pages 16–20).

SYSTEM SIMPLIFICATION

The home and community-based service system is overwhelming in its size, and confusing in the range of options that upon closer examination may not be all that different from one another. There are currently only two relatively well-defined and well-understood services. First, immediately after a hospitalization home care services are provided by a *Certified Home Health Agency (CHHA),* which is chosen by the consumer while in the hospital. However, services are for relatively short duration and if long-term care is needed the best choice is not readily apparent. Second, the Personal Care program is the program most widely known, simplest to understands and easiest to enroll in. It is also generally regarded by consumer advocates as the only program which has served the most vulnerable of New York City's home care population–those with the most complex needs, whether due to physical disabilities, mental or behavioral health issues.

[*] For dually eligible consumers Medicaid is the primary payer for long-term care services and Medicare is the primary payer for primary and acute care.

There are three major programs for serving chronically ill and disabled people in New York City (see tables comparing programs services and enrollments on pages 21–22).

- **Personal Care**–*The NYC Human Resources Administration Home Care Services Program* contracts with licensed home care agencies to provide personal care aide or home attendant services. The population served consists of both frail older people and adults with disabilities. This program has a high proportion of consumers with behavioral health issues and approximately 20% of the participants require and receive 12-24 hours of personal care a day. Approximately 5% of the participants use Consumer-Directed Personal Assistant Services (CD-PAS) in which the consumer hires and oversees their direct care workers and agencies act only as fiscal intermediaries and the employer of record. Many CD-PAS participants receive high hours of service.

- **Long-Term Home Health Care Program**– The *LTHHCP* provides a broad range of home-based services, although 60–70% of its costs are for personal care. The critical driver of a *LTHHCP* operationally is the individual budget cap of 75% of average nursing home costs. The practical implication of the cap is that it generally precludes the most complex people from receiving care through a *LTHHCP*. There are thus very few, if any, patients with significant levels of disability and patients requiring more than 6 hours of personal care a day in the LTHHCP. Care management is largely performed and paid through nursing visits. The *LTHHCP* uses an "*organized health delivery system*" model in which the sponsoring organization provides one or more Medicaid services directly and has agreements with other organizations or individuals to provide additional services.

- **Managed Long-Term Care**–*MLTC* plans provide a similar set of services as the *LTHHCP,* but also pay for nursing home care and some assorted other services such as outpatient rehabilitation services, podiatry and dental care. However, personal care represents 60–70% of the costs, similar to the *LTHHCP*. *MLTC* plans receive a capitated rate per member per month enabling the plan to function, in effect, with a global budget.

Care management is a distinct, required covered service and the plan is responsible for coordinating all care for a participant, not only covered services. Plans must provide care management directly and contract for covered services with organizations and individuals, including affiliated agencies.

In addition to these three major programs, three other substantial programs are part of the service system for chronically ill and disabled New Yorkers. Consumers needing long-term home health services have historically been served by *CHHAs* as well. However, *CHHAs* were originally designed to serve individuals who needed skilled medical care. The *NYS Department of Health* plans to implement a *Value Based Purchasing Episodic Pricing Model* which will establish a base price for *CHHA* Medicaid home care services, adjust the base price for variations in labor costs and patient acuity/case mix, and reward the provision of quality health care services. This payment system is designed for relatively short episodes of care and not for consumers with long-term needs who are chronically ill and disabled.

The *Program of All Inclusive Care for the Elderly (PACE)* is the only form of managed long-term care which integrates Medicaid and Medicare funding and primary, acute and long-term care services. It is a specific model designed to serve a frail elderly population and uses an adult day program as its core. However, it is based in Federal law and the model can not be changed by state action. It is an important part of the home and community-based service system. It will always have limited enrollment due to the Federally-defined program requirements and its current program model is not well-suited for all long-term care consumers.

The *Nursing Home Transition and Diversion Program (NHTDP*) is a relatively new waiver program that has very little enrollment in New York City and has minimal visibility and presence. The *NHTDP* contracts with independent case management centers. These centers are separate from the fee-for-service care providers and the specialized waiver providers which makes comprehensive care coordination exceptionally difficult.

CARE MANAGEMENT FOR CONSUMERS WITH COMPLEX CARE NEEDS

Care management is defined here as a person-centered, interdisciplinary process designed to integrate health care and social support services.[*] It includes a health assessment of functional strengths and limitations, medical problems or issues, and service needs; a social assessment of support needs, including housing, benefit issues and barriers to effective service delivery; development of a care plan with the participant and family and/or informal caregivers; ordering or arranging for appropriate services; coordinating with other providers, especially the primary care physician; monitoring the quality of care and making adjustments as necessary; monitoring; and making re-assessments at least every 180 days or if there is a significant change in status.

Care management is a valuable resource and should be targeted to consumers with complex care needs. It is not required for consumers who only require personal care on an ongoing basis. Complex care needs are defined here as the needs of individuals in one or more of the following categories:

- The person cannot safely or appropriately perform three or more *Activities of Daily Living (ADL)*[1]
- The person cannot safely or appropriately perform two or more ADLs and one or more *Instrumental Activities of Daily Living*.[2]
- The person cannot safely or appropriately perform one or more ADL and has a cognitive impairment or demonstrates unmanaged behavioral health symptoms.[3]

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[*] See a report commissioned by the *National Coalition on Care Coordination "Structuring, Financing and Payment for Effective Care Coordination"* July, 2009 by Robert Berenson and Julianne Howell at: http://www.urban.org/UploadedPDF/1001316_chronic_care.pdf.

[1] Activities of Daily Living are bathing, dressing, eating, mobility, transferring from one surface to another, such as from bed to chair, and toileting.

[2] *Instrumental Activities of Daily Living* (IADL's) includes housekeeping, shopping, laundry, meal preparation, financial management, using the telephone and arranging and using transportation.

[3] *Behavioral Health Symptoms* may be documented by a clinician or service provider or by demonstrating current behavioral health symptoms. These symptoms include: memory deficits or disorientation to person, place or time; wandering; refusal to accept needed care on a consistent basis; drug or alcohol abuse; decline in cognitive functioning; depression; inconsistently takes medication, follows treatment plans or makes medical appointments; physically abuses self or others, and neglects self or home environment.

- The person requires a range of medical and social interventions due to multiple serious chronic conditions and disabilities.
- The person requires frequent changes in services due to intermittent or unpredictable changes in her or his condition.

Care management needs are often tied to critical transitions, times when consumers feel most vulnerable and overwhelmed. The most common transitions are hospital or nursing home entrance or discharge or potential loss of housing. Service-related problems such as a change in relationship with home care aides or family caregiver or a breakdown in mobility equipment, are also major events in a consumer's life that must be addressed as quickly as possible. Resolving these major events can often be complicated due to the interplay of behavioral and mental health issues and/or substance abuse with the specific problem. The most difficult situations usually involve *Adult Protective Services (APS*) or even the two working together and rarely does the agency or *APS*, even together, have the appropriate and/or sufficient resources to properly address these situations**.**

PARITY IN WAGES FOR HOME CARE AIDES

New York City's home care aide workforce is divided, about equally, into two segments:

1) Home health aides are employed by licensed home health service agencies which contract with *Certified Home Health Agencies*, *LTHHCP's* and *MLTC* plans; and
2) Home attendants are employed in agencies which contract with the city's personal care program.

Although the home health aide position is a higher level in regulation, with more clinically related responsibilities, home health aides are generally paid approximately $1.50–2.75 an hour less than home attendants. This "*wage inversion*" is the direct result of the home attendant sector being unionized for over 20 years with a master collective bargaining agreement administered by *HRA*. Further, the city program is governed by a "living wage" law which requires a $10 minimum wage for agencies with city contracts. Home health aides, however, have only been

unionized in the last 5-10 years and there remains a wide variation in wage rates. The "L*iving Wage*" law does not apply to this group of workers because they do not work directly under a NYC government contract, even though they are paid largely through Medicaid funding.

There is no justification for home health and personal care aides being paid at different levels. Even the city "*living wage*" level is a very low floor. Aides doing comparable work in hospitals and nursing homes have significantly higher wages and better benefits. Turnover rates among aides are four times that of home attendants–40 to 50 percent vs. 10 percent–and are directly related to the differences in pay and benefits. Although bringing home health aides up to the "living wage" level represents an upfront and continuing expense, it also represents an investment. A stable workforce that retains its more experienced and skilled caregivers is critical to any strategy to reduce costs and improve outcomes through effective management of chronic illness and disability.

THE PROPOSAL

This proposal is an attempt to rationalize and simplify New York City's home and community-based service system. It consists of two basic components: 1) restructuring programs; and 2) establishing parity in wages between home health aides and personal care aides.

RESTRUCTURING PROGRAMS

The home and community-based service system will be restructured to shift most care of clinically complex individuals into Care Management Organizations (CMOs) and to consolidate the overlapping patchwork of existing home and community-based service programs in New York City:

1. **LTHHCPs and MLTC**–plans will be consolidated into one program for the long-term care of chronically ill and disabled Medicaid consumers. The agencies operating under this program will be considered *Care Management Organizations* that will operate as an

organized health delivery system with care management as the one service it will be required to operate themselves.

2. **HRA Home Care Services Program**–will operate as it does today. However, all new consumers with complex care needs entering the system will be referred upon initial assessment by the *CASA* to an agency acting as a *Care Management Organization*.. For those consumers interested in personal care, *HRA* staff will conduct an assessment. In the event that the beneficiary is determined to have complex care needs, the consumer will be given a choice of CMOs to enroll in. If the consumer does not make a choice she/he will be auto-enrolled in a *CMO* on a rotating basis, taking into account geographic service areas and/or specialization in certain conditions and disabilities. HRA will use a nursing home level of care eligibility standard and the same assessment tool as the CMOs to enable valid comparisons across programs.

3. **Certified Home Health Agency (CHHA)**–will focus on serving consumers with short-term, acute care needs and begin to be paid through the newly developed episodic pricing model. Consumers, who require ongoing services after two acute episodes of CHHA care, will be transitioned to one of the CMOs.

4. **The Nursing Home Transition & Diversion Program (NHTD)**–will no longer operate in New York City, but continue to operate in the rest of the state. The waivered services will remain in effect for Medicaid–covered services and be included in the covered services for the *Care Management Organizations* proposed here. Housing subsidies currently in the *NHTD* will also be attached to the *CMO* program. Current enrollees in the NHTD program will be transitioned to either the HRA personal care program or the new CMO program.

CARE MANAGEMENT ORGANIZATION PROGRAM

The key elements of the *Care Management Organization* will be the following:

- **Licensure**–The entity will operate as a *Care Management Organization*, a new operating certificate that will replace both the *Long-Term Home Health Care Program* and the *Managed Long-Term Care Plans*. Existing entities will automatically receive a certificate of authority*. There will be a moratorium on new programs for at least five years. Contract standards will be developed to ensure the ability to provide care management for consumers with complex care needs and an organized delivery system to provide the care.

- **Payment**– The *CMO* will be paid on a capitated per member per month (PMPM) basis, as in *MLTC*. Capitated payment for a set of bundled services provides incentive for more efficient use of available resources, rather than encouraging higher volume of services as in fee-for-service payments. The payments will be risk-adjusted for medical expenses and care management using the recently developed methodology of the *New York State Department of Health* for *MLTC*, which will continue to be refined over time. Payments will be made for all covered services, except for one-time expenditures for waiver services such as community transitional services or environmental modifications which will be paid for separately. An additional PMPM payment for administration will be based on the average of administrative costs for all *CMO*s operating in New York City. The total payment will also include a 3% surplus/profit, as in *MLTC*.

- **Sponsors**–Eligible sponsors will be *CHHA*s, nursing homes and nonprofit organizations with experience in home and community-based services and/or working with the elderly and adults with physical disabilities. This is similar to the eligible

* Agencies who have both a LTHHCP and an MLTC will receive only one new certificate of authority which will include all of the approved geographic areas in their different licenses.

sponsors for *MLTC* plans. New programs will be subject to Certificate of Need requirements, as in the LTHHCP, once the moratorium is no longer in effect.

- **Required Direct Service**–The one required service to be performed directly by the entity will be care management. It may choose to provide other services directly, through an affiliate or through contracts with other agencies.

- **Other Covered Services–** The covered services will include all services currently covered by *MLTC* plans, the *LTHHCPs* and the *NHTD* programs. It will also limit nursing home services, now covered entirely by *MLTC*, to short-term stays. A three month stay in a nursing home will trigger disenrollment. This parallels the nursing home component of managed long-term care coverage in most other states (A table comparing the covered services in *MLTC, LTHHCP* and the proposed CMOs is on page 23).

- **Medicare**–The *CMO* will cover only Medicaid-funded services, as in *MLTC*. Providers of Medicare-covered services for dually eligible participants will bill Medicare directly as the first payor. *CMOs* that formerly operated as *LTHHCP*s can continue to operate their *CHHA* as part of the *CMOs* organized delivery system or stop operating a *CHHA*. The *CMO*, as a *Managed Care Organization*, will be able to link to *Medicaid Advantage Plus* and *Medicare Advantage or Special Needs Plans,* but will not be required to.

- **Assessments**–The *CMO* will conduct participant assessments every 180 days and with any major change in health status. The *CMOs* and *HRA* will use the same assessment tool to accurately capture the health and social status and needs of participants in both programs. Uniform assessments will include assessment of hours of service for personal care including 12–24 hour care. A common assessment tool and a common eligibility standard for the personal care program and for CMOs also provide an opportunity to significantly change the assessment oversight process and

make it more efficient. The assessment can be designed as a web-based application, similar to Wisconsin's Long-Term Care Functional Screen, to provide an automated assessment which calculates eligibility, range of required personal care hours, and a risk score for capitated payment to a CMO. Staff who have taken a training course and passed a certification exam will conduct the assessment. On-site retrospective reviews by IPRO/HRA staff will be done to ensure assessments accurately reflect the beneficiary's conditions and functional limitations.

- **Care Management Capacity**–Many CMOs will have to strengthen their care management capacity to serve increasing numbers of consumers with complex care needs. There are two additional kinds of care management that are more specialized than the basic form of care management described on page 7. First, enhanced care management focuses on reducing avoidable medical complications, in collaboration with physicians. This form of care management is not widely practiced today, but is made possible through shared hospital cost saving arrangements (see page18). It requires a higher level of clinical skills than basic care management. Second, addressing behavioral health and mental health issues will require different kinds of staff with specialized training, and CMOs with a high proportion of consumers with serious behavioral health issues, will need separate state/city Medicaid mental health funding for the equivalent of an *Assertive Community Treatment Team* and/or an *Intensive Case Management Unit.*

- **Financial Capacity**–The *LTHHCP* and *MLTC* operate under very different requirements with regard to financial capacity. Consolidation of the two programs requires setting a new standard that is commensurate with the level of risk and the ability of the entities to maintain operations. This standard will have two components, one for working capital and one for a restricted financial reserve. The working capital requirement proposed here is a minimum balance of at least 2.5% of annual Medicaid revenue. The financial reserve proposed here is 5% of anticipated medical expenses for the year, excluding expenses for services provided by the *CMO* directly or by its

affiliates. *LTHHCPs* operating as a CMO must meet the working capital requirement and a reduced financial reserve requirement of 2.5% of anticipated medical expenses at the outset and meet the full requirement within three years.

- **Current Program Regulations**–In consolidating the *LTHHCP* and *MLTC* there are regulations that are currently in force specific to each program that will be eliminated. For instance, there will be no need for "slots" or joint nursing visits prior to enrollment that exists in the current *LTHHCP*. Similarly, the current requirement in *MLTC* that no new plan can be approved or an existing plan allowed to expand without a companion *Medicare Advantage* or *Special Needs Plan* will no longer be required.

REGULATORY FRAMEWORK

The *Care Management Organization* approach described here is very similar to Wisconsin's Family Care Program[*]. It has similar functions, covered services, payment methodology and financial reserve requirements. The *Family Care Program* was largely developed in response to the strengths and limitations of its predecessor, the *Wisconsin Partnership Program*, and to the limitations of the underlying county-based home and community-based service system.

The framework proposed here takes the model of a *CMO* and adapts it to New York reflecting the history and development of home and community-based services in New York city and state. The result is a hybrid of managed long-term care and an organized home care delivery system. A hybrid model provides significant challenges for establishing government oversight at both the state and city level. At the state level, it will require establishing a dedicated office within the *Department of Health* to guide the transition to the new *CMO* structure. For

[*] For more background information on the Wisconsin programs see: http://dhs.wisconsin.gov/ltcare.

CMOs, it will require a commitment to combining the management of care roles in managed care with the skill set and perspective of home and community-based service providers.

PARITY FOR HOME CARE AIDES

Home care aides represent 70–80% of the paid hands-on care in the home setting. Parity in wages between home health aides and personal care aides is a critical financial investment in the core workforce that has been ignored for too long. State contracts for Medicaid home care services, both acute and long-term, will require agencies to pay "living wages" to home health and personal care aides in geographic areas where there is a local "Living Wage" law in force. This will establish parity between aides employed through NYC contracts and those employed though state contracts.

Extending the "*living wage*" requirement to all home care aides will be the major additional cost in this proposal. If the "Recruitment and Retention" Funds now made available as a separate funding stream to Medicaid CHHAs, MLTCs and LTHHCPs are folded into the base Medicaid payments that will be a substantial contribution toward the amount required. An additional contribution will come from increased efficiencies related to lower turnover in the licensed agencies and reduced overhead costs in the CMOs. Parity could also be implemented over a three year transition period, if necessary.

Parity is a prerequisite for building the stable and skilled workforce that is required in the future. However, the pay will still be low compared to other aide positions in hospitals, and nursing homes, health insurance coverage will remain poor, hours of employment will remain inconsistent and unstable and there will still be few opportunities for upgrading to a higher level position and pay. Restructuring programs will provide a significantly better platform than exists today for addressing these issues. However, in order for these issues to be given serious ongoing consideration in the work and the business models of the new CMOs the culture of home care will also have to change to embrace home care aides as a vital component of the service team for achieving quality health outcomes and providing a good service experience for consumers.

ALIGNMENT WITH FEDERAL HEALTH REFORM

Federal health reform places special emphasis on rebalancing of spending to home and community-based services from nursing homes. This rebalancing has been a long-term thrust of state and city policy. However, continued progress in bringing Medicaid consumers back into the community from extended nursing home stays or hospitalizations requires targeted attention and specialized resources.

The *Patient Protection and Affordable Care Act* also focuses on developing enhanced care management capacity, through both *Primary Care Medical Homes* and *Accountable Care Organizations.* Both of these models focus on physicians and hospitals, but their principles can be applied to home and community-based services.

Some specific provisions of the *PPACA* that tie into this proposal include the following:

- **Center for Medicare and Medicaid Innovation**–The legislation establishes a Center for Medicare & Medicaid Innovation within CMS to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding will be provided to allow for testing of models that require benefits not currently covered by Medicare and successful models can be expanded within both programs.

- **Health Homes for Chronic Conditions** – This provision offers planning grants to states for development of comprehensive care management, care coordination and transitional care services delivered by designated providers as "health home" services. States can receive greatly enhanced (90%) federal match funding for two fiscal years for the health home services, beginning in January 2011.

- **Federal Coordinated Health Care Office (CHCO)**–The legislation requires the Secretary to establish the CHCO within the Centers for Medicare and Medicaid

Services (CMS) to bring together officials of the Medicare and Medicaid programs to more effectively integrate benefits under those programs, and improve the coordination between federal and state governments for dually eligible consumers. CHCO has new waiver authority under PPACA to enable states to work with Medicare and Medicaid combined funding on coordination of care and funding for dual eligibles.

- **State Balancing Incentive Payment Program**–The legislation creates financial incentives for states to shift Medicaid consumers out of nursing homes and into home and community-based services. States that rebalance their spending between nursing homes and home and community-based services will receive a Federal Medical Assistance Percentage increase of 2 or 5 percentage points.

The *CMO* structure proposed here provides the core capacity to undertake this work. The demonstration programs described below would develop enhanced care management capacity in the participating *CMOs.* These demonstrations offer an additional vehicle for moving towards the integration of Medicaid and Medicare with considerable potential for additional State revenue and increased capacity for coordination of care across primary, acute and long-term care settings.

CMOs and Medical Homes

The *CMO* model would be considerably strengthened by enabling appropriate physician, group practices and health centers to enter into a formal collaborative arrangement to function as medical homes. These entities would be paid a care management fee above their usual payment for medical treatment. This enhanced rate would recognize their willingness to become more skilled at caring for individuals with multiple serious chronic conditions and disabilities and to enable nurse practitioners to play a significant role in this process.

The *CMO* staff would provide support to the consumer between physician visits and hospitalizations, maintaining contact and coordinating care with their multiple physicians–primary care and specialists–and other caregivers including nurses, therapists, home care aides and providers of equipment and supplies. The combination of a community-based care coordination program with a primary care medical home network is similar to two model programs–*Community Care of North Carolina* and *Vermont Blueprint for Health Integrated Health Program*.

Shared Hospital Cost Savings

The incentive to develop enhanced care management models in collaboration with physicians will be considerably strengthened if the CMOs share in cost savings from reduced hospitalizations, extensive lengths of stay and emergency room visits resulting from to avoidable medical complications such as pressure ulcers and urinary tract infections. One approach would be similar to a quality pool proposed by the *NYS Department of Health* as part of its proposal for a new CHHA episodic payment methodology. New York would establish a CMO quality funding pool which rewards performance on one or more quality measures tied to reduced utilization of acute care. There would be increased payment for those plans that are among the top performers.

Another approach would be to develop a demonstration project to establish a shared savings arrangement between the federal and state governments and the care coordination entities based on the difference between projected hospital and emergency room costs and actual utilization. The program would be applicable to both dually eligible and Medicaid-only consumers enrolled in *CMOs*. A pilot program could be initiated with Medicaid-only participants in advance of the full demonstration. The *NYS Department of Health* would have to share historical utilization and cost information with the *CMOs* about their participants and provide ongoing data on a reasonably timely basis. The Centers for Medicare and Medicaid Services would have to do the same for Medicare data.

Advanced Home Care Aide

Home care aides are an underutilized resource in the home and community-based service system. Creation of an Advanced Aide position would provide substantial added value to consumers and providers while offering genuine cost efficiencies to the service system. A fundamental redesign of the aide role would provide a real rung in a career ladder, midpoint between an aide and a Licensed Practical Nurse (LPN).

A demonstration program would provide an opportunity to test the effectiveness and cost benefit of combining two distinct direct-care roles:

- Care coordination team member, responsible for the direct contact role of information flow from the consumer to the rest of the care coordination team, including family caregivers, and from the team to the consumer.
- Enhanced clinical aide, with additional responsibilities that would deepen their current role–similar to medication aides or rehabilitation aides.

Broadening and/or deepening the aide role in this way presents an opportunity to break the mold of very low expectations for home care aides. Instead, it offers higher compensation and support in exchange for increased efficiency, particularly in substituting for nurse visits, with the same or better level of quality care. Scope of practice and liability issues will have to be addressed as part of the program. A demonstration program could assess different approaches to combining these roles and evaluate the potential of improved efficiency and improved health/service outcomes.

CMOs and Nursing Home Transition

New York, like many states, has struggled to implement federal nursing home transition and diversion grants. Reducing nursing home utilization at scale will require dedicated staff, access to housing subsidies and the ability to provide sufficient hours of personal care, especially at the outset of home care. Specific *CMOs* should be designated to specialize in nursing

home/long-stay hospitalization transitions and offered financial incentives from additional federal Medicaid funding through either the federal *Money Follows the Person Demonstration Program* or the *State Balancing Incentive Payment Program* related to performance.

CONCLUSION

This proposal attempts to rationalize and simplify the home and community-based service system while ensuring that the system is built on those features that the key actors value the most:

- Cost reductions are focused on those consumers least in need of services and not those most in need.
- Uniform assessments and eligibility standards are established across programs
- Care management is targeted for consumers with complex care needs
- Demonstration projects are developed using federal innovation funds to test integrated Medicaid–Medicare financial arrangements and enhanced care management models for better health outcomes and a reduction in hospitalizations.
- Parity in wages among home care aides is achieved and career ladder opportunities are created.

Reform of the home and community-based service system represents a vast undertaking in very difficult financial times. However, it is precisely because of these times, that it is critical that we move down this path as rapidly as possible.

COMPARISON OF MAJOR PROGRAMS BY KEY CRITERIA

	NYC HRA Home Care Services Program (HCSP)	Long-Term Home Health Care Program (LTHHP)	Managed Long-Term Care (MLTC)
Services Provided	Provides only personal care through contracts with licensed agencies	Provides broad range of home-based services. 60–70 percent of costs are for personal care. Care management is provided through RN home visits	Provides broad range of home-based services, nursing home and office-based services, such as rehab services and dentistry. 60–70% of costs are for personal care. Care management is a discrete, core service, independent of a service visit.
Regulatory Framework	NYC program with City contact. Living wage requirements part of contract.	State licensure as Certified Home Health Agency operating under federal waiver regulations.	State certificate of authority operating under NYS Insurance Law and Medicaid managed care regulations.
Financial Payments	Fee-for-service reimbursement	Fee-for-service reimbursement with individual budget cap tied to 75 percent of average nursing home cost in region.	Capitated payment per member per month with new risk adjustment methodology as of April, 2010.
Patients Served	Broad service population including frail elderly and physically disabled. Approximately 2/3 of population is nursing home eligible. About 25 percent are clinically complex or in need of special care.	Patients do not generally receive more than 48 hours of personal care a week due to budget cap. Few, if any patients, with significant levels of disability and virtually no younger adults with disabilities.	Mostly elderly population with exception of one plan with concentration of younger adults with physical disabilities. All enrollees are nursing home eligible, although clinical complexity varies considerably among plans.

CURRENT ENROLLMENT IN MEDICAID LONG-TERM CARE PROGRAMS IN NEW YORK CITY

Program	Enrollment	Date
HRA Home Care Services Program *(personal care)1	44,416	December 2009
Long Term Home Health Care Program1	14,073	December 2009
Managed Long-Term Care1,2	26,272	December 2009
Nursing Home Transition & Diversion Program3	392	December 2009

Sources:

1 – NYC HRA Office of Data Reporting and Analysis, HRA Facts: January 2010. (http://www.nyc.gov/html/hra/downloads/pdf/hrafacts_2010_01.pdf)
* This number includes consumers who use consumer-directed personal assistant services. It also includes both Home Attendant and Housekeeper cases.

2 – Managed LTC enrollment includes both MLTC PACE plan and MLTC Partial Capitation plan enrollment.

3 – Freedom of Information Law (FOIL) Request #10-05-157, prepared by the NYSDOH Division of Home and Community Based Services: NHTD Waiver Participant Enrollment Count Report Between 2004 and 2009

Note: Certified Home Health Agencies are not included here because their publicly available census consists of both short-term and long-term participants.

COMPARISON OF COVERED SERVICES UNDER
MLTC, LTHHCP AND PROPOSED CMO

Covered Services	MLTC	LTHHCP	Proposed CMO
Care Management	√	√	√
Home Care Nursing	√	√	√
Home Health Aide–Personal Care Aide	√	√	√
Physical Therapy (PT) Home Care	√	√	√
Occupational Therapy (OT) Home Care	√	√	√
Home Care Speech Pathology (SP)	√	√	√
Medical Social Services	√	√	√
Homemaker	√	√	√
Housekeeper/Homemaker	√	√	√
DME, including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetic, Orthotics and Othopedic Footwear	√	√	√
Personal Emergency Response System	√	√	√
Non-emergent Transportation	√	√	√
Respiratory Therapy	√	√	√
Audiology/Hearing Aids	√	√	√
Nutritional Counseling	√	√	√
Private Duty Nursing	√	√	√
Home Delivered or Congregate Meals	√	√	√
Social Day Care	√	√	√
Social and Environmental Supports, including home maintenance tasks and home adaptation	√	√	√
Nursing Home Care	√		√
Adult Day Health Care	√		√
Podiatry	√		√
Dentistry	√		√
Optometry/Eyeglasses	√		√
PT, OT, SP or other therapies provided in a setting other than a home	√		√
Respite		√	√
Moving Assistance		√	√
Telehealth		√	√