Reverse or Correct CMS Administrative Actions

The Centers for Medicare and Medicaid Services (CMS) has proposed new regulations, reinterpreted existing regulations and imposed restrictions by rule that adversely affect the delivery of home and community-based services (HCBS) in New York State. These include case management services, spousal impoverishment protections under Medicaid home and community-based waiver programs and rules for receiving services from more than one HCBS waiver program.

Issue: Case Management Services

On December 4, 2007, CMS issued an interim final rule, effective March 3, 2008, that significantly modifies the way states can be reimbursed for case management services under Medicaid. The rule: (i) precludes case management as an integral part of the delivery of health services; (ii) precludes reimbursement for case management as part of a bundled rate; (iii) precludes reimbursement for case management while patients are institutionalized (e.g., affecting transitional care services); (iv) structures case management reimbursement based only on 15 minute increments; and (v) provides for other changes to this service.

If implemented, the rule could turn back three decades of progress in coordinated service delivery and care management in New York State. It could fracture both long-standing and emerging programs that integrate and coordinate services, recreating the fragmentation New York State's home care community has long worked to reduce.

The core duties that home care agencies provide include the coordination and management of the patient's care. New York State codifies this responsibility in its rules, regulations and program guidelines. Yet, the CMS rule would separate case management from the provision of service and the service provider.

For patients with chronic illness and/or disability, our principal home and community-based services program is the Long Term Home Health Care Program, which was designed and implemented 30 years ago to provide persons who would otherwise be placed in an institution with a comprehensive, managed program in their own homes – a "Nursing Home *Without* Walls. Similar to when a patient is in a facility, the "Nursing Home Without Walls" is designed to provide for and coordinate the patient's medical, psychosocial and environmental service needs. Case management is a core part of this consolidated model and is integral to its success. Care costs in the program have averaged 50% of the nursing home rate and are capped on a per patient basis at 75% of this rate, with certain exceptions for AIDS and other special needs cases. The original federal home and community-based wavier statute (OBRA1981) was largely based on the success of our "Nursing Home Without Walls"/Long Term Home Health Care Program.

CMS' proposed redefinition of case management will disallow or restrict payments for case management services that are an integral component in the provision of home and community based services. The rule runs contrary to a provider's mission of delivering a coordinated plan of care for patients, which is critical to keeping patients at home.

The rule also will adversely impact individuals with complex health problems that require interdisciplinary and cross-specialty services by prohibiting the provision of case management by, or collaboration between, more than one provider involved in the care of patients served by multiple waiver programs. This is equivalent to precluding a patient with both medical and mental health needs from having both a primary care physician and a psychiatrist.

- **Recommendation:** HCA supports legislation to retract this CMS rule.

Issue: Spousal Impoverishment Protections

Last year, as part of the Children's Health and Medicare Protection Act of 2007 (CHAMP), the House of Representatives enacted provisions (Section 804) clarifying federal Medicaid law to allow states to protect spouses of home and community-based waiver patients from impoverishment.

This "spousal impoverishment" protection originally was passed by Congress in 1988 to allow nursing home patients to receive Medicaid benefits while permitting their spouse to retain some income and resources. At that time, Congress also permitted states to make this same protection available to couples when one spouse is enrolled in a home and community-based waiver program under section 1915(c), such as New York's Long Term Home Health Care Program (LTHHCP). In extending the same protection to these programs as afforded to nursing home patients, Congress also wisely sought to avoid an inadvertent financial incentive bias toward institutional care for protection of a well-spouse's resources. Since 1989, New York has extended this protection to the spouses of patients enrolled in the LTHHCP, and subsequently to waiver programs providing specialized care, such as the Traumatic Brain Injury (TBI) waiver programs.

The Centers for Medicare and Medicaid Services (CMS) has reinterpreted its rules on spousal protection for community-based care patients, thwarting the intent of the original policy. Last year, CMS refused to approve New York's application for a new waiver program, the Nursing Home Transition and Diversion Waiver (NHTDW), because the state proposed to provide the spousal impoverishment protection to the spouses of patients enrolled in this new program. In addition, CMS informed the state that it will not renew New York's LTHHCP and TBI waivers (the TBI waiver program expires March 31, 2008 and the LTHHCP waiver expires December 31, 2008) unless the present spousal impoverishment protections are removed.

CMS' reinterpretation of the long-standing spousal impoverishment protection policy will mean that **thousands** of New Yorkers in home and community-based waiver programs will face impoverishment or institutionalization for their long term care needs.

The result is that "well spouses" will face the impossible choice of placing their spouses into nursing homes so they can retain enough income to live in the community or keeping their ill spouses at home without home and community-based waiver services. CMS' position on spousal budgeting runs counter to state and federal efforts to shift the delivery of long term care services from institutional to home and community-based settings, creates a financial bias to choose nursing home placement over home care and is contrary to the *Olmstead* Supreme Court Decision which requires care in the most integrated and preferred setting.

- **Recommendation:** HCA supports Congressional action to clarify that spousal impoverishment budgeting protections apply to individuals receiving home and community-based waiver services.

Issue: Prohibition on Needy Individuals Being Served by Dual Waiver Programs

CMS has told New York State that individuals who are receiving home and community-based waiver services cannot be served by providers under more than one waiver program.

This arbitrary rule severely impacts individuals with complex health problems that require interdisciplinary and cross-specialty services, often from providers participating in different waiver programs. As more and more specialized services – e.g., HIV/AIDS, mental health, developmental disabilities, and pediatric care – are enhanced through the creation of waiver programs, this CMS policy is creating barriers of growing severity to basic patient care. Federal waivers were meant to *provide,* not impair, flexibility.

For example, HCA was notified that approximately 900 HIV/AIDS patients in New York City who need health related care under the LTHHCP also have distinct needs relating to their social, vocational, legal and/or residential circumstances in connection with their AIDS diagnosis. The state has specialized HIV/AIDS case management services under a separate waiver to assist with these non-medical needs. However, because of the CMS policy, these very sick and frail New Yorkers have to choose between programs – and thus face the loss of one service or the other – rather than have the benefit of collaborating services. Providers in other parts of the state, including pediatric providers, have similar cases that are equally affected by the CMS policy.

CMS' position also adversely affects many disabled children in New York who need health-related services from a waiver program like the LTHHCP and other specialized services from a mental health or mental retardation/developmental disabilities provider whose services are also covered under a waiver. Again, the two programs would work together to ensure that the basic care plan and any highly specialized service that a patient might require are efficiently provided and coordinated, but are precluded from doing so under the CMS policy.

CMS' position is contrary to both the Administration's and Congress' efforts to rebalance the delivery of long term care services from institutional to home and community-based services and threatens the home health services received by potentially thousands of elderly and disabled New Yorkers. The policy forces the patient's care to conform to the system, rather than allowing the system to fit the needs of the patient.

- **Recommendation:** HCA requests Congressional action to require CMS to either reverse this policy or at least create the necessary flexibility so that care planning can be coordinated among waiver providers where it is in the best interest of the patients, the system and taxpayers.

Issue: Revise *Home Health Compare*

Since October 2003, CMS has posted information on its *Home Health Compare* website that allows individuals to compare Medicare home health agencies based on location, services provided, and certain quality measures. Now CMS is considering establishing different payment levels for providers of care based on their performance on measures of quality and efficiency, known as Pay-for-Performance (P4P).

Some of New York's programs that would be adversely affected by P4P are the Long Term Home Health Care Programs (LTHHCPs) and Certified Home Health Agencies (CHHAs) that sponsor and operate a LTHHCP.

LTHHCPs treat Medicaid patients that have chronic, long term illnesses and disabilities, with a goal of helping them remain stable at home in a quality manner for as long as possible. This differs from CHHA patients who most often need short term skilled or rehabilitative home care after a surgery or the onset of another condition that is expected to improve. LTHHCP patients often stay on the program for extended periods, like patients in nursing homes, as opposed to CHHA patients who may receive services for only a time-limited period. In addition, LTHHCP patients tend to have higher rates of hospitalization compared to CHHA patients due to their duration of care, instability and multiple chronic conditions. The result is that the lack of distinction between LTHHCP and CHHA data misrepresents the performance of both categories of providers.

Despite repeated requests from the home care community in New York State to segregate the data, CMS has decided to not only include blended quality data from New York's CHHA sponsored LTHHCPs but CMS has decided against exempting non-CHHA affiliated LTHHCPs on CMS' *Home Health Compare* website.

Non-CHHA sponsored LTHHCPs and CHHA-sponsored LTHHCPs (whose data has been blended) would be adversely affected by P4P. Due to the nature of the populations they serve, LTHHCPs will be unfairly and inaccurately assigned "lower" quality measures within *Home Health Compare*. When LTHHCP patients (who have chronic rather than rehabilitation health care needs) are discharged from Medicare episodes of care with the same chronic and progressive conditions with which they entered, their true quality of care or levels of gradual improvement will not be captured in the performance measures used by P4P. As a result, these agencies will be misrepresented as having worse outcomes on *Home Health Compare* than typical free-standing CHHAs. No one would expect hospital and nursing home patients to have similar treatments or outcomes; so it should be with LTHHCPs and CHHAs.

- **Recommendation:** HCA requests Congressional action to require CMS to remove or segregate New York's non-CHHA sponsored LTHHCPs from any P4P initiative. HCA also believes that with the advent of the National Provider Identifier (NPI), CMS must extract CHHA sponsored LTHHCP data from free-standing CHHA data so that accurate comparisons of the *Home Health Compare* quality data are made and future efforts to establish P4P do not penalize any providers involved with our LTHHCP.