LeadingAge New York **BUDGET BRIEF**

SENIOR HOUSING | ASSISTED LIVING | ADULT CARE FACILITIES | HOME CARE | RETIREMENT COMMUNITIES
ADULT DAY HEALTH CARE | PACE/MLTC | NURSING HOMES

Managed Care Contracting for Home Health Services

The Department of Health (DOH) has issued a policy directive requiring all "home health services" delivered under contracts with mainstream Medicaid managed care plans and managed long term care plans (collectively "managed care plans") to be provided by a home health agency that meets the Federal Conditions of Participation (i.e., a Certified Home Health Agency (CHHA) or a Long Term Home Health Care Program (LTHHCP), rather than a Licensed Home Care Services Agency (LHCSA)). The impact of this policy, both in terms of cost and the ability of Medicaid beneficiaries to maintain relationships with existing caregivers is certain to be significant.

Currently, managed care plans arrange for the delivery of skilled home health services to their members in a variety of ways – some may contract directly with LHCSAs for both skilled and personal care services, some may contract only with CHHAs for skilled services and with LHCSAs for personal care services, and some may contract with CHHAs that subcontract with LHCSAs for certain skilled services, as well as for personal care services. Contractual arrangements between managed care plans and LHCSAs for skilled and unskilled home health services have been approved and even encouraged by DOH for many years.

Under the new policy, managed care plans would no longer be permitted to contract directly with LHCSAs for home health services. The scope of this prohibition remains unclear. At a minimum, managed care plans are now prohibited from contracting with LHCSAs for skilled home health services such as nursing and rehabilitation therapies. Since home health services are defined under federal regulations to include not only skilled nursing and rehabilitation therapies, but also *home health aide* services, the ability of managed care plans to contract with LHCSAs for paraprofessional and personal care services has been called into question. Further, the extent to which managed care plans may continue to contract with CHHAs that subcontract with LHCSAs to deliver home health services is also unclear.

An expansion in the use of CHHA services will drive higher costs for managed care plans and ultimately for the State. CHHAs are more expensive than LHCSAs because they are required by the Federal Conditions of Participation to conduct more frequent assessments than LHCSAs, and they must conduct not only the State-mandated UAS assessment, but also the Federally-required OASIS assessment. These assessments must be conducted by nurses and typically last at least an hour and often more than two hours. CHHAs are also required to provide more frequent nurse supervision of home health aides through visits to the patients' homes than are LHCSAs.

This policy will not only cost more money but will also disrupt established relationships between patients and their caregivers. Medicaid managed care beneficiaries who are currently receiving home health services through a contract with a LHCSA will be transitioned to a CHHA. In many, if not most cases, this will entail a change in the nurses, therapists and home health aides that serve those beneficiaries. This is likely to be extraordinarily distressing to the beneficiaries, as they typically develop longstanding and trusting relationships with their providers, and especially their home health aides. (In some, but not all cases, a single organization may operate both a CHHA and a LHCSA and may be able to shift staff between the two organizations in order to maintain continuity of care).

Recognizing the challenges associated with this new directive, the Executive Budget allocates $17 million in SFY 2014-15 to adjust managed care premiums to reflect the increased costs to plans of complying with this requirement. Given the current volume and expected growth of home care services furnished under managed care, it will be critically important to quantify accurately the added compliance costs and adjust managed care premiums appropriately to ensure that premiums are adequate to support the services Medicaid beneficiaries need to remain in the community.

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