

New York State Department of Health  
Office of Health Insurance Programs  
Division of Long Term Care

**LONG TERM HOME HEALTH  
CARE PROGRAM  
MEDICAID WAIVER**

**Program Manual**

Revised: 5/18/12



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# **Forward: Long Term Home Health Care Program (LTHHCP) Waiver Manual**

## **Program Manual – Purpose and Layout**

**This Long Term Home Health Care Program (LTHHCP) Reference Manual replaces the last version issued in June 2006.**

This Manual provides information for local departments of social services (LDSS) and provider agency staff specific to the LTHHCP 1915(c) Medicaid (MA) Home and Community Based Services waiver. The Manual supplements applicable State laws, regulations, and policy directives governing its implementation. Providers may also reference the eMedNY Provider Manual for Medicaid policies applicable to all enrolled MA providers, as well as claiming requirements for LTHHCP providers. To assure program quality and accountability, LDSS and service providers must comply with all the requirements set forth in these sources.

LTHHCP agencies may serve individuals who pay privately for the agencies' services including payments using the individual's third party insurance, such as Medicare. This Manual does not apply to these private pay individuals.

The Manual is available on the New York State Department of Health (NYSDOH) website at: [www.health.state.ny.us/facilities/long\\_term\\_care](http://www.health.state.ny.us/facilities/long_term_care). It is also available on the eMedNY website under Provider Manuals at: [www.emedny.org](http://www.emedny.org).

### **Accessing Information in the Manual**

Each section of the Manual provides detailed information about various aspects of the waiver, and is structured to begin with an overview of contents and end with a summary of key points, names of forms, and references to relevant MA policy statements and governing laws/regulations.

NOTE: Use of the term “applicant” or “participant” in this Manual also refers, if applicable, to a court appointed Legal Guardian or Committee, or other legal entity designated to act on behalf of the applicant/participant, unless specifically stated otherwise.

## What is New? – Programmatic Changes

- Reassessment timeframe is extended from every 120 days to 180 days
- Medical Social Services are enhanced to include Community Integration Services to provide supportive counseling for individuals adjusting to living in the community with a disability
- Home Modifications service renamed to Environmental Modifications and broadened to include vehicular modifications
- Assistive Technology added as a new waiver service incorporating the current Personal Emergency Response Services (PERS)
- Community Transitional Services (CTS) added as a new waiver for individuals transitioning from a nursing facility and needing assistance with first time moving expenses such as security deposits
- Home and Community Support Services added as a new waiver service to provide for the combination of personal care with oversight and supervision to support individuals with cognitive deficits
- Contingent on the Centers for Medicare and Medicaid Services (CMS) approval, Medicare/Medicaid dual eligible LTHHCP participants, age 21 and older in need of community based long term care for more than 120 days, are being transitioned into Managed Long Term Care (MLTC). There are three models of MLTC plans operating in New York State, including Partially Capitated Managed LTC, Program of All-Inclusive Care for the Elderly (PACE), or Medicaid Advantage Plus (MAP). Another option that will be available for participants, similar to a MLTC plan, will be plans approved to operate as a Care Coordination Model (CCM). Participants that are non-dual (Medicaid only) will also have the option of a mainstream Medicaid Managed Care organization (MCO).

As the time for transition approaches, LTHHCP participants will be notified that they must choose a MCO, a Managed Long Term Care Plan (MLTCP) or a Care Coordination Model (CCM). More information will be made available to address continuity of care as participants transition to MLTC.

Within the managed care environment, LTHHCP agencies will have the option to establish a corporate entity to apply to be a MLTCP or CCM or make contractual arrangements with MCOs, MLTCPs or CCMs to provide home care services.

Additional information is available on the Medicaid Reform website at:  
[http://www.health.ny.gov/health\\_care/medicaid/redesign](http://www.health.ny.gov/health_care/medicaid/redesign).

# Section I: Introduction Long Term Home Health Care Program (LTHHCP) Waiver

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## LTHHCP Waiver Overview

The Medicaid LTHHCP 1915 (c) Home and Community Based Services (HCBS) waiver provides a coordinated plan of care and services for individuals who would otherwise require nursing facility care. Also commonly referred to as the *Lombardi Program* or the *Nursing Home Without Walls* program, LTHHCP waiver services may be provided in a person's home, adult care facility (other than a shelter for adults), or in the home of a responsible adult. Initially authorized by the federal government in 1983, the waiver has been renewed six times, most recently for the period 9/1/10 to 8/31/15.

The LTHHCP waiver has three main goals:

- To prevent premature and/or unwanted institutionalization of individuals;
- To enable individuals living in nursing facilities to return to the community by providing MA funded supports and services that assist individuals with disabilities and seniors toward successful inclusion in the community when informal

supports, or other local, State and federally funded services and MA State Plan services are insufficient to assure the health and welfare of the individual in the community; and

- To prevent or reduce costs associated with unnecessary hospitalization and other costly health services, through coordinated access to case management, appropriate services, and ongoing monitoring of the participant's health status.

The LTHHCP waiver is available statewide, with the exception of the eight following New York counties: Livingston, Hamilton, Schoharie, Lewis, Essex, Chenango, Schuyler, and Wyoming Counties.

## **Role Of The New York State Department Of Health**

The Department is designated as the single State agency responsible for the administration of the MA program. Within NYSDOH, the Deputy Commissioner of the Office of Health Insurance Programs (OHIP) is the designated State Medicaid Director and has final authority with regard to administration of aspects of MA in New York State, including its waiver programs.

## **Role Of Local Department Of Social Services (LDSS)**

In New York State, the local departments of social services (LDSS) are charged with implementing the MA program, including the LTHHCP waiver. The respective roles and responsibilities of the State and the LDSS are established by the State Public Health Law Sections 201 and 206, Social Services Law §363-a, the Medicaid State Plan and, specific to the LTHHCP, Public Health Law §3616, Social Services Law §367-c, and §367-e and 18 NYCRR §505.21. In addition, NYS bulletins, specifically General Information System (GIS) messages and Administrative Directives (ADM), are issued and updated as needed to provide ongoing guidance regarding MA program administration, including eligibility determination, system management, provider reimbursement, monitoring and corrective actions.

## **Eligibility Requirements for the LTHHCP Waiver**

To be eligible for the LTHHCP waiver the individual must be financially eligible for MA, and programmatically eligible for the LTHHCP waiver, and a physician must determine whether the individual's health and safety needs may be met in the home. If the physician determines the individual cannot be safely cared for at home, the person may not be admitted to the waiver.

The individual must also require coordination of services, including assessment, coordination and monitoring of all services needed to support the individual in the community, provided through case management services of LLDS and LTHHCP staff.

Waiver participants must meet **all** of the following requirements:

1. be medically eligible for placement in a nursing facility as determined by the level of care form required by NYSDOH;
2. verify a preference to remain at home;
3. have an assessment to confirm that their needs can be met safely at home;
4. have physician verification they are able to remain at home;
5. have substantiation that they require case management provided by the waiver;
6. require at least one waiver service every 30 days in addition to case management;
7. verify that they have freely chosen the LTHHCP waiver over other available program and services options;
8. have Plan of Care costs that fall within the 75 percent budget cap for the approved level of care (except those designated as having special needs); and
9. have MA coverage that supports community based long-term care services.

NOTE: Per 11 OLTC/ADM-1 released April 26, 2011 and GIS 11 OLTC/008 released June 23, 2011, an individual must be in need of and in receipt of case management and at least one other waiver service every 30 days to participate in the waiver. LDSS and LTHHCP agency must take the necessary steps to find alternative care and dis-enroll individuals identified as not needing at least one waiver service every 30 days, from the LTHHCP waiver.

## **Budget Considerations: Expenditure Cap**

To be eligible for the LTHHCP waiver, a participant must be able to be served safely and effectively with a Plan of Care the cost of which falls within the seventy-five percent budget cap. The enabling legislation, Social Services Law §367-c, authorizes waiver services to be provided when the total monthly MA expenditures for health and medical services for an individual do not exceed seventy-five percent (75%) of the cost of care in either a skilled nursing facility (SNF) or a health-related facility (HRF) located within the local district. The State law authorizing the waiver continues to mandate two levels for this 75% budget cap, one for skilled nursing facilities and a second for "Health Related Facilities" (HRF). While HRF is no longer a distinct category of nursing facility for other purposes, the waiver continues to meet the requirement of the authorizing law by calculation of a proxy for the "HRF" lower level of need.

The county specific monthly budget cap for each level of care is computed by NYSDOH. The cost limit is calculated by NYSDOH using a uniform methodology applicable to each LDSS based on the average cost of nursing facility care in each county.

The costs of services may be averaged over twelve months to ensure the annual cost of care remains under the 75% cap. In effect, this permits the participant's monthly budget to be exceeded from time to time as long as the annual budget cap is not exceeded.

NOTE: The statutory reference to “intermediate care facility”, equated to “health related facility” at the time the law was written, should not be confused with the term “intermediate care facility for the developmentally disabled” (ICF/DD) still in use for facilities certified by the Office of Persons with Developmental Disabilities (OPWDD) for adults and children who have a developmental disability.

## **Exceptions To the 75% Expenditure Cap**

### **Individuals in Adult Care Facilities (ACF)**

The ACF has a responsibility to provide certain services, such as room and board, housekeeping, laundry and some personal care assistance, included in the cost of ACF residency. Therefore, for those individuals living in an adult care facility, expenditures cannot exceed fifty percent (50%) of the average cost of care in a nursing facility in the individual’s county of residence for his/her assessed intensity of resource need (HRF or SNF). The use of LTHHCP for residents of adult care facilities is discussed in Section VII, “The LTHHCP and Adult Care Facilities”.

### **Individuals with Special Needs**

NYS Social Services Law §367-c (3-a) was enacted to allow certain individuals with specific health care needs to exceed expenditure caps. Recent legislative changes removed the sunset date for the demonstration, continuing the special needs provisions affording budget flexibility up to one hundred percent (100%) of the average cost of nursing facility care in their county of residence for their assessed intensity of resource need (HRF or SNF).

NYS statute defines a person with special needs as an individual needing care including, but not limited to respiratory therapy, tube feeding, decubitus care, or insulin therapy which cannot be appropriately provided by a personal care aide or who has a mental disability (Section 1.03 of the NYS Mental Hygiene Law), acquired immune deficiency syndrome, or dementia including Alzheimer’s disease.

Local districts must limit special needs individuals to twenty-five percent of their total LTHHCP waiver capacity (with the exception of New York City, where only fifteen percent of capacity may be special needs individuals). Section 367-c provides that in the event that a district reaches their prospective percent limitation for special needs cases, the district may, upon approval of the commissioner, authorize payment for services for additional persons with special needs.

Per 11 OLTC/ADM-1 released April 26, 2011 and GIS 11 OLTC/008 released June 23, 2011, budgeting for the AHCP must follow the same rules as for other LTHHCP participants. Budgets for AHCP participants who entered the waiver prior to 9/1/10 must be reviewed against this new requirement at their next scheduled reassessment. If the participant’s budget cannot be maintained within the cap using the tools discussed in Section IV, “Budgeting for Participants”, the LDSS and LTHHCP agency must take



the necessary steps to arrange alternative care and disenroll the participant from the LTHHCP waiver.

## **Choice Of Home Community Based Services**

When individuals, their family and/or significant others approach the LDSS for long term care either directly or through referral, LDSS staff must provide objective information regarding available long term care options. LDSS staff must offer all waiver applicants a choice between institutional care and appropriate available community based services, including the choice of available waiver programs, Medicaid State Plan services, and providers of such programs/services as part of their participation in the Plan of Care development.

Individuals considered likely to need nursing facility care must be notified upon admission into a hospital of home and community based services available to them upon discharge.

## **Required LTHHCP Agency Services**

LTHHCP agencies must provide case management (included in the agency's administrative cost reimbursement). All participants must receive case management from the LTHHCP agency they have selected.

In addition to case management, the LTHHCP agency must furnish the following non-waiver, State Plan services:

Nursing	Medical Supplies and Equipment
Physical Therapy	Homemaking/Housekeeping
Occupational Therapy	Home Health Aide
Speech Therapy	Personal Care Aide
Audiology	

## **Other Waiver Services**

The LTHHCP agency is required to provide some services not normally covered for home care under MA, including these waiver services:

- Medical Social Services
- Nutritional Counseling/Education
- Respiratory Therapy

The LTHHCP agency may also provide other LTHHCP waiver services, some of which require prior authorization by the LDSS:

- Assistive Technology
- Community Transitional Services
- Congregate and Home Delivered Meals

- Environmental Modifications (E-mods)
- Home and Community Support Services (HCSS)
- Home Maintenance
- Moving Assistance
- Respite
- Social Day Care
- Social Day Care Transportation

LTHHCP agencies that do not directly provide optional waiver services through subcontractors must, as part of their case management responsibilities, work with an individual to identify how the participant's needs will be met and arrange appropriate alternate services.

## **Where Waiver Services Can Be Provided**

LTHHCP waiver services can be provided in the individual's home, in the home of a responsible adult, or in an adult care facility (ACF) other than a shelter for adults. By definition, certain waiver services, such as Respite or Social Day Care, may be provided outside of the home setting. Refer to Section III, "Waiver Services", for more specific information.

## **AIDS Home Care Program (AHCP)**

The AIDS Home Care Program (AHCP) was implemented in 1992 to meet the challenge of the high incidence of AIDS in New York State. Certain LTHHCP agencies are approved by the NYSDOH to provide the AIDS Home Care Program.

AHCP may serve persons medically eligible for placement in a nursing home and diagnosed by a physician as having AIDS, or are deemed by a physician, within his or her judgment, to be infected with the etiologic agent of AIDS, and who have an illness, infirmity or disability that can be reasonably ascertained to be associated with such infection.

AHCP agencies provide the full complement of health, social, and environmental services provided by all LTHHCP agencies, including case management and coordination of participant services. Because of the special needs of persons with AIDS or HIV-related illnesses, AHCP agencies are expected to coordinate care with other facilities and agencies conducting clinical trials for HIV therapies; arrange for substance abuse treatment services; and assure patient access to such services as pastoral care, mental health, dental care, and enhanced physician services.

LTHHCP/AHCP agencies are also responsible for providing or arranging training, counseling and support to staff caring for persons with AIDS or HIV-related illnesses and for the security of staff in order to fully serve patients.

AHCP participants will not be included in the approved client capacity (slots) of a sponsoring AHCP certified LTHHCP agency; however, AHCP census numbers must be reported to NYSDOH on the required annual census report. An LTHHCP agency that has not become a certified AHCP may serve individuals with AIDS; however, these participants/slots would be counted in the LTHHCP agency's capacity.

For persons requesting AHCP services in adult care facilities, the joint assessment by the AHCP and the LDSS must occur prior to the delivery of services. Unless otherwise noted, policies and procedures for individuals served by an AHCP under the LTHHCP waiver are the same as those for other LTHHCP applicants and participants.

## **Summary of Key Points**

1. The LTHHCP waiver uses case managed comprehensive home and community based services and supports to enable individuals, who would otherwise require nursing facility care to remain in their communities.
2. In addition to Case Management, LTHHCP agencies provide certain Medicaid State Plan and waiver services. (See page I-5)
3. The LTHHCP waiver serves individuals who are eligible for admission to a nursing facility and have needs that can be met within the applicable budget cap.
4. Individuals with one of the following conditions are identified as having special needs: mental disability, dementia, HIV/AIDS, or those in need of care including but not limited to: respiratory therapy, insulin therapy, tube feeding, or decubitus care that cannot be appropriately provided by a personal care aide.
5. The AIDS Home Care Program (AHCP) serves individuals with HIV/AIDS as a component of the LTHHCP waiver.

## **Associated Medicaid Policy Directives (Appendix C)**

- 78 ADM-70, *Implementation of Chapter 895 of the Laws of 1977: Long Term Home Health Care Program*, August 14, 1978
- 79 ADM-58, *Long Term Home Health Care Program Notification Requirements*, September 7, 1979
- 83 ADM-74, *Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program*, December 30, 1983
- 85 ADM-27, *Long Term Home Health Care Program: Federal Waivers Permitting Expanded Medicaid Home and Community-Based Services*, July 15, 1985
- 86 INF-26, *Chapter 629 and the Laws of 1986: Demonstration Program*, October 22, 1986

- 86 INF-47, *Licensure of Home Care Services Agencies and Certification of Home Health Agencies*, December 29, 1986
- 89 INF-20, *Long Term Home Health Care Program: Animalization of Service Costs*, April 6, 1989
- 91 LCM-198, *Use of Social Day Care in Long Term Home Health Care Programs*, November 4, 1991
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011
- GIS 11 OLTC/008, *Clarifications and Updates to Long Term Home Health Care Program (LTHHCP) 11OLTC/ADM-1*, June 22, 2011

### **Associated Laws and Regulations**

- Public Health Law §3602 (8) and (14), §3610
- Social Services Law §367-c, §367-e
- 18 NYCRR §505.21
- 10 NYCRR Parts 761, 762 and 763

# Section II: Becoming a Waiver Participant: Program Referral, Eligibility and Assessment

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## **Referrals and Initial Intake**

Local districts are responsible for ensuring that their staff and local health, social, and community services professionals are aware of the LTHHCP waiver as one of the New York State MA Program options for community based care. Initial referrals to the waiver may come from many sources, with these being the most common:

- Providers
- Individuals, family members, or someone who speaks on their behalf
- Physicians
- Discharge planners in hospitals and nursing facilities
- LDSS representatives

The Long Term Home Health Care Program checklist has been designed to serve as documentation that individuals have been informed of LTHHCP services, and to collect certain data about why patients reject, or physicians deem individuals inappropriate for LTHHCP services. The checklist appears in two forms: the LDSS-3057 for the institutionalized individual and the LDSS-3058 for the individual at home who enrolls in the LTHHCP. (See appendix B for copies of the two forms)

As required by NYS law authorizing the waiver, if an individual of any age is potentially eligible for a nursing facility level of care and a LTHHCP agency serves the county in which the individual resides, the individual or his/her representative must be made aware in writing that LTHHCP waiver services are an available option. LTHHCP agencies differ with respect to the range of waiver services they provide. Therefore, if more than one agency is available to serve the individual, the differences must be explained.

To provide the written notification, LDSS staff must give the *LTHHCP Consumer Information Booklet* to all individuals, family, or significant others inquiring about or applying for nursing facility placement, community based services, or upon application for the waiver program. The *Booklet* provides information about the waiver and available waiver services, a Freedom of Choice form, the Home Health Hot Line phone number and other important contact information for waiver participants. The Booklet is included in this Manual, Appendix C, and is available on the NYSDOH website at [www.health.state.ny.us/facilities/long\\_term\\_care](http://www.health.state.ny.us/facilities/long_term_care).

LDSS staff must coordinate their efforts with hospital or nursing facility discharge planners within their districts to assure timely information about the LTHHCP is provided to patients and their families as early after admission as feasible if it is anticipated that nursing facility level of care may be needed on a long term basis after discharge. Information for a patient's family is especially important when the patient's condition is such that s/he is unable to participate fully in planning for their own ongoing long term care.

The LTHHCP Freedom of Choice form, included in the *Booklet*, has been designed to serve as documentation that patients have been informed of LTHHCP services, and to collect certain data about why patients reject application to the program or why physicians deem patients inappropriate for LTHHCP services.

## **Assessment**

An important feature of the LTHHCP waiver is the comprehensive and coordinated assessment/reassessment process that leads to the formulation of a summary of the individual's required services and development of a Plan of Care (POC). This process is critical to assuring the individual meets the federal nursing facility level of care requirement for waiver participation (i.e., that s/he is medically eligible for nursing facility care), and the POC provides for his/her health and welfare. The process provides the LDSS with information needed to authorize an individual's waiver participation.

The assessment by the LDSS and LTHHCP agency staff must involve as appropriate:

- the applicant;
- applicant's family or legally designated representative; and/or
- other individuals of the applicant's choice.

As part of the process to assess the individual's strengths and needs, their service preferences and desired outcome/goals must be identified. There must also be a discussion of related risks of community care and agreement as to how to lower risk or determine applicant's willingness to assume the risk(s).

Two tools are used in the comprehensive assessment process:

1. *New York State Long Term Placement Medical Assessment Abstract (DMS-1)*
2. *Home Assessment Abstract (HAA)*

NOTE: Local revision or use of alternate tools is permitted only with DOH approval.

## **The Physician's Role**

To comply with federal and State regulations (18 NYCRR § 505.21[b] [2]) and 42 CFR §484.18) and assure the POC reflects the physician's evaluation of the patient's immediate and long term needs, the participant's physician must be involved in the assessment/reassessments and the development of both the initial Plan and those for each reauthorization period. In this regard, the importance of the physician's understanding of how the LTHHCP waiver functions, including its capabilities and limitations, cannot be overemphasized.

A physician's order is not required for the LTHHCP agency initial level of care assessment, the first step in determining program eligibility for the waiver; accordingly, the DMS-1 and pediatric assessment may be completed before the agency obtains an order.

A physician's order is, however, required when an assessment is being done to develop the POC, including the HAA or federal OASIS required of Certified Home Health Agencies (CHHA). For preparation of the HAA, the physician orders may be "initial" reflecting a general request that the applicant be assessed for a POC under the waiver, or indicate specific services that are needed immediately by the applicant, such as nursing or therapy visits, rather than the waiver services which can require longer time frames to arrange such as the addition of a ramp to the home.

Once the POC is developed, the physician's signature on the POC becomes the sustaining physician's order applicable to the POC and required for an applicant approved to begin waiver participation.

Once an individual has been approved for waiver participation by the LDSS, the physician must renew all medical orders every 60 days in accordance with federal rules for home health agencies. As required by waiver rules, s/he must also verify the individual's continued ability to be cared for at home and must approve of any change in the Summary of Service Requirements arising from changes in the individual's health status as part of the waiver's 180 day reassessment process.

If the responsible physician determines that the individual's health and safety needs cannot be met in a home or community based setting, the individual shall be deemed ineligible for care under the program.

## **Uniform Assessment Tool (UAS-NY)**

As part of the NYS Medicaid Redesign effort, a new uniform assessment system (UAS-NY) will be established for MA home and community-based programs and services. The goal is to consistently evaluate an individual's functional status, strengths, care needs and preferences to guide the development of individualized long term care service plans to ensure that individuals receive needed care, within the setting and in a timeframe appropriate to their needs and wellbeing, as well as to maximize efficiency and minimize duplication through automation.

NYSDOH has selected the interRAI Suite of assessment instruments currently used in many other states, as a basis of the assessment tool. The UAS tool is currently in a development phase and when implemented will be used for all long term care MA applicants, including adults, children, and waiver participants. NYSDOH will provide information and training in use of the UAS prior to the pilot program and subsequent implementation.

Questions regarding the new UAS may be sent to [UASNY@health.state.ny.us](mailto:UASNY@health.state.ny.us).



## **New York State Long Term Care Placement Form - Medical Assessment Abstract (DMS-1)**

Pending statewide implementation of the new UAS process, LTHHCP applicants and participants will continue to be assessed using the DMS-1 form.

### **Reviewer's Role**

A registered nurse (RN), or physician, must complete the DMS-1 to evaluate an individual's current medical condition. Using this form, the nurse assesses and records the individual's current medical status, nursing care needs, incontinence (level of urinary and bowel function), functional status, mental status impairments, and rehabilitation therapy needs.

The initial assessment may occur in the individual's home, the home of a responsible relative or friend with whom the individual is living, or a hospital or nursing facility if the individual is a patient in one of those settings. The assessment may be completed by a nurse representative of a LTHHCP agency or a nurse from the hospital/nursing facility; the LDSS also has the option to request that a nurse from a CHHA complete this initial medical assessment instead of a prospective LTHHCP agency.

Note: The hospital or nursing facility discharge planner may complete the DMS-1 using data from the individual's medical chart in consultation with the physician and nursing staff.

### **DMS-1 Predictor Score Function**

The score on the completed DMS-1 is used to determine if an individual meets the LTHHCP waiver nursing facility level of care requirement.

The *New York State Health Department numerical Standards Master sheet* is used as the numerical standard scoring mechanism for determining predictor scores. A DMS-1 score of 60 or greater indicates an individual is nursing facility level of care eligible. Therefore, a minimum DMS-1 score of 60 is required for LTHHCP waiver programmatic eligibility. An indicator score of 60-179 equates to a proxy calculation for the lower level of resource intensity historically referred to as Health Related Facility (HRF) and still referenced in the authorizing rules of the LTHHCP waiver. A score greater than 180 indicates the higher level of resource intensity referred to as Skilled Nursing Facility (SNF) level of care.

In addition to establishing the level of resource intensity for which the individual is eligible, HRF or SNF, the score is also used to assign the monthly expenditure cap associated with reference levels of HRF or SNF. The monthly MA dollar expenditure cap is based on 75 percent of the local cost of HRF or SNF care, although certain

exceptions apply to the 75 percent cap. This cost control mechanism provides cost neutrality assurance to the federal government and is in accordance with State statutory authority for the LTHHCP waiver.

LDSS staff must review 100 percent of all DMS-1 and pediatric assessment forms submitted for applicants/participants. If there appears to be discrepancies in documentation or scoring, LDSS staff must confer with the LTHHCP agency to discuss and resolve all identified issues. If agreement is not reached, the LDSS local professional director must review the case and make the final decision regarding the issue. NYSDOH waiver management staff will provide technical assistance as needed and review the DMS-1 or pediatric assessment upon request by either party to assist in resolving disagreements.

### **Physician Override of the DMS-1 Score**

When the individual's predictor score does not reflect the person's true medical or functional status with regard to the required level of care a physician override may be used. For example:

- a patient with a low predictor score (below 60) may require nursing facility care due to emotional instability or safety factors; or
- an individual may score HRF level (60-179) but be more appropriate for SNF level (180+) based on increased care needs.

For an individual to be LTHHCP waiver eligible in either circumstance, the individual's physician or the local professional director must provide a written override including justification, after the DMS-1 assessment has been conducted. The written justification must include, but is not limited to, the medical, psychosocial, and/or rehabilitative needs that would otherwise require an individual to be institutionalized if it were not for available waiver services or would require institutionalization at the higher level of resource need (SNF). For subsequent reassessments, the POC must include a statement that the physician override justification of a specified date, previously signed and on file in the case record, remains in effect.

## Illustration II-1 Sample Physician Override (Local Form)

Date: July 31, 2005  
To: Dr. Alan Horowitz  
From: Ames County LTHHCP  
Subject: Ms. Emily Brown

Your patient's DMS-1 predictor score is 47 and does not adequately reflect the higher level of care that is needed to maintain him or her safely at home. A score of 60-179 indicates a Health Related Facility level and 180+ indicates a Skilled Nursing Facility level.

I have attached the DMS-1 form for your review and request you certify that a higher level of care is needed because of the following assessments:

Medical: Ms. Brown has multiple health problems that need close monitoring. These include peptic ulcer, hypertension, diverticulitis, and depression. She is elderly and in fragile condition.

Psychosocial: Ms. Brown has no family members able to provide support. A social day care program could help her overcome her social isolation and prevent additional regression.

Rehabilitation:

Other:

I certify that this patient warrants a nursing facility level of care because of the above stated reasons.

<u>Dr. Alan Horowitz</u>	<u>Dr. A. Horowitz</u>	<u>August 5, 2005</u>	<u>License #</u>
Physician's name (please print)	Signature	Date	<u>xxxxxx</u>

## Home Assessment Abstract (LDSS-3139)

The *Home Assessment Abstract* (HAA or LDSS-3139) is the tool used to determine whether the individual's total health and social care needs can be met in the home environment and, if so, how that can be accomplished. The HAA concludes with the Summary of Service Requirements that includes a prospective monthly budget based on the assessment findings. The HAA form and complete instructions are included in Appendix B.

The home assessment is scheduled in the individual's home after the:

- applicant (and/or his/her family or chosen representative) has indicated a desire to use the waiver to remain at home;
- physician has concurred that home care is appropriate for the individual;
- completed DMS-1 (or other NYSDOH authorized assessment tool) indicates a need for SNF/HRF level of care; and
- LDSS has authorized the initiation of the home assessment.

The assessment is to be a collaborative effort between the LTHHCP agency, to be providing services to the individual, and the LDSS. While there are benefits to scheduling the assessment visits so the nurse and LDSS representative visit the applicant/participant at the same time, this is not always possible. In such cases, the nurse and representative must consult closely on their findings to complete the HAA.

One of these parties may have had prior contact with the individual and, therefore, best situated to facilitate the assessment process. In addition, the hospital discharge planner will often be able to provide valuable input in the assessment process and in developing the summary of services required by the individual.

The timing of the LDSS and LTHHCP agency's actions during the waiver assessment process are specified by MA waiver rules and federal Medicare Conditions of Participation, NYSDOH rules governing Certified Home Health Agency (CHHA) and LTHHCP agencies, and physician's orders.

Some of the key timing requirements imposed by federal and State rules on LTHHCP agencies include:

- Unless the physician's order designates an alternate time frame, the LTHHCP agency must have a first visit with the applicant within 24 hours of the physician's order;
- The LTHHCP initial medical assessment is required before the start of care;

- The LTHHCP comprehensive assessment (including the Outcome Assessment and Information Set) must be completed within five (5) days after the start of care date; and
- The LTHHCP agency must complete the POC within 10 days after the start of care.

## **Summary of Service Requirements**

When the needs assessment of the individual is completed, the Summary of Service Requirements must be developed by the LTHHCP agency and LDSS. The Summary is a list of the types of services, and the required frequency and amounts of such services necessary to maintain the individual at home, in accordance with the physician's orders and the joint assessment. While it projects the associated costs for all the services to be delivered to the individual, it also indicates the payer source, since only those paid by MA are compared to the individual's budget cap. (See Section IV "Budgeting for Participants" for further information on costs to be included in calculation of the budget and certain incidental items not calculated in the budget.)

## **Budget Review and LDSS Authorization**

Following the development of the Summary of Service Requirements, the LDSS representative computes the projected monthly cost of care and compares it to the budget cap allowed for a particular individual. For more information, see Section IV, "Budgeting for Participants", which reviews budgetary tools and requirements in detail.

If the costs of care fit within the approved budget cap, and the services noted in the Summary of Service Requirements support the individual's needs, goals, health and welfare, the LDSS:

- authorizes the individual's waiver participation;
- notifies the LTHHCP agency to begin providing care;
- issues the "Notice of Decision" regarding approved waiver participation; and
- enrolls the individual in LTHHCP by placing the recipient restriction/exception (R/E) code 30 on the individual's WMS file.

If the budget determination indicates the cost of care would exceed the individual's approved annual budget cap, and/or if services cannot be arranged to meet the individual's needs to assure health and safety, LDSS staff cannot authorize waiver participation. In such cases, they must assure the individual is referred to other appropriate community based or institutional resources such as Personal Care Service (PCS), CHHA programs, other HCBS waivers, or a managed long term care plan.

When an applicant cannot be enrolled in the LTHHCP, LDSS staff must issue the “Notice of Decision” form regarding denial for waiver participation, and inform the applicant of his or her right to request a fair hearing to challenge the denial. For more information on fair hearing requirements, see Section VIII, “Fair Hearings”.

## **Plan of Care**

The Plan of Care (POC) is a clinical document describing the care to be given to the individual, developed from the assessment information. The POC becomes part of each individual’s comprehensive case record maintained by the LDSS and in the LTHHCP agency’s comprehensive records for the individual. This requirement is in accordance with federal and State requirements for CHHA agencies, e.g., the Medicare Conditions of Participation.

The goal of a POC is to increase the waiver participant’s independence, functional abilities, and community integration with assurance of the health and welfare of the waiver participant. Identification of the participant’s strengths, abilities, and preferences are the starting point for its development. The POC includes a complete description of the range of services, including waiver/non-waiver services, as well as, informal supports necessary to allow the individual to remain in his/her community, and addresses the individual’s health, welfare and personal goals. The POC must clearly state responsibility for each of the services and supports identified in the participant’s assessment.

## **LTHHCP Agency**

The LTHHCP agency RN must develop the POC using the Summary of Service Requirements and other information gathered during the assessment process. The POC includes specific goals and objectives for the individual and outlines the methodology and procedures that will be employed to reach those goals. It must be signed by the applicant/participant’s physician and implemented by the LTHHCP agency nurse who is responsible for coordinating both waiver and other services included in the POC.

The LTHHCP agency RN and therapist or other professionals also must perform a comprehensive assessment that involves both observation and interview. This comprehensive assessment must be conducted in accordance with federal and State rules applicable to CHHA and must take into account the participant’s preferences, desired outcome and goals and related risks, with the assurance of his/her health and welfare. Federal regulations mandate that:

- clients are accepted for treatment on the basis of a reasonable expectation that their medical, nursing, and social needs can be met adequately by the LTHHCP agency;

- the POC covers all pertinent diagnoses, including mental status, type of services and equipment, required frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for a timely discharge or referral, and any other appropriate items.

By incorporating the participation of applicants/participants, family members and/or designated others in POC development, the case manager can help assure identification of realistic strategies that will mitigate foreseeable risk with consideration of the individual's unique desires and goals.

Risk factors and safety considerations must be identified by the LTHHCP RN case manager during POC development. Back up arrangements must be included in the POC. Such arrangements may include availability and use of family members or other informal supports (e.g., neighbors, friends or designee of the participant's choice) to assist with such things as ADL, medication management or other interventions directly related to health and safety.

The LTHHCP agency must give a summary of the POC to the individual and/or responsible family member/designated other so they are aware of services being provided and the proposed budget. The LTHHCP must also provide a physician signed copy of the completed POC to the LDSS for retention in the case record.

## **LDSS Responsibilities**

The LDSS staff plays an integral part in POC development and assuring the individual's assessed needs are met. To monitor service delivery and ensure all needs are met, LDSS staff reviews the:

- individual's POC signed by the physician;
- Summary of Service Requirements form; and
- the claim detail reports of services rendered.

Since waiver participation can be authorized by LDSS staff only if the POC supports the individual's health and welfare, LDSS staff must identify all unmet needs. If potential unmet needs are identified, the LDSS staff must contact the LTHHCP agency for discussion and resolution.

If the LDSS staff does not agree with the proposed POC for the individual, they must advocate for the individual with the LTHHCP agency and the physician, when needed, to adjust the services to meet the individual's needs.

## Plan of Care Review and Reassessment

POC review and reassessments must be conducted consistent with both federal and State CHHA requirements and MA waiver requirements. Therefore, the POC must be reevaluated and revised as necessary at least every 60 days by the LTHHCP agency. Each review must be documented in the clinical record, and the POC must be signed by the physician and implemented as physician orders.

In addition, at least once every 180 days, a reassessment of the participant must be conducted by the LTHHCP agency RN and the LDSS staff to verify the participant's eligibility for the LTHHCP waiver program and determine whether the participant's POC needs to be modified based upon the results of the reassessment of the participant's condition.

Refer to the Reassessment subsection of this Section for further information on the 180 day reassessment process.

## Alternate Entry

Occasionally, a MA recipient requires services before the LDSS has all the information it needs to make a decision about the individual's participation in the LTHHCP waiver (e.g., a patient able to be discharged home from the hospital or nursing home, or a patient in community in need of immediate service). This can include but is not limited to the case when the individual's physician has ordered the LTHHCP agency to initiate immediate services and the agency must act promptly before the comprehensive assessment with LDSS can be arranged.

To allow for expedited enrollment in the LTHHCP, State legislation allows the LTHHCP agency to admit an individual following the completion of an initial assessment. The federal renewal of the waiver in 2010 supports the continuation of this "Alternate Entry."

When an individual is being considered for Alternate Entry:

- LTHHCP agency must inform potential participants of all long term care options, including use of general Medicare or MA home care services, other HCBS waivers, and Managed Long Term Care.
- LTHHCP agency must provide the potential participant with a copy of the *Consumer Information Booklet* and its attachments. (Manual, Appendix C, and NYSDOH website at [www.health.state.ny.us/facilities/long\\_term\\_care](http://www.health.state.ny.us/facilities/long_term_care))
- Freedom of Choice form must be signed by the potential participant and the LTHHCP agency representative to document the applicant's exercise of choice of waiver program and provider agencies.



The LTHHCP agency must perform the initial assessment based on the physician's orders, and develop a proposed Summary of Service Requirements. After development of the proposed Summary and approval by the physician, the LTHHCP agency must estimate whether the cost of care will be within the appropriate budget cap as determined by the assessment score.

Following the budget determination and subsequent determination that the individual is potentially a suitable waiver candidate, the LTHHCP agency may decide to initiate services prior to LDSS authorization.

Within 30 calendar days after such initiation of services, the LDSS must complete the waiver eligibility determination, based on a joint LDSS/LTHHCP assessment, including service requirements, budget determination, and POC, and notify the LTHHCP agency of its decision.

In order that the LDSS can fulfill its responsibilities, the cooperation of all parties is essential. For example, a timely decision by the LDSS depends upon its ability to schedule the home assessment with the applicant and obtain complete information in a timely manner from the LTHHCP agency. For these reasons, the LTHHCP agency must notify the LDSS about the individual as soon as it opens the case to service.

The LTHHCP agency may initially notify the LDSS by telephone, but must follow-up in writing with the following information and forms:

- Individual's identification data (name, address, Social Security number, MA number, and Medicare eligibility information)
- Referral source
- Completed *Home Assessment Abstract* (Section of the HAA usually completed by the LDSS is completed by the LTHHCP RN and reviewed for accuracy by LDSS during subsequent home visit)
- Scored DMS-1 Form, pediatric assessment, or other assessment tool designated by NYSDOH
- Physician's Orders; and
- Summary of Service Requirements and LTHHCP budget determinations

The following rules apply to billing for services in Alternate Entry situations:

- The LDSS is **not** required to approve all the services initiated by the LTHHCP agency or to authorize waiver participation for the individual.
- The LTHHCP agency is financially responsible for any provided service not included in the final POC agreed upon with the LDSS, and for all services provided to individuals that the LDSS finds ineligible for the waiver.

- The LTHHCP agency may **not** seek recovery of costs from the individual.
- If granted, LDSS authorization will be retroactive to the start of service if the individual is financially eligible for MA and programmatically eligible for the waiver.
- The LTHHCP agency must **not** bill MA until the LDSS has issued its decision with regard to participant eligibility. However, it should bill Medicare for any of the home health services for which Medicare coverage is available.
- If the LDSS does not complete the applicant's assessment within thirty (30) days of the LTHHCP agency assessment and subsequently determines the individual is ineligible for the LTHHCP waiver, the LTHHCP agency will be financially responsible only for the non-authorized services provided during the 30 day period. The agency may bill MA for services provided from the 31<sup>st</sup> day through the date the LDSS notifies the individual of his/her ineligibility for LTHHCP participation. The LDSS will also inform the LTHHCP that the individual has been determined ineligible for the program.

## **Prohibition of Alternate Entry to ACF Residents**

The alternate entry provision does not apply to the Adult Care Facility (ACF) population. The LTHHCP provider cannot initiate services to ACF residents prior to the completion of the joint assessment and authorization of the services by the LDSS. (See Section VII, "LTHHCP and Adult Care Facilities", for a full explanation of the role of the LTHHCP in ACF.)

## **Waiver Participant Rights and Responsibilities**

Every waiver participant has certain rights, and must agree to accept certain responsibilities related to their services.

As required by State regulation (10 NYCRR Part 763.2), when an individual is accepted into the waiver as a participant s/he is also given a copy of the "Bill of Patient Rights" by the LTHHCP agency. The applicant must be given a statement of the services available from the LTHHCP agency; related charges if any; the right to participate in planning care and treatment; and information on all services in the POC, including when and how services will be provided and by whom. The clinical record must document the participant has received the bill of rights and that the participant is in agreement with the POC as verified by his/her signature. A copy of this verification is forwarded to the local district along with the POC signed by the physician.

## **Differences of Opinion and Dispute Resolution**

If differences of opinion exist regarding whether an individual should be admitted to the LTHHCP waiver or about the kind or amount of service(s) to be provided to the individual, or if problems in implementing the POC are anticipated, the following appeal process must be followed:

- The LDSS representative and the LTHHCP agency representative meet to discuss the issues and concerns. At this time, all relevant documentation with regard to the case should be reviewed to determine how to best support the individual's POC.
- If no resolution is reached, the case is referred to the local professional director or physician designee for review and resolution. In such instances, the referring party is obligated to notify the other that the local professional director has been contacted. An opportunity must be afforded to supply additional documentation as needed.
- The local professional director makes the final decision regarding the issue(s) involved. Appropriate notification will be sent to the individual as indicated (including LTHHCP authorization, reauthorization, denial, or discontinuance).
- NYSDOH waiver management staff provides technical assistance as needed and reviews proposed Plans of Care upon request.

If there is disagreement about the decision, the affected individual(s) is entitled to request a Fair Hearing to appeal the LDSS decision that denies, reduces or discontinues LTHHCP services. (See Section VIII, "Fair Hearings", for additional information about the Fair Hearing process.)

## **Reassessment**

A complete reassessment, including complete re-evaluation of the participant's current health, medical, nursing, social, environmental, and rehabilitative needs, must be conducted no later than 180 days from the individual's previous assessment. No single authorization for LTHHCP participation may exceed 180 days.

LDSS and LTHHCP agency staff must use due diligence to complete the tasks necessary to meet the 180 reassessment cycle in a timely manner. Any delay in completing the reassessment within 180 days must be documented by both parties, with a notation of the corrective action(s) that will be taken to complete the reassessment as quickly as possible and avoid a repetition of delays for the next cycle. While necessary services from the existing POC can be maintained should an unavoidable delay occur, the LTHHCP agency must not provide for any new services until the reassessment process is completed and such services are approved for inclusion in the new POC.

Note: The physician must verify the continued ability of the individual to be cared for at home and must approve of any change in the Summary of Service Requirements arising from changes in the individual's health status. If the individual's level of care was determined based on a Physician Override, the physician must state whether the override is still appropriate.

If it is determined, at the time of reassessment, that the waiver is no longer the most appropriate program for the individual, the LDSS and LTHHCP team must make appropriate and timely discharge plans.

## **Summary of Key Points**

1. An assessment/reassessment process is required in the LTHHCP waiver, with a representative of the LTHHCP agency and a representative of the LDSS, completing the process together. The assessment must involve, as appropriate, the applicant, the applicant's family, others chosen by the applicant and any legally designated representative(s). A complete reassessment is required at least every 180 days.
2. In addition to the physician's orders, two tools are currently available for use in the assessment processes:
  - New York State Long Term Care Placement Form Medical Abstract (DMS-1) which is completed and signed by the LTHHCP agency RN
  - Home Assessment Abstract (HAA), jointly completed by LDSS and LTHHCP staff, and includes three assessment components: Home Environment, Psychosocial, and Support Systems
3. The assessments result in the development of these three key documents:
  - Summary of Service Requirements (a component of the HAA)
  - Projected Monthly Budget
  - Plan of Care
4. Every waiver participant has certain rights, and must agree to certain responsibilities.

The roles of the LDSS, LTHHCP, and physician involved in the assessment are shown in Table II-1 Assessment Roles of the LTHHCP Team. (See next page)

**Table II-1 Key Assessment Roles of the LTHHCP Team**

<b>Roles in Team:</b>	<b>Physician</b>	<b>Discharge Planner</b>	<b>LDSS Representative</b>	<b>LTHHCP Representative</b>
Notify individuals and family of service and LTHHCP options	NA	Gives written or verbal notification if discharge to community is planned	Gives verbal and written information about the LTHHCP and other options available	Gives verbal and written notification to LDSS in cases of Alternate Entry
Medical Assessment	<ul style="list-style-type: none"> <li>Indicates if individual is appropriate for waiver and deemed safe to be cared for at home</li> <li>Writes orders</li> <li>May complete assessment</li> <li>Assists in reassessment (every 180 days)</li> </ul>	Contacts LTHHCP agency and arranges for screening (DMS-1)	<ul style="list-style-type: none"> <li>Assures the DMS-1 is complete and accurate</li> <li>Participates in reassessment (every 180 days)</li> </ul>	<ul style="list-style-type: none"> <li>Completes the DMS-1, if another appropriate party has not</li> <li>Makes sure physician's orders are carried out and renewed every 60 days</li> <li>Participates in reassessment (every 180 days)</li> </ul>
Home Assessment Abstract (HAA)	NA	Collaborates with RN from LTHHCP and LDSS representative	<ul style="list-style-type: none"> <li>Provides input on social/environmental needs</li> <li>Completes HAA</li> <li>Participates in reassessment (every 180 days)</li> </ul>	<ul style="list-style-type: none"> <li>Collaborates with LDSS representative in completing HAA</li> <li>Participates in reassessment (every 180 days)</li> </ul>
Summary of Service Requirements	NA	NA	Collaborates with the RN in developing the Summary	Collaborates with the LDSS in developing the Summary
Medicaid (MA) and Waiver Budgeting	NA	NA	<ul style="list-style-type: none"> <li>Assures that MA financial eligibility is determined</li> <li>Prepares monthly and annual budget to ensure the individual's care fits under his/her budget cap</li> <li>Computes, authorizes and tracks any accrued paper credits</li> </ul>	May prepare preliminary budget at initial assessment in an Alternate Entry case
Plan of Care (POC)	<ul style="list-style-type: none"> <li>Provides written orders to authorize delivery of health services; must be signed within 30 days of service start-up</li> <li>Renews medical orders every 60 days</li> </ul>	NA	<ul style="list-style-type: none"> <li>Reviews POC signed by physician to monitor service delivery and ensure all needs are met</li> <li>If potential unmet needs are identified, must contact the LTHHCP agency for discussion and resolution.</li> <li>Authorizes waiver participation only when services support the individual's health and welfare</li> <li>Encourages and obtains individual's and family input, as well as that of others chosen by the applicant or participant</li> <li>Advocates for individual with the LTHHCP agency and physician when needed to ensure services meet identified needs</li> </ul>	<ul style="list-style-type: none"> <li>Establishes goals for the individual and identifies methods for achieving these goals</li> <li>Coordinates personal care and other therapeutic and supportive modalities (including waiver services)</li> <li>Updates goals every 180 days (and whenever indicated)</li> <li>Makes the nursing POC available to all providers of services and the individual</li> <li>Encourages and obtains applicant/participant and family input, as well as that of others chosen by the applicant/participant</li> <li>Keeps LDSS aware of changes in service needs and level of care</li> </ul>
Case Management	NA	NA	<ul style="list-style-type: none"> <li>Collaborates with the LTHHCP agency to ensure case management</li> <li>Has general case management responsibilities [505.21(b)(7)]</li> </ul>	<ul style="list-style-type: none"> <li>Maintains overall responsibility for case management</li> <li>Collaborates with the LDSS representative to ensure coordination of care</li> </ul>

## **Associated Forms (Appendix B)**

- Long Term Home Health Care Program Checklist LDSS-3057 – Institutionalized Patient
- Long Term Home Health Care Program Checklist LDSS-3058 - Patient At Home
- NYS Long Term Care Placement Form Medical Assessment Abstract (DMS-1)
- New York State Health Department Numerical Standards Master Sheet
- New York State Department of Health Guidelines for Completing the Long Term Home Health Care Placement Form, Medical Assessment Abstract (DMS-1)
- Physician Override Sample Form
- Department of Health Office of Health System Management Home Assessment Abstract (HHA) LDSS-3139
- OHSM Instructions for Completing the HAA

## **Associated Medicaid Policy Directives (Appendix C)**

- 78-ADM-70, *Implementation of Chapter 895 of the Laws of 1977: Long Term Home Health Care Program*, Aug. 14, 1978
- 83 ADM-74, *Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980*, December 30, 1983
- 90 ADM-25, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in the Adult Care Facilities*, August 24, 1990
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011
- GIS 11 OLTC/008, *Clarifications and Updates to Long Term Home Health Care Program (LTHHCP) 11OLTC/ADM-1*, June 22, 2011

## **Associated Laws and Regulations**

- Public Health Law §3616
- 18 NYCRR §505.21
- 10 NYCRR §763.5
- Social Services Law §367-c

# Section III: Waiver Services

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## Waiver Services

Participants in the waiver are eligible to receive one or more of the waiver services developed to assure health and welfare and provide support for community living. The 2011 waiver renewal requires that an individual must be in need of and in receipt of at least one waiver service to participate in the waiver. For purposes of this requirement, case management does not count as the one service, because it is an administrative function of the LTHHCP agency and not a discrete billable waiver service.

It is important to keep in mind that the definitions provided in this section should be read with the understanding that not all specific covered tasks and services are included in the descriptions, and that the examples provided here should be read as broad general guidelines for service rather than as an all-inclusive list. A local district may decide, for example, that a certain task/item not listed here can be reasonably covered under the definition of a particular waiver service if it will enable the individual to remain in the

community and/or function independently in the home. This requires, however, a careful analysis of the individual's overall circumstances and Plan of Care, including:

1. alternatives for achieving the needed outcome;
2. cost-effectiveness of the requested task/item; and
3. need to avoid duplication with other services.

## **Basic Service Standards**

The following standards apply to the services defined below and are considered basic standards for the development, implementation and provision of these services:

- The LTHHCP participant, responsible family, landlord or home owner, third-party payers or other financially and/or legally responsible sources will be considered for financial liability prior to the provision and/or payment under MA of the services defined.
- Services will be provided in the least expensive, safest and most appropriate manner to maximize both the individual's ability to function as independently as possible and to reduce the risk of institutionalization.
- Services cannot be provided for the general utility of the household or home.
- DOH Health regulations regarding provider responsibilities for services specify that LTHHCP agencies will be responsible for the safety, quality, reliability and appropriateness of all services described.
- For services provided in a clinical facility or agency dwellings (social day care, respite, congregate meals), all buildings, premises and equipment shall be maintained in good state of repair and sanitation and shall conform to all applicable laws, ordinances and to the rules and regulations of all local authorities relative to the provision of services such as safety, fire, health, sanitation, and occupancy.
- Services shall be provided only by appropriately insured, certified, registered licensed or otherwise regulated individuals, agencies or facilities.
- All other local, state and federal regulations relating to the usual provision of any or all services described, unless otherwise noted, remain in effect under the waiver.

## **Required Waiver Services**

There are three waiver services that every LTHHCP provider must offer:

**Medical Social Services** is the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments



to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to home visits to the individual, family or both; visits preparatory to the transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services. The service may also assist waiver participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability, integrating into the community, and on-going life in the community.

Provider qualifications: Medical social services must be provided by a qualified social worker, a person licensed by the Education Department to practice social work in the State of New York. The social worker can be either an employee of or a contractor of a LTHHCP agency. When employed by a LTHHCP agency, a social worker must have had one year prior social work experience in a health care setting. [10 NYCRR § 700.2(b)(24)]

Note: Medical Social Services has been a waiver service in the LTHHCP since its initial approval in 1983. The service definition was updated in the 2010 renewal of the waiver to broaden the service to reflect current approaches to community living and, thereby, improve participant satisfaction.

**Nutritional Counseling/Education Services** includes the assessment of nutritional needs and food patterns, or the planning for the provision of food and drink appropriate for the conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs. Services may include:

- Assessment of nutritional status and food preferences;
- Planning for provision of appropriate dietary intake within the individual's home environment and cultural considerations;
- Nutritional education regarding therapeutic diets;
- Development of a nutritional treatment plan;
- Regular evaluation and revision of the nutritional plan;
- Provision of in-service education to health agency staff;
- Provision of consultation with regard to specific dietary problems; and
- Provision of nutrition education to individuals and families.

Provider qualifications: Staff of the LTHHCP agency providing nutritional counseling/education services must be licensed as a Registered Dietician pursuant to Article 157 of NYS Education Law or be registered as a Registered Nutritionist pursuant to Article 157 of the NYS Education Law. An individual or entity subcontracted by the LTHHCP to provide nutritional counseling/education services must also be appropriately licensed/registered pursuant to Article 157 of the NYS Education Law.

**Respiratory Therapy** is an individually designed service, specifically provided in the home, intended to provide preventive, maintenance, and rehabilitative airway-related techniques and procedures. Services include:

- Application of medical gases;
- Application and monitoring of humidity and aerosols;
- Application and monitoring of intermittent positive pressure;
- Application and monitoring of continuous artificial ventilation;
- Administration of drugs through inhalation and related airway management; and
- Instruction administered to the participant and informal supports.

This service supplements the MA State Plan Service of Respiratory Therapy for such services not provided in the home.

Provider qualifications: LTHHCP agency staff providing Respiratory Therapy must be licensed and currently registered as a Respiratory Therapist pursuant to Article 164 of the NYS Education Law. An individual or entity that is under contract with the LTHHCP to provide Respiratory Therapy also must be appropriately licensed pursuant to Article 164 of the NYS Education Law.

**Case Management** – Under the waiver renewal, case management is authorized as an administrative function of the LTHHCP agency.

The LTHHCP agency furnishes case management to waiver participants through the POC development and implementation. The LTHHCP agency RN obtains the Physician Orders, completes the assessment forms, identifies necessary services, develops the POC, and assures that the POC signed by the physician is implemented as intended and modified when necessary. The LTHHCP agency RN coordinates, delivers, and oversees all services. The LTHHCP agency RN monitors all service providers and supervises personal care aides and home health aides in the home.

## **Other Waiver Services**

Depending on the particular LTHHCP provider, a number of other waiver services may also be available. Some of the additional waiver services must be prior authorized by the LDSS. Form LDSS – 3394 is used by the LDSS for this prior authorization. These additional waiver services are described in detail below, and the prior authorization stipulation is included where it applies.

**Assistive Technology (AT)** is a service supplementing the MA State Plan Service of Durable Medical Equipment and Supplies that provides a broad range of special medical equipment and supplies. The MA State Plan and all other sources must be explored and utilized before considering Assistive Technology. AT items covered as State Plan Durable Medical Equipment are not covered or billable as an LTHHCP waiver service.

An AT device may include a medically necessary item, piece of equipment, or product system, whether acquired ready to use, modified, or customized, that is used to increase, maintain, or improve functional capabilities of waiver participants. AT is a service that directly assists a waiver participant in the selection, acquisition, or use of an assistive technology device. This service will only be approved when the requested equipment and supplies are deemed medically necessary, and/ or directly contribute to improving or maintaining the waiver participant's level of independence, ability to access needed supports and services in the community or are expected to maintain or improve the waiver participant's safety as specified in the plan of care. AT includes the Personal Emergency Response Services (PERS) service that was previously included in the waiver but expands the types of devices that may be covered under this service.

AT may include, but is not limited to items such as:

- Lift chair that allows the participant independence in rising to a standing position, reducing the need for personal assistance;
- Devices to assist the hearing impaired that flash a light when the doorbell rings;
- Personal Emergency Response Services (PERS) and such devices with expanded functions;
- Speech recognition software;
- Medication Dispensing Machines;
- Extension grabbers;
- Pencil grips;
- Modified toothbrush handle; or
- Sensor to activate an alarm when a cognitively impaired individual opens the entrance door to elope from the home.

Justification for the AT must include how the specific service will meet the medical and/or other needs of the participant in the most cost effective manner. Justification must show how and why the service or product is needed and what rehabilitative or sustainability function it serves in order to show that only the most reasonable and most cost-effective services are being provided. Equipment loan programs or trial periods of non-customized equipment, if available, should be explored before extensive commitments are made to provide/purchase products.

The service provider is responsible for training the waiver participant, natural supports and paid staff who will be assisting the waiver participant in using the equipment or supplies.

Assistive Technology must be prior authorized by the LDSS:

- For Assistive Technology costing under \$1,000, only one bid is required.
- For Assistive Technology costing \$1,000 or more, three bids are required

Personal Emergency Response Systems or PERS are home devices, typically worn on the neck or wristbands, which connect the person to a 24 hour call center with the push of a button. PERS is generally used by individuals who are home bound, at significantly heightened risk of falling due to an exacerbation of a medical condition, heart attack, or a similarly debilitating physical event. A risk assessment will be completed to define the level of risk associated with the condition.

Most LTHHCP agencies offer PERS as a waiver service and may continue to do so within the assistive technology service. Alternatively, PERS may be provided as a MA State Plan service in some instances. However, a cell phone that is programmed to dial 911 with a single button push may be more appropriate than a PERS, as it would likely have greater scope of coverage and would be in service if the participant travels away from the base unit at home. A cell phone option such as a "SafeLink" may be appropriate and cost effective for individuals who are alert and self-directing, able to communicate independently, and living in an area where cell coverage is adequate.

The availability of PERS through both State Plan and waiver allows the most efficient method of administration, preventing duplication of effort for LDSS, providers, and participants. For the majority of participants who receive PERS as a waiver service, assessment and authorization occurs in coordination with development of their full Plan of Care. In those few instances in which the LTHHCP agency does not provide the service, it is still accessible with LDSS assessment and authorization as a State Plan service.

The LDSS role in both authorization of the State Plan service and authorization of LTHHCP plan of care prevents duplication of payment. In addition, there are separate rate codes for PERS depending on whether provided as a State Plan or the waiver service. The separate rate codes enable the eMedNY system to prevent payment of duplicate claims for the same client for the same service period.

Provider Qualifications: Depending on the type of item approved, assistive technology may be provided by a licensed pharmacy (registered by the State Board of Pharmacy pursuant to Article 137 of the NYS Education Law), a provider of Personal Emergency Response Services contracted by the LDSS, or a durable medical equipment provider that supplies assistive devices not covered by the State Plan.

**Community Transitional Services (CTS)** are defined as individually designed services intended to assist a participant to transition from a nursing home to living in the community. CTS is a one-time service per waiver enrollment. Former participants currently residing in a nursing home and reenrolling in the waiver may be provided CTS again, if needed.

This service is only provided when the individual is transitioning to the community from a nursing home. It cannot be used to move the participant from his/her home in the community to another location in the community. Some support is available for moves

within the community through Moving Assistance services. The funding limits vary, and the two services may not be used at the same time in any approved Plan of Care.

CTS includes:

- Cost of moving furniture and other belongings from the nursing home to the new residence in the community;
- Security deposits, including broker's fees required to obtain a lease on an apartment or home to obtain a lease, but may not include the actual monthly rental fees;
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating);
- Purchasing essential furnishings, such as a bed, table for meals, linen, or, dishes; and
- Health and safety assurances, such as pest removal, allergen control, or one time cleaning prior to occupancy.

The service must **not** be used to purchase diversional or recreational items, such as televisions, VCR/DVD, or music systems.

There is no discrete maximum dollar limit per waiver enrollment for CTS. Like all other LTHHCP waiver services, the cost must be factored into the budget for the individual. The amount that can be spent on CTS will depend on many factors such as the individual's specific needs for CTS, the need for other services, the availability of informal supports, and the potential flexibility afforded through annualization of the budget.

Provider Qualifications: Persons employed or contracted to arrange or manage CTS must either have a Master of Social Work, or a Master of Psychology, or be a Registered Physical Therapist (licensed by the NYS Education Department pursuant to Article 136 of the NYS Education Law), Registered Professional Nurse (licensed by the NYS Education Department pursuant to Article 139 of the NYS Education Law), Licensed Speech Pathologist (licensed by the NYS Education Department pursuant to Article 159 of the NYS Education Law) or Registered Occupational Therapist (licensed by the NYS Education Department pursuant to Article 156 of the NYS Education Law). Providers shall have, at a minimum, one (1) year of experience providing information, linkages and referral regarding community based services for individuals with disabilities and/or seniors.

For moving services from the nursing facility, the LTHHCP has the responsibility for assuring that the service is provided in a safe and efficient manner. Therefore, any moving company used must be appropriately licensed/certified by the NYS Department of Transportation.

**Congregate and Home Delivered Meals** is an individually designed service that provides meals to participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation.

These meals are aimed at assisting the participant to maintain a nutritious diet. They do not constitute a full nutritional regimen, and must not be used to replace the regular form of “board” associated with routine living in an Adult Care Facility. Participants eligible for non-waiver nutritional services must maximize those resources first.

Provider Qualifications: These services may only be provided by facilities or agencies whose home-delivered or congregate meal services are regulated and monitored by the applicable local or New York State agency.

**Environmental Modifications (E-mods)** are internal and external physical adaptations to the home, that are medically necessary to assure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence in the home or community and help prevent institutionalization.

E-Mods for the home include, but are not limited to:

- Installation of ramps and grab bars;
- Widening of doorways;
- Stair glides;
- Modifications of bathroom facilities and kitchen areas;
- Removal of architectural barriers that restrict, impede, or impair the performance of daily living activities;
- Portable air conditioner units;
- Installation of specialized electrical or plumbing systems to accommodate necessary medical equipment; or
- Purchase and installation of a backup generator for **critical** life sustaining medical equipment.

E-Mods for the home may NOT be used to:

- Build any portion of new housing construction;
- Build room extensions, additional rooms or spaces beyond the existing structure of a dwelling that add to the total square footage of living space in the home;
- Renovate or build rooms for the use of physical therapy equipment;
- Purchase equipment such as any therapeutic equipment or supplies, exercise equipment, televisions, video cassette recorders, personal computers, etc.;

- Purchase swimming pools, hot tubs, whirlpools, steam baths or saunas for either indoor or outdoor use;
- Pave driveways;
- Purchase central air conditioning or humidifiers;
- Purchase and/or install an elevator;
- Purchase items that primarily benefit members of the household other than the LTHHCP participant or are of general utility for the residence; or
- Purchase service or maintenance contracts.

E-mods can only be provided where the participant lives. If a participant is moving to a new location that requires modifications, the modifications may be completed prior to the participant's move. If an eligible individual is residing in an institution at the time of application, the modifications may be completed no more than 30 days prior to the participant moving into the modified residence. All modifications must meet State and local building codes.

E-mods also include **vehicle modifications** that may be made if the vehicle is in good repair and is the primary means of transportation for the waiver participant. Modifications to assist with access into or out of a vehicle may include, but not be limited to:

- a portable or motorized ramp; or,
- a swivel seat

E-Mods for a vehicle are **not** to be authorized, if:

- The vehicle is not in good repair.
- The vehicle is not the primary means of transportation for the participant.
- The cost of the modification cannot be managed within the individual's expenditure cap

The vehicle may be owned by the participant; a family member who has consistent and on-going contact with the participant; or a non-relative who provides primary, long term support to the participant. These modifications will be approved when the vehicle is used to improve the participant's independence and inclusion in the community.

All E-mods must be prior authorized by the LDSS. The following process is to be followed for authorizing E-Mods for the home or vehicle:

- If the cost of the project is under \$1,000, the LDSS may select a contractor (taking steps necessary to ensure reasonable pricing) and obtain a written bid from the selected contractor, that includes all terms and conditions of the project.

- If the cost of the project is \$1,000 or more, a minimum of three written bids must be obtained. The LDSS may waive this requirement at its discretion (e.g., geographic limitations), documenting the reasons in the case record.
- Bids over \$10,000 also require architectural and engineering certification that ensures the improvement meets the NYS Fire and Building Codes.

Provider Qualifications: The LTHHCP agency must ensure that individual(s) working on the E-mods are appropriately qualified and/or licensed to comply with any State and local rules. All materials and products used must also meet any State or local construction requirements, and providers must adhere to safety standards as addressed in Article 18 of the New York State Uniform Fire Prevention and Building Code Act as well as all local building codes.

**Home and Community Support Services (HCSS)** are the combination of personal care services with oversight/supervision services, as well as assistance with activities of daily living (ADL) and/or instrumental activities of daily living (IADL) or oversight/supervision as a discrete service for the individual who is cognitively impaired. HCSS is provided to a waiver participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed. Services are to be complementary but not duplicative of other services.

HCSS are provided under the direction and supervision of a Registered Nurse. The Registered Nurse supervising the HCSS staff is responsible for developing a plan of care and for orienting the HCSS staff.

HCSS differ from the personal care services provided under the Medicaid State Plan in that oversight/supervision is not a discrete task for which personal care services are authorized.

In the development of the Plan of Care, LDSS and LTHHCP agency staff must identify whether the applicant/participant has unmet needs for discrete oversight and/or supervision. If, in addition to discrete oversight and/or supervision, the individual requires assistance with ADLs and/or IADLs, the waiver Plan of Care will include HCSS to meet all those needs. The individual will receive discrete oversight and/or supervision and assistance with ADLs/IADLs through the provision of HCSS by the LTHHCP agency. Such services are to be billed by the LTHHCP agency using the appropriate HCSS rate code.

If an individual's personal care needs are being met through the provision of HCSS under the waiver, the individual cannot also receive personal care as a discrete service. If there is no need for discrete oversight and/or supervision, but there is an unmet need for assistance with ADL and/or IADL, personal care services may be appropriately provided and billed by the LTHHCP agency as personal care services.



If applicants/participants require the provision of skilled tasks, these tasks are not included in the waiver service of HCSS. They should be provided to LTHHCP participants through the LTHHCP agency's nursing services.

Provider Qualifications: The LTHHCP agency must ensure that HCSS staff are at least 18 years old; are able to follow written and verbal instructions; and have the ability and skills necessary to meet the waiver participant's needs that will be addressed through this service. HCSS may be provided by staff of the LTHHCP agency, a personal care aide supervised by a RN, or through contract with a License Home Care Services Agency (LHCSA). In addition, staff providing HCSS must meet all other requirements under Title 18 NYCRR §505.14 for the provision of Personal Care Aide services.

**Home Maintenance Services** includes those household chores and services that are required to maintain a participant's home environment in a sanitary, safe, and viable manner. Home maintenance tasks/chores differ from those provided by personal care or home health aides. Environmental support functions in personal care includes such tasks as dusting and vacuuming rooms the patient uses, making and changing beds, or light cleaning of the kitchen, bedroom and bathroom. The nature of personal care is to provide those routine tasks necessary to maintain the participant's health and safety in the home while Home Maintenance tasks are those chores accomplished in only one instance or on an intermittent basis when deemed necessary.

Home Maintenance Tasks - Chore services are provided on two levels:

- Light Chores – These services are provided when needed for the maintenance of the home environment. Programs utilize these services when other means of supplying such services are unavailable or more costly. This service is often an appropriate substitute for part or all of personal care services. Light Chore services may include (but are not limited to) tasks such as:
  - Cleaning and/or washing of windows, walls, and ceilings;
  - Snow removal and/or yard work to maintain egress and access;
  - Tacking down loose rugs and/or securing tiles; and,
  - Cleaning tile work in bath and/or kitchen.
- Heavy-Duty Chores – These services are provided to prepare or restore a dwelling for the habitation of a participant. They are usually limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Since these services are labor intensive and more costly than routine cleaning, they should not be provided more than twice per year. Heavy-Duty Chore services may include (but are not limited to) tasks such as:
  - Scraping and/or cleaning of floor areas (including situations where the movement of heavy furniture and/or appliances is necessary in order to perform the cleaning task)

- Cleaning of items within an individual's dwelling and/or removal of any item(s) that may threaten the home's sanitary, fire safety, or other safety conditions.

Home Maintenance Tasks – Other – These include those essential services required for the maintenance of the participant's home and home environment but which are not suitable for setting specific rates because of the variety of case situations or individuals involved. Services must meet all local building and safety standards. Services included in this category might include, but are not limited to, tasks such as:

- Unique tasks, such as maintenance of a leaky sink trap; or,
- Other heavy-duty chore services (those for which rates may not be determined before provision)

All services in the category "Home Maintenance Tasks – Other" must be prior authorized by the LDSS.

Provider qualifications: Home Maintenance services are provided by LTHHCP agencies either directly or through contractual arrangement. The LTHHCP agency, as employer or contractor, is responsible for verifying that individual(s) maintain if applicable the needed license or certification.

**Moving Assistance Services** are individually designed services intended to transport a participant's possessions and furnishings when the participant must be moved from an inadequate or unsafe housing situation to a viable environment that more adequately meets the participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the participant is moving to a location where more informal supports will be available, and thus allows the participant to remain in the community in a supportive environment.

Moving Assistance does **not** include:

- Security deposits, including broker's fees required to obtain a lease on an apartment or home
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)
- Health and safety assurances such as pest removal, allergen control or cleaning prior to occupancy

Provider qualifications: Moving Assistance is provided by DOH approved LTHHCPs either directly or through contractual arrangement. The LTHHCP agency has responsibility for assuring the moving service is provided in a safe and efficient manner. Therefore, any moving company used must be appropriately licensed/certified by the NYS Department of Transportation.

**Respite Care** is an individually designed service intended to provide relief to informal, non-paid supports who provide primary care and support to a waiver participant. The primary location for the provision of this service is in the waiver participant's home, or where appropriate, temporarily in an institutional setting. These services will be provided for the benefit of family and other caregivers who ordinarily care for the individual, as temporary relief from these duties and are included in the physician approved Plan of Care.

Respite care may be provided in hourly increments or on a 24 hour basis in the home or in the home of a relative or other individual, but is limited to a total of 14 days (or 336 hours)/year. When respite care is provided in the home of a relative or other individual, room and board is not included as an element of this service. Any request for respite care in a home in excess of this time must be prior authorized by the LDSS.

Respite care may also be provided in a nursing facility through a contractual arrangement with the LTHHCP agency, but is limited to a total of 14 days (or 336 hours)/year. Any request for respite care in a facility in excess of this time period must be prior authorized by the LDSS and may not exceed 29 days in duration of stay. Scheduled short-term nursing home stays arranged through the LDSS are **not** available for LTHHCP participants.

Respite services must be billed as a waiver service and not as increased hours of personal care aide, home health aide, nursing, or housekeeper services. The cost of respite care, regardless of location in a hospital or nursing facility, must be managed within the individual's expenditure cap.

If the services needed by the waiver participant exceed the type of care and support provided by the Home and Community Support Services, then other appropriate providers must be included in the plan for Respite and will be reimbursed separately from Respite.

Provider qualifications: Providers of respite must meet the same standards and qualifications as the direct care providers of nursing, home health aide, personal care, and housekeeping trained and certified under NYS rules and regulations. Institutional Respite may be provided by hospitals or nursing homes licensed under Article 28 of NYS Public Health Law.

**Social Day Care** makes available the opportunity for individual socialization activities, including educational, craft, recreational and group events. Such services may include hot meals, or other services that may be offered and are authorized in a Plan of Care approved by a physician.

Adult social day care offered through the LTHHCP waiver can provide a cost effective means for delivering services to multiple individuals, improve the quality of life of functionally impaired adults, and provide respite for informal caregivers and provide an alternative to inappropriate and unwanted institutionalization.

All parties involved in determining an individual's plan of care are expected to choose the most appropriate and the most cost effective service options. Social day care should be considered when it is beneficial for the individual and when its use can reduce the cost of care. A useful measure of whether or not social day care actually reduces costs particularly for this segment of the population is to compare the individual day or half-day cost of social day care, social transportation and any peripheral home care (i.e., personal care or home health aide) with what would have been that day's care cost without social day care. (91 LCM-198)

Acceptable social day care services may be developed and provided directly by the LTHHCP agency or be made available through contract with community agencies such as senior service centers, adult homes, programs for the elderly approved by the New York State Office for the Aging, and activities programs provided by residential health care facilities approved under Article 28 of the New York State Public Health Law.

Provider qualifications: Programs must comply with Title 9 NYCRR §6654.20 NYSOFA Social Adult Day Care Regulations and, as appropriate, 18 NYCRR Part 492- Adult-Care Facilities Standards for Day Programs for Nonresidents.

**Social Day Care Transportation** includes providing transportation between the participant's home and the social day care facilities within reasonable distances. Social Day Care Transportation service is limited solely to the purpose of transporting LTHHCP participants to and from approved social day care programs as discussed under that service section.

The LTHHCP agency contracts with a Social Day Care program and negotiates a cost for the service either with transportation included in the cost of the program or in addition to the cost of the program. The rate payable through eMedNY for each LTHHCP agency is calculated based upon this agreement with the Social Day Care program. If transportation was included in the negotiated cost of services, the LTHHCP cannot submit an additional claim for transportation.

All transportation to Social Day Care must be prior authorized by the LDSS. Attendance at a Social Day Care does **not** qualify the individual for Medical Transportation under the MA State Plan.

Provider qualifications: The LTHHCP agency must assure that transportation services are provided in accordance with the regulatory criteria specified by the New York State Departments of Transportation, Motor Vehicles, and Health as appropriate for the carrier, including Title 9 NYCRR § 6654.20; NYS Transportation Law, Articles 4 and 7; NYS Vehicle and Traffic Law.

## **Summary of Key Points**

1. The waiver services in the LTHHCP waiver are services not usually paid for by MA.
2. All LTHHCP agencies must offer Case Management, Medical Social Services, Nutritional Counseling/Education Services, and Respiratory Therapy.
3. Other waiver services may also be offered and arranged by the LTHHCP agency, (See page I-5)
4. There is a prior authorization required for Assistive Technology, Environmental Modifications, Home Maintenance Tasks – Other, Social Day Care Transportation, and more than 14 days of Respite

## **Associated Forms** (Appendix B)

- Long Term Home Health Care Program Waivered Services Prior Authorization LDSS – 3394

## **Associated Medicaid Policy Directives** (Appendix C)

- 85 ADM-27, *Long Term Home Health Care Program: Federal Waivers Permitting Expanded MA Home and Community Based Services for LTHHCP*, July 15, 1985
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011
- GIS 11 OLTC/008, *Clarifications and Updates to Long Term Home Health Care Program (LTHHCP)* 11OLTC/ADM-1, June 22, 2011

# Section IV: Budgeting For Participants

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## Importance of the Service Plan Budget

The LDSS can authorize waiver participation only after determining service costs are within the expenditure cap of the approved level of care. (See Section II, “Becoming a Waiver Participant: Program Eligibility and Assessment”) The expenditure cap requirement must be implemented in the context of the waiver's goals and philosophy and in accordance with the budgeting strategies that have evolved since the program was initially established.

One of the primary goals of the LTHHCP waiver is to prevent the premature institutionalization of individuals and allow individuals who are at risk for institutionalization to remain in the community. The underlying philosophy of the waiver is that proper delivery of home and community based services can be substituted, with equal appropriateness and lower costs, for placement in a skilled nursing facility. The budgeting strategies of paper credits; annualized budgeting; household budgeting; or budgeting for special needs individuals supports this goal and philosophy by enabling individuals to enter or remain in the program while maintaining cost-effectiveness. Both paper credits and annualization of the budget are also effective in addressing fluctuations in a participant's needs so s/he does not need to be prematurely disenrolled from the LTHHCP.

In addition to these strategies, LDSS and LTHHCP agency staff must consider other means of maintaining the budget within the limit, including: maximization of third party resources; increased use of informal supports, including community social services and/or family; and service substitution. For example, it may be possible to use the waiver service of “moving assistance” to relocate a participant closer to a family member; the family member is then able to provide informal support on a more frequent basis lowering the participant’s budget for paid assistance. Alternatively, initiating attendance at adult day health care may be a more cost effective means of providing coordinated services.

Each case is unique and requires discussion with the participant about his/her options and choices. LDSSs and LTHHCP agencies must work together to address the individual participant’s circumstances if the required services cause his/her cost limit to be exceeded. If services cannot be maintained within the budget after these options are considered, participants must be informed of and referred to other options as necessary. This can include the range of existing State Plan home care services, as well as other available 1915c waivers such as the Nursing Home Transition and Diversion Waiver.

## **Preparing the Monthly Budget**

The budget is based on the Summary of Service Requirements for the monthly expenditures anticipated to be billed to MA, i.e., the cost of services for which MA is the payer.

When MA will be paying the coinsurance on a service paid by a third party, these coinsurance payments by MA should be included in the budget. Other than the coinsurance, the cost of services reimbursed by a third party, including Medicare, should be indicated in the Summary of Service Requirements and on the budget; however, these costs are not calculated in the monthly budget total.

To compute a LTHHCP waiver budget, LDSSs must take the following steps:

1. List all services in the Summary of Service Requirements (Section 16 of the Home Assessment Abstract), documenting provider of service, frequency and projected cost of each service, including designated payment source;
2. Total only the costs of services to be billed to Medicaid;
3. Compute the total monthly cost by using 4.33 weeks; and
4. Compare those costs to the appropriate LTHHCP expenditure cap.

LTHHCP waiver budgets must be recalculated at each scheduled reassessment or sooner if the participant’s condition necessitates a change in the Plan of Care (POC). LTHHCP agencies must notify LDSS immediately when there is a change of payer for any service included in the POC so districts can re-budget the case appropriately.

In projecting MA expenditures, the MA rates/fees used should be those established by the NYSDOH Office of Health Insurance Programs (OHIP) or other NYS agency overseeing the services that have been approved by the NYS Division of the Budget. Rates/fees may have been established specifically for the agency providing the service, e.g., each LTHHCP agency, and established for all providers in a category of service, e.g., physicians. NYSDOH issues LTHHCP agency rates annually, or whenever rate adjustments are made. LTHHCP agencies must share assigned rates with the LDSS.

## **Services Included in Budget Calculation**

In addition to LTHHCP agencies' services and waiver services, other Medicaid State Plan services, such as physician, adult day health care, medical transportation, durable medical equipment, pharmaceuticals and Office of Mental Health (OMH) community residence rehabilitative services (listed below) must be included in the monthly budget. Estimates of the frequency of these services must be also included.

- 1. Physician/Nurse Practitioner Services** – This includes visits to specialists as well as primary care physicians/nurse practitioners and scheduled office visits.
- 2. Clinic Services** – This includes visits to primary care and specialty clinics. Clinic services related to renal dialysis are excluded from the nursing home rate and are therefore excluded from inclusion in the monthly budget calculation.
- 3. Nursing Services** – This includes nursing visits for treatment and supervision of the aide when a nursing task is also provided. Unless provided by an adult day health care provider, nursing services are provided by the LTHHCP agency and would be billed at the rate set by DOH for that agency.
- 4. Therapies** – This includes physical therapy, occupational therapy, speech therapy, audiology, and respiratory therapy. Unless provided by an adult day health care provider, therapy services are provided by the LTHHCP agency in the home and are billed at the rate set by DOH for that agency. In the instance of children, Early Intervention services must be included as well as School Supportive Health Care Services.
- 5. Medications** – The total cost of all medications reimbursed by MA must be included when the LTHHCP participant's total monthly MA expenditure is calculated.
- 6. Personal Care Services** – For budget purposes, Personal Care includes services covered by the eMedNY LTHHCP rate codes for personal care aide, home health aide, homemaker service, and housekeeper service. Unless provided by an adult day health care provider, personal care services are provided through the LTHHCP agency and paid at the rates set by NYSDOH for that agency. If an individual is receiving services through Consumer Directed Personal Assistance Program (CDPAP), the cost must be included in the participant's budget.
- 7. Transportation** – This includes projected cost of livery, ambulette, and ambulance service, to and from hospitals, and other MA reimbursable services. Reimbursable MA services include, but are not limited to, physician and dental appointments,



laboratory tests, and x-ray services. The cost of transportation services is based on local prevailing charges or locally negotiated rates.

- 8. Adult Day Health Care (Medical Day Care)** – Adult Day Health Care consists of medically supervised services for individuals with physical or mental impairment. Services may include nursing, medication management, transportation, leisure activities, nutrition assessment, medical social services, psychosocial assessment, rehabilitation, and socialization, in addition to physical, occupational, and speech therapy. Services (generally offered one to five days a week) must meet NYSDOH standards (10 NYCRR §425) and require a Physician Order. All services included in the Adult Day Health Care rate that are determined necessary by the individual’s Plan of Care must be provided by the Adult Day Health Care Program during the hours the individual is in attendance. (For example: the individual requires physical therapy three times a week and attends the Adult Day Health Care Program two days a week. Physical therapy would be provided twice a week by the Adult Day Health Care Program and once a week by the LTHHCP agency.) There must be no duplication of services by the Adult Day Health Care provider and any other provider of services under the waiver.
- 9. Medical Supplies** – This includes disposable medical supplies not normally incorporated in agency rates.
- 10. Durable Medical Equipment** – The need for hospital beds or wheelchairs may require a one-time cost or a monthly rental fee. In instances when their use is required, the cost of expensive items such as a hospital bed or a wheelchair may be averaged for a year (divided by twelve) and included in the monthly budget for one year. The Office of Health Insurance Programs (OHIP) processes requests for durable medical equipment and can be reached at (518) 474-8161.
- 11. Mental Health Services** – LTHHCP participants may receive mental health services through MA State Plan Personalized Recovery Oriented Services (PROS) and may reside in a supportive Community Residence. Cost related to PROS and such supportive services of community residences must be included in the monthly budget.
- 12. Waiver Services** – The Plan of Care must include one or more LTHHCP waiver services. (See Section III, “Waiver Services”)

## **Expenses Not Calculated in the Budget**

- 1. Initial Assessment and Reassessment** – Payment to a provider for the initial assessment, which includes completion of the DMS-1 Form and the provider agency’s portion of the *Home Assessment Abstract* to determine the appropriateness and extent of services, is not included in the monthly budget. Reassessment is also not included in the monthly budget. Payment for the initial assessment is as follows:
  - Payment for staff participation in discharge planning, including completion of the assessment forms by nurses or physicians on staff, is included in the current hospital facility MA rate.

- If the individual is in a hospital (or other facility) and the physician is not on staff, reimbursement for the initial assessment is included in the physician's visit fee.
  - If an individual is living in the community and the assessment takes place in a clinic, reimbursement for the initial assessment is included in the clinic rate for the care provided.
  - If the assessment takes place in the home, reimbursement for a physician performed assessment is included in the physician's home visit fee (or, if in the office, by the office visit fee).
  - Assessment by a CHHA nurse is reimbursed through the CHHA visit fee.
  - Reimbursement for all assessment and reassessments by a LTHHCP agency is included in its administrative costs.
2. **Case Management** – Because the cost of case management is reimbursed through administrative costs of the LTHHCP calculated in the reimbursement rates, case management costs are not discretely allocated in budget calculations. (See Section III, "Waiver Services" for a definition of Case Management.)
  3. **Incidental Items** – Items that are required infrequently and incidentally (such as eyeglasses, hearing aids, dentures, and prostheses) and that are not included in the Summary of Service Requirements are not included in the monthly budget.
  4. **Expenses Not Included in Nursing Facility (NF) Rates** – Other expenses not normally included in NF rates may also be excluded from the budget. Each county will have a description of what is included in its NF rates, including specific services such as kidney dialysis, radiation therapy, chemotherapy, and the cost of medical transportation to those services.
  5. **Medications** – Certain high cost pharmaceuticals are "carved out" of the monthly budget and are not included in the calculation.

## **Additional Budget Determinations**

Because the cost of every item for each individual cannot be anticipated in advance, unexpected costs may be incorporated into the monthly budget retroactively. The provision of unanticipated services requires LDSS prior approval only when their costs exceed 10% of the monthly budget cap.

The LDSS must authorize a reassessment when the individual's monthly budget exceeds the cap by more than 10% for two consecutive months and the accrued paper credits (explained later in this Section) have been used. This reassessment should determine whether the participant is still eligible for the waiver based on an annualized budget and other budget strategies explained in this Section.

If it is determined that the individual will continue to require services in excess of both the monthly and yearly cap, LTHHCP participation is no longer appropriate; and

alternate arrangements must be made as discussed in the Discharge Planning subsection of Section V, "Case Management".

## **Change in Level of Care Needs**

If the participant's condition changes to such a degree that the individual moves from one budget level to another (HRF to SNF, for example), the LTHHCP agency must notify the LDSS by the first working day following noting the change in the individual's condition. The change in level of care is verified by documented completion of a new level of care form.

A revised *Home Assessment Abstract*, including a new Summary of Service Requirements and a new monthly budget, must be prepared based on the change in the individual's care needs. In such instances, the LTHHCP agency and the LDSS must collaborate on the preparation of the new forms and budget according to their usual working arrangements.

## **Preparing an Annualized Budget**

Some LTHHCP applicants/participants require complex Plans of Care (POC) that often approach or exceed the budget cap. Experience has also shown that for many individuals, the cost of the initial POC exceeds the budget cap, but it can reasonably be anticipated that subsequent costs will eventually fall below the cap.

An *annualized budget* is the result of the process by which the costs of care for an individual are averaged over the year so that care costs that may exceed the budget cap in one or more months, do not prevent the use of the LTHHCP waiver. Annualized budget determinations may be done during the initial authorization or any time after the LDSS and LTHHCP agency determine that all monthly accrued "paper credits" have been used and monthly expenditures will continue to exceed the individual's budget cap.

The LDSS is responsible for ensuring the decision to use an annualized budget is a reasonable alternative strategy. During the assessment process, the LDSS representative reviews the anticipated expenditures and possible changes in the monthly budget over the year with the LTHHCP nurse. The LDSS representative authorizes services within the annualized budget strategy. High-cost cases admitted under these circumstances must be closely monitored at regular intervals.

Authorizations based upon an annualized budget require that the LDSS and the LTHHCP determine and show in writing that the yearly cost of services is not expected to exceed the budget cap for that individual. As with all other cases, they must reassess the budget every 180 days following the date of the initial authorization. At this time, the LDSS and LTHHCP agency should determine whether the projected changes in the participant's status and service needs have taken place.

The LDSS and LTHHCP agency may consider the following for budget annualization and document their considerations on the *Home Assessment Abstract*:

- Anticipated changes in individual status that would result in a decrease in the cost of care (such as anticipated improvements in the individual's medical condition or projections concerning an individual's or family's ability to learn and assume a larger role in meeting the participant's needs).
- Anticipated changes in the individual's service needs such as a one-time cost for a piece of expensive medical equipment or for a one-time service needed by the individual (such as moving assistance or home modification).
- Anticipated expensive health and medical services for a limited period of time (.e.g., a recent stroke requiring short term physical therapy or a newly diagnosed diabetic individual requiring skilled nursing instruction).

## **Paper Credits**

Monthly paper credits may be accumulated by a participant and used at a later date if service needs exceed the expenditure cap. A paper credit is the difference between the costs of MA services used in a month and the applicable SNF/HRF budget cap. If the individual uses services in an amount less than the SNF/HRF spending cap for a given month, a paper credit is accrued. When calculating the amount of paper credits available to the participant, a look back period should be used to determine the available credit, using only the previous 11 months and the current month. The LDSS representative is responsible for tracking and authorizing this paper credit. The credit can be used in the event of a period of higher service needs. These credits may be used with the LDSS representative approval for:

- additional services following the exacerbation of an illness
- increased services due to caregiver illness or absence
- equipment purchases
- other needs identified in the Plan of Care

## **Paper Credits for Individuals with Special Needs**

When accruing credits for individuals with special needs authorized for 100% of the SNF/ HRF budget cap, the 100% budget cap amount should be used, rather than the 75 percent budget cap. The paper credit is, therefore, the difference between the Medicaid cost of service on the monthly budget and the 100 percent budget cap. The individual accrues paper credits (using the 100% cap) when, in any given month during the year, the MA cost of services falls below the 100% budget cap.

## **Household Budgeting**

Two people, both in need of long term care and living in the same household, often can remain at home as long as they can depend on one another for support. If this mutual support is lost due to the institutionalization of one member, the other person frequently has to be institutionalized as well.

In such cases, the LDSS is not required to compute separate budgets for each household member. Instead, the LDSS may perform a combined computation of the waiver budget cap for the two persons living in the same household. This flexibility has been a feature of the waiver since Chapter 904 of the Laws of 1984.

If two members of the same household are eligible for the waiver as a result of their level of care, and their assessments indicate they can receive the appropriate level of care at home, services can be provided when the total monthly expenditures do not exceed the combined 75 percent budget cap for both members of the household. If expenditures would exceed the 75 percent budget cap, but the LDSS reasonably anticipates expenditures would not exceed an annual budget cap, the LDSS may prepare an annualized budget.

## **Paper Credits and Household Budgeting**

When two persons living in the same household have their cost of care computed jointly, their paper credits also accumulate jointly. Therefore, when an individual accumulates paper credits prior to a second member of the household becoming eligible for the LTHHCP waiver, the original individual's paper credits should be carried over and applied to the joint case. Similarly, if paper credits accumulate in a case with two individuals in the LTHHCP waiver, those paper credits should be carried over and applied to the remaining waiver participant when one is no longer in the waiver.

## **Medicare and Third-Party Payers**

State and federal laws provide that MA is the payer of last resort. This means that all individuals must apply for and make full use of Medicare and any available third-party health insurance (such as health benefits resulting from pensions, union, military, Veteran's benefits, and insurance through a parent's health plan). If an individual, eligible for other insurance, fails to apply for full Medicare coverage or third-party health insurance, the individual will be ineligible for MA. Therefore, it is very important that the LDSS and the provider help the individual to apply for Medicare and third-party resources when applicable.

## **LTHHCP Provider Billing Responsibility**

As required of all participating MA providers, LTHHCP waiver providers are responsible for billing all other applicable health insurance plans for any covered services prior to

billing MA. Providers must have knowledge and understanding of the services covered by Medicare and any applicable third-party health insurance. It is also their responsibility to forward the individual's insurance information to the LDSS.

### **Case Example: Medicare Maximization:**

Mr. Eagle is a 70-year old man who suffered a stroke three months ago. After his four week hospitalization, he was sent to a rehabilitation center for physical therapy for a month. He has returned home from the rehabilitation center with left-sided weakness, neurogenic bladder (requiring a Foley catheter), and depression. He also has difficulty with expressive speech. He uses a walker and requires assistance with transfers to his wheelchair. His wife has been able to learn many of the procedures required for his care (such as irrigating the Foley catheter) but he still requires many professional services to make living at home feasible, including the following services:

- *Skilled Nursing* to maintain the Foley catheter and to assess his cardiovascular function, bowel functioning, nutritional status, and respiratory status
- *Physical Therapy* to improve his transfer skills
- *Home Health Aide* to help him with following his exercise plan and to provide him with assistance with activities of daily living
- *Personal Care Aide* to provide assistance with the activities of daily living his wife is unable or unwilling to provide
- *Speech Therapy* to improve his expressive skills
- *Occupational Therapy* to improve his fine motor skills and strengthen his upper extremities for transfer purposes
- *Nutritional Therapy* to provide counseling regarding his diet
- *Medical Social Work Service* to assess his level of depression and assist with planning for the future

Both Medicare and MA will cover Mr. Eagle's complex Plan of Care. By spreading the costs between the two payers, Mr. Eagle is able to keep within the MA SNF budget cap of \$4,000 for Ames County. The following budget illustrates how the budget was maximized using Medicare resources.

Illustration IV-1, Sample Budget Based on Service Requirements, shows the costs for various services. (An X appears in the MC column when Medicare will cover the cost for a service.)

SUMMARY OF SERVICE REQUIREMENTS

Indicated services required, schedule, and charges (allowable in area)

Services	Provided by	Hrs./Days/Wk	Date		Est.	Unit	Payment by			
			Effective	Dur.			Cost	MC	MA	Self
Physician	Dr. Rani	1 x m	3/1/11	4m	14			14		
Nursing	CareCo	2 x m x 3 m 1 x w/ 1 m	3/1/11 3/1/11	3m 1m	83.72		X	167.44		
Home Health Aide	CareCo	2hr/ 7d/ 4wk	3/1/11	1m	25.56		X			
Physical Therapy	CareCo	1-3 x wk/ 4wk	3/1/11	1m	86.16		X			
Speech Pathology	CareCo	2 x wk/ 4wk	3/1/11	1m	86.37		X			
Resp. Therapy										
Med. Soc. Work	CareCo	1x m/2 m	3/1/11	2m	89.82			89.92		
Nutritional	CareCo	1 x mo	3/1/11	4m	82.90			82.90		
Personal Care	CareCo	2 hr/ 7 d/ wk	3/1/11	4m	12			727.44		
Homemaking										
Housekeeping										
Other (Specify) OT		1 x wk/ 2 m 1 x wk / 1 m	3/1/11 3/1/11	4m 1m	66.34		X	287.25		
Medical Supplies/Medication			3/1/11	4m			x			
1. Plavix 75 mg po qd										
2. Zoloft 50 mg po qd										
3. Prilosec 20 mg po qd										
4. Ditropan XL 10 mg po qd										
Medical Equipment	CareCo							22.74		
1. Catheter/supplies										
2. Wheelchair	CareCo									
3. Walker	CareCo									
Home-Delivered Meals										
Transportation	Wheel - chair van	1 x mo	3/1/11		52.00			52.00		
Additional Services										
1.										
2.										
SUBTOTAL								1443.59		
Structural Modification										
Other (Specify)										
1.										
2.										

SUBTOTAL \_\_\_\_\_

TOTAL COST \$1443.59 Medicaid

## **Summary of Key Points**

1. When the MA monthly budget is developed, all services are listed; but only those items paid by MA are used to determine whether the individual's expenses are under the SNF/HRF budget cap.
2. Consequently, higher costs in one part of the year do not force discharge from the waiver; the costs of care may be averaged over the year to annualize the individual's budget.
3. Paper credits are the difference between the cost of services budgeted in a given month and the budget cap. This difference can be accumulated and applied to increased costs over the year. When calculating paper credits, a look back period is used to determine available credits, using the previous 11 months and the current month. Previous unused paper credits (prior to the 11 month period) are not available for use.
4. Household budgeting is the process of averaging the service costs of two household members to keep costs under their joint budget caps, enabling them both to continue in the LTHHCP waiver.
5. State and federal laws provide that MA is the payer of last resort. It is the provider's responsibility to bill all third-party payers for services before billing MA.

## **Associated Medicaid Policy Directives (Appendix C)**

- 79 ADM-60, *Long Term Home Health Care Program Medicare Maximization Requirements*, September 7, 1979
- 83 ADM -74, *Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program*, December 30, 1983
- 85 ADM-26, *Long Term Home Health Care Program Budgeting*, July 12, 1985
- 86 INF-26, *Chapter 629 of the Laws of 1986: Demonstration Program*, October 22, 1986
- 89 INF-20, *Long Term Home Health Care Program: Annualization of Service Costs*, April 6, 1989
- 90 ADM-25, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Services Provided in Adult Care Facilities*, August 24, 1990
- *Letter from Robert Barnett, Office of Continuing Care, NYS DOH*, January 26, 1999

## **Associated Laws and Regulations**

- 18 NYCRR §595.21(b)(4)
- 18 NYCRR §540.6(e)
- *Social Services Law §367-c*



# Section V:

## Case Management

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### **Definition of Case Management in the LTHHCP Waiver**

Case management is not a discrete LTHHCP waiver service separately billable by the LTHHCP agency; case management costs are reimbursed as part of the overall administrative costs.

Case management is an administrative function of the LTHHCP agency with complementary, not duplicative, functions fulfilled by the LDSS. (See Table V-1) While not a discrete waiver service, it is a critical component of waiver eligibility and continued participation. To be eligible for the LTHHCP waiver, the individual must require the coordination of services (assessing the need for and then coordinating and monitoring all services needed to support the individual in the community) provided through case management.

Providing comprehensive care to individuals in the community who would otherwise require nursing facility care requires case management involving a comprehensive approach to the assessment and reassessment for all needed medical, psychosocial and environmental services; and, the coordination, delivery and monitoring of all services needed to support the LTHHCP participant in the community in accordance with the individual's approved Plan of Care (POC).

Because service needs may “fall through the cracks” if someone is not monitoring individual care, the case manager must provide overall coordination of services in order to efficiently carry out complex POC often needed by individuals in the LTHHCP waiver. The level of service required in the LTHHCP requires collaboration and consistent communication between LTHHCP providers, LDSS staff, and community supports (such as family members, other individuals of the participant’s choosing, or other caregivers).

The case manager provides the leadership to assure that communication is clear and consistent and that all members of the team are providing their services to achieve optimal delivery of comprehensive care.

Case management includes these key tasks and responsibilities:

- assuring the POC is implemented as intended and modified when necessary
- monitoring and supervising of paraprofessionals
- act as liaison among caregivers, community resources, and service providers

This approach to case management allows services to be tailored to meet individual needs and assures timely, cost-effective and efficient implementation of each individual's POC. Similarly, LTHHCP agencies providing an AIDS Home Care Program (AHCP) are able to tailor services to the needs of individuals with HIV/AIDS.

Because of the complex interconnections between the various members of the waiver assessment team and the services provided to waiver participants, the specific roles and responsibilities of the LTHHCP agency and LDSS staff must be clearly defined.

While the LTHHCP agency and LDSS share certain responsibilities, other case management tasks are carried out separately by the LTHHCP agency and the LDSS. For example, LDSS staff has a financial oversight role with regard to assuring the participant's POC can be safely followed within the approved level budget cap. Although the LTHHCP agency staff must also be concerned about the finances involved, their major role is assuring that the physician's POC is carried out appropriately by health care professionals and paraprofessionals.

## **LDSS and LTHHCP Agency Responsibilities**

Both the LTHHCP agency and LDSS are concerned with providing appropriate services and assuring a comprehensive POC for LTHHCP waiver participants so that the individual can safely remain in the community; there is, therefore, certain shared responsibilities, particularly:

1. Assessment – Complete the *Home Assessment Abstract* (HAA) needed to determine the individual's eligibility for the waiver
2. Individual's Care – Work closely with the individual's family, others of the individual's choosing and community care providers to ensure that the individual's needs are met

In some instances, the LTHHCP agencies complete the initial assessment independently when services must be provided as quickly as possible; in such alternate entry cases, the LDSS must be notified so that an assessment can be completed as soon as possible. (See Section II – Becoming a Waiver Participant, for more information about acceptance into the waiver.)

## LDSS Responsibilities

Local district staff is responsible for all of the following:

1. **Individual Notification** – The first responsibility of the LDSS is the development of a notification process that assures that all potential individuals, their families, and/or significant others are notified, verbally and with printed materials about the availability of home and community based long term care services in the communities served by the LDSS.
2. **Management of LTHHCP Cases** – For each potential and active waiver participant, the LDSS must designate one LDSS staff member to be accountable for the completion and/or performance of the various management responsibilities described in the remainder of this list.
3. **Medicaid Eligibility Application and Recertification** – The assigned LDSS staff person assures MA eligibility determination or recertification is completed by MA eligibility staff for potential and active LTHHCP participants, and may perform the following tasks:
  - assisting the applicant in securing appropriate documentation and information
  - monitoring the status of the MA application and recertification, including identifying any missing documents and/or information, and notifying the LTHHCP agency and applicant appropriately
  - notifying the LTHHCP agency and the applicant regarding MA acceptance, denial, or discontinuance; the applicable dates of MA coverage; and the amount of monthly surplus income, if any
4. **Physicians Orders and DMS-1 Form** – The LDSS representative assures that the LTHHCP agencies obtain necessary medical documentation of service needed, including the physician's recommendation(s) and the level of care assessment form (the DMS-1).
5. **Home Assessment** – The LDSS representative is responsible for these tasks:
  - authorizing the initial Home Assessment to determine the appropriateness of the waiver
  - completing the appropriate sections of the HAA in conjunction with the LTHHCP agency nurse, a process that may include family interviews and consultations with the nurse concerning the social/environmental aspects of the individual's needs
6. **Budget Computations** – See Section IV
7. **Third-Party Insurance** – The LDSS representative assists the individual in applying for the Medicare Savings Program and in paying third-party health insurance premiums (when appropriate). If the individual is paying health insurance premiums

(including Medicare), the LDSS representative assists in obtaining payment or reimbursement for cost-effective health insurance.

8. **Authorization of Waiver Participation** – LDSS representative authorizes waiver participation and notifies the LTHHCP agency concerning the authorization period (at a minimum, every 180 days). LDSS must also authorize specific waiver services. (Section III “Waiver Services”)
9. **Referral of Ineligible Individuals to Alternate Services** – With the assistance of the LTHHCP agency, the LDSS representative refers individuals who have been determined ineligible for the waiver to alternate services.
10. **Provision of Non-LTHHCP Services** – The LDSS representative assists the LTHHCP agency in arranging for the delivery of services not available in the LTHHCP waiver, including (but not limited to) the following:
  - Public Assistance
  - Food Stamps
  - HEAP
  - Adult protective services
  - Legal counseling
  - Recreation therapy
  - Financial counseling
  - Friendly visitors and/or telephone reassurance
11. **Reassessment** – The LDSS representative participates in the periodic reassessment (at a minimum, every 180 days) on an ongoing basis, as well as in the event of any change in the waiver participant’s care needs.
12. **Changes in Plan of Care** – LDSS representative is responsible for the following:
  - incorporating changes in Summary of Service Requirements in the monthly budget
  - authorizing a change that exceeds the authorized budget by more than 10 percent
  - adjusting paper credits
  - making adjustments when the individual’s budget changes from Health Related Facility (HRF) to Skilled Nursing Facility (SNF), or vice versa

13. **Monitoring** – The LDSS representative, in cooperation with the LTHHCP agency, must review and monitor the POC to assure that services are provided within the budget cap and in accordance with the Summary of Service Requirements.
- The LDSS staff screens each POC for consistency with current Summary of Service Requirements to assure that the participant's assessed needs are met.
  - Annually, the LDSS must review paid claims reports (eMedNY claims or MA Statement of Benefits reports), copies of pharmacy print outs, or receipts for medical supplies and equipment to confirm that MA costs fall within the case approved expenditure cap.
14. **Relationship with the Individual and Family** – One of the most significant roles of the LDSS representative is to maintain a positive relationship with the applicant/participant, family, significant others and any other chosen representatives. This includes clearly identifying important names and telephone numbers, explaining the responsibilities of the social services personnel who will be contacting the individual or others, and supporting family involvement. Maintenance of this relationship should not be taken as a substitute for the medical social worker services provided by the LTHHCP agency; rather, the LDSS representative's role is to support and reinforce the POC developed by the LTHHCP agency.
15. **Notice and Fair Hearing Rights** – The LDSS is responsible for sending fair hearing notices to the LTHHCP participant/applicant when an LDSS or a LTHHCP agency proposes to:
- deny or discontinue participation in the LTHHCP waiver
  - deny, reduce or discontinue one or more services in the Plan of Care contrary to the treating physician's orders
  - change the participant's approved level of care

## **LTHHCP Agency Responsibilities**

In addition to the actual provision of services, LTHHCP agencies have a range of specific case management responsibilities, including the following:

1. **Medicaid Eligibility Application and Recertification** – The LTHHCP agency assists the applicant in completing required forms and securing documentation for MA determination and recertification.
2. **Physician Orders and DMS-1 Form** – The LTHHCP agency Registered Nurse (RN) must obtain necessary physician orders, and complete the level of care assessment form (DMS-1) for submission to the LDSS. If the assessment form has been completed by another individual, the LTHHCP RN must obtain a copy and assure it is submitted to the LDSS.

3. **Home Assessment** – In conjunction with the LDSS representative, the LTHHCP agency RN completes the appropriate sections of the HAA.
4. **Budget Computations** – The LTHHCP agency must submit a list of services and POC cost to the LDSS to compute applicant/participant budget. Some LTHHCP agencies calculate and propose a budget to the LDSS, which has final sign-off. Agencies often calculate a budget when the individual comes into the program on an Alternate Entry basis to assure the individual's budget cap is not exceeded while initiating necessary services. The LDSS may disallow payment for services that are considered unnecessary, that exceed the budget cap, or that were provided to individuals who were not MA eligible at the time services were provided.
5. **Third-Party Insurance** – Because MA is the payer of last resort, LTHHCP agencies must assure all other applicable health insurance plans are billed for covered services prior to billing MA. The agency must also forward the individual's third-party health insurance information to the LDSS if the health insurance information is not already known to the LDSS.
6. **Plan of Care (POC)** – The LTHHCP agency provides case management to waiver participants through development and implementation of the POC. The LTHHCP agency RN assures that the POC, signed by the physician, is implemented as intended and modified when necessary, and shared with the LDSS.

The LTHHCP agency RN monitors all service providers and supervises personal care aides and home health aides in the home. Specific services related to physical therapy, occupational therapy and speech pathology are implemented and overseen by those professionals. If LDSS staff identifies issues with implementation of a POC, they collaborate with the LTHHCP agency staff for remediation.

7. **Referrals of Ineligible Individuals to Alternate Services** – The LTHHCP agency assists the LDSS representative in referring individuals determined ineligible for the waiver to appropriate alternative services.
8. **Provision of Services** – The LTHHCP agency has the primary role in the coordination of the provision of agency services (including nursing, home health aide, physical therapy, etc.). Nursing supervision is critical, and typically more frequently required than in traditional home care. Aide supervision is required for home health aides and for personal care services. The LTHHCP agency also assists the LDSS in obtaining non-waiver services.
9. **Reassessment** – The LTHHCP agency is responsible for periodic reassessment (at a minimum, every 180 days) on an ongoing basis and any time there is a change in the participant's care needs. The reassessment includes level of care determination through completion of the DMS-1 or other authorized assessment tool, and the joint assessment with LDSS staff through completion of the HAA.

**10. Provider Notices: Changes in Plan of Care** – The LTHHCP agency must:

- Notify the LDSS on the first working day following a change in the individual's condition requiring a significant adjustment in the intensity of needed care and concerning any changes in the authorized Summary of Services, using a new level of care assessment form (DMS-1)
- Obtain prior authorization from the LDSS for any service change that exceeds the budget cap for the individual by 10 percent or more, as well as when the budget changes from HRF to SNF, or vice versa
- Notify the LDSS of a waiver participant's hospital admission, as well as, any other change in status

## **Discharge Planning in the LTHHCP Waiver**

If the LTHHCP participant's DMS-1 score decreases to below 60 and a Physician Override is not appropriate for continued participation in the waiver, the LTHHCP provider and the LDSS representative must seek appropriate alternatives for the individual if continued services are needed. Such alternatives may include a traditional home care aide, homemaker services, or volunteer friendly visitors to help maintain the individual's stability. In such instances, the change in services must be carefully explained to the individual's family or other caregivers so that they will understand the reasons for the change.

Similarly, there may come a time when the participant will require more services than can be provided under the LTHHCP waiver. The participant's condition may deteriorate, services may not be able to be provided within the budget even with annualization or use of paper credits, or perhaps the family or community caregivers may no longer be able to continue providing care. The LTHHCP agency and the LDSS representatives must then seek appropriate alternative service providers (including institutional placement when necessary or preferred) to assure a smooth transfer of services. Case managers must explain the reasons for LTHHCP discharge to the individual, and/or family and designated others.

LTHHCP agencies may not stop or decrease services without notifying the LDSS. The LDSS must send a *Fair Hearing Notice* to the participant or family regarding the discontinuance of the individual's participation in the LTHHCP waiver. In such instances the participant or family has the right to ask for a Fair Hearing and may request "Aid to Continue" of the authorized services until a fair hearing decision is issued. Section VIII, "Fair Hearing Notices", includes a full discussion of the fair hearing process with respect to the waiver.

## **Summary of Key Points**

1. Case management is required and crucial for participants in the waiver because of the complexity of their care needs and the necessity for efficient coordination of services from both formal and informal caregivers.
2. The roles of the LDSS representative and the LTHHCP agency in managing the care of the individual in the waiver are similar in some instances, but their responsibilities differ with regard to emphasis and specific task considerations. (Table V-1, LTHHCP Case Management Responsibilities, outlines the specific tasks and responsibilities of the LTHHCP agency and the LDSS staff.)

## **Associated Medicaid Policy Directives (Appendix C)**

- 78 ADM-70, *Implementation of Chapter 895 of the Laws of 1977: Long Term Home Health Care Program*, August 14, 1978
- 83 ADM-74, *Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program*, December 30, 1983
- 85 ADM -26, *Long Term Home Health Care Program Budgeting*, July 12, 1985
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011

## **Associated Laws and Regulations**

- 18 NYCRR §505.21
- 10 NYCRR §763.5



**Table V-1 LTHHCP Case Management Responsibilities**

<b>Management Responsibilities</b>	<b>LDSS Representative</b>	<b>LTHHCP Provider Representative</b>
Case Management		Coordinates, delivers, and monitors all services needed to support the individual in the community within approved budget cap.
Individual Notification	Notifies all potential individuals and others about availability of home and community based service options, LTHHCP services (verbal and written notification) and choice.	In alternate entry cases, notifies all potential individuals about availability and choice of home and community based service options, LTHHCP services (verbal and written notification).
Medicaid Eligibility Application and Recertification	Assists individuals in securing documentation and information.  Monitors status of MA Application, identifies missing documents and/or information, and notifies the LTHHCP provider and individual.  Notifies provider and individual of MA acceptance, denial, or discontinuance; dates of MA coverage; amount of monthly surplus income.	Assists individual in completing forms and securing documentation.
Physician's Orders and DMS-1 Form	Obtains physician's recommendation and level of care assessment from the provider.	Completes level of care assessment (DMS-1) form and obtains necessary physician orders.
Home Assessment	Authorizes initial home assessment. Completes the Home Assessment Abstract (HAA). Assessment may include family interviews, home visits, and consultation with the RN concerning the social/environmental aspects of the individual's needs.	Completes the appropriate sections of the HAA.  Develops Plan of Care.
Budget Computations	Computes monthly and/or annual budget based upon the completed Summary of Service Requirements in the HAA for comparison with appropriate ceiling. Gives final approval on budgets proposed by LTHHCP program. Maintains and authorizes use of "paper credits" for individual.	Assists LDSS staff in determining necessary services and costs.  May propose budget for individual for LDSS approval.
Authorization of LTHHCP Services	Authorizes LTHHCP services and notifies provider concerning admission dates.	
Referral to Alternate Services	Refers ineligible individuals to alternate services.	Assists the LDSS in referring ineligible individuals to alternate services.

<b>Management Responsibilities</b>	<b>LDSS Representative</b>	<b>LTHHCP Provider Representative</b>
Provision of LTHHCP and Non-LTHHCP Services	Assists LTHHCP provider in arranging for the delivery of services not available from the LTHHCP (adult protection, legal counseling, recreation therapy, financial counseling, friendly visitors and/or telephone reassurance) as well as making referrals to LDSS programs (such as Food Stamps, HEAP, and TA).	Coordinates provision of LTHHCP Services (nursing, home health aide, physical therapy etc.) and (with the LDSS representative) arranges for non-LTHHCP services.  Provides nursing visits every two weeks.
Reassessment	Participates in periodic reassessments (every 180 days) and when there is a change in the individual's care needs.	Participates in the periodic reassessment (every 180 days) and whenever there is a change in the individual's care needs.
Changes in Plan of Care	Incorporates changes, as necessary, into the Summary of Service Requirements for the monthly budget and adjusts paper credits.  Authorizes any changes that exceed the approved budget by more than 10%.	Notifies the LDSS on the first working day following note of a change in an individual's condition and for purposes of considering any changes in the authorized Summary of Service Requirements.  Seeks prior authorization for any service change that exceeds the spending cap for the individual by 10% or more or when the level of service needed changes.  Notifies LDSS concerning hospital admissions and other changes in status that might indicate the need for discharge.
Monitoring	Monitors to assure that LTHHCP services are provided under the spending cap and services are provided in accordance with the Summary of Service Requirements.	Monitors service providers in the home and supervises PCA or home health aide.
Relationship with Individual, Family and others	Maintains positive relationships with the individual and involved family/others. Clearly identifying the names and telephone numbers of LDSS personnel who will be contacting the individual and supporting the family/other's involvement, and explaining their responsibilities.	Maintains a positive relationship with the individual, family and all other involved parties.  Notifies the LDSS of any changes in family or informal/formal supports.

<b>Management Responsibilities</b>	<b>LDSS Representative</b>	<b>LTHHCP Provider Representative</b>
Discharge Planning	<p>Coordinates (with provider RN) any needed changes in services and works with the family/others to help them understand the changes.</p> <p>Seeks appropriate alternatives when decreasing services or referring to more intensive services; provides comprehensive information to any agency to which individual is referred.</p> <p>Sends notice to the individual/authorized representative regarding proposed discontinuance of the recipient's participation in the waiver; proposed reduction, denial, discontinuance of service contrary to treating physician orders or when level of budget cap changes from SNF to HRF.</p>	<p>Coordinates (with the LDSS representative) any changes in services and works with the family/others to help them understand the changes.</p> <p>Seeks appropriate alternatives when decreasing services or referring to more intensive services; provides comprehensive information to any agency to which individual is referred.</p>
Third-Party Insurance	Assists the individual in purchasing Medicare Buy-In program and paying health insurance premiums as appropriate.	Bills Medicare and third-party insurance prior to billing MA, and informs the LDSS of any third-party insurance coverage.

# Section VI:

## Medicaid Eligibility

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### **Medicaid Eligibility**

The purpose of this section is to present basic information as it relates to current MA eligibility and the LTHHCP. For more detailed information, please refer to the *Medicaid Reference Guide* available on the NYSDOH web site at:  
[www.health.state.ny.us/health\\_care/medicaid/reference/mrg/](http://www.health.state.ny.us/health_care/medicaid/reference/mrg/)

### **Medicaid Eligibility Determination**

Medicaid eligibility determination is a multifaceted process that begins with the submission of a completed application, along with associated documentation of the individual's identity, residence, citizenship or satisfactory immigration status, income, and resources. Effective May 1, 2010, individuals who declare to be a U.S. citizen on the application are not required to document citizenship or identity. An electronic file match with the Social Security Administration (SSA) will verify citizenship and identity. Only individuals whose citizenship cannot be verified through use of the SSA data match will be required to provide documentation. If the individual is determined to be otherwise eligible, Medicaid coverage will be provided pending an opportunity to provide acceptable documentation. Specific information on Medicaid eligibility and the application process is available at: [http://www.health.ny.gov/health\\_care/medicaid/#apply](http://www.health.ny.gov/health_care/medicaid/#apply)).

### **Spousal Impoverishment Budgeting**

*Spousal Impoverishment Budgeting* is the process used for determining MA eligibility when only one of the spouses from a married couple is applying for a waiver service. In such situations, the spouse not receiving a waiver service is considered the community spouse. The individual receiving a waiver service is considered the institutionalized spouse, since he/she requires nursing home level of care. Alternatively, when both

spouses require waiver services, community budgeting is used to determine the couple's eligibility for MA.

The spouse is considered the *institutionalized spouse* when he/she is:

1. In a medical institution or nursing facility and is likely to remain there for at least 30 consecutive days; or
2. Receiving home and community based services provided pursuant to a waiver under section 1915(c) of the federal Social Security Act and is likely to receive such services for at least 30 consecutive days; or
3. Requiring institutional or non-institutional services under a Program of All-Inclusive Care for the Elderly (PACE) program as defined in sections 1934 and 1894 of the federal Social Security Act; and
4. Married to a spouse (community spouse) who does not meet any of the criteria set forth under (1) through (3).

Spousal Impoverishment Budgeting helps to ensure that some of the couple's income and resources are not spent on the cost of the waiver recipient's care. These rules allow the community spouse of a waiver recipient to retain more income and resources than under MA community budgeting rules.

For further information on spousal impoverishment budgeting, including the allowable spousal impoverishment income and resource amounts, refer to the *Medicaid Reference Guide* available on line at:  
[www.health.state.ny.us/health\\_care/medicaid/reference/mrg](http://www.health.state.ny.us/health_care/medicaid/reference/mrg)

## **Waiver Services and Spousal Impoverishment Budgeting**

In order to be eligible for Spousal Impoverishment Budgeting, an individual in the LTHHCP must be expected to receive waiver services for at least 30 consecutive days.\* Spousal budgeting begins the month that the individual begins receiving the ongoing waiver service. If an individual in the LTHHCP no longer receives a waiver service, spousal impoverishment budgeting ceases to apply the first day of the month following the month in which the waiver service ends. The recipient's MA eligibility must be redetermined under community budgeting rules.

*\*If a person's Plan of Care includes a waiver service over the duration of 30 days, this meets the requirement for 30 consecutive days. For example, an individual may have respiratory therapy every two weeks for two months, meeting the requirement for 30 consecutive days.*

## **Summary of Key Points**

1. Individuals cannot be in the LTHHCP and a Medicaid Managed Care program at the same time.
2. Spousal Impoverishment Budgeting is the MA budgeting process used for a married couple when one of the spouses is an institutionalized spouse. (see definition of an institutionalized spouse in Appendix A) This allows the community spouse to retain more of the couple's income and resources.

## **Associated Medicaid Policy Directives** (Appendix C)

- 89 ADM-47, *Treatment of Income and Resources for Institutionalized Spouses/Individuals and Legally Responsible Relatives*, Dec. 5, 1989
- 93 ADM-29, *Documentation and Verification Requirements for the Medical Assistance Program*, Sept. 21, 1993
- 96 ADM -11, *Spousal Impoverishment: Community Spouse Resource Amount*, May 28, 1996
- 04 OMM/ADM-6, *Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)*, July 20, 2004
- 08 OHIP/INF-1, *Citizenship and Identity Requirements of the Deficit Reduction Act (DRA) of 2005: Final Guidelines*, January 28, 2008

## **Associated Laws and Regulations**

- 18 NYCRR §360-3.7, §360-4.8, §360-4.9, §360-4.10
- *Social Services Law*, §364-i, §364-j, §366-c

## **Other Resources**

NYS DOH Medicaid Reference Guide contains information on many of the topics in this section and is available online at the following web site:  
[www.health.state.ny.us/health\\_care/medicaid/reference/mrg/](http://www.health.state.ny.us/health_care/medicaid/reference/mrg/)

# Section VII: The LTHHCP Waiver and Adult Care Facilities

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## **The LTHHCP Waiver in Adult Care Facilities**

Social Services Law §367-c(5) permits the provision of LTHHCP waiver services in Adult Care Facilities (ACF), other than shelters for adults, which are considered the resident's home. The ability to provide services to waiver participants in an ACF enhances the ability of ACF operators to retain and care for residents who might otherwise be prematurely placed in a nursing facility.

Because of the generally declining physical or mental health or other temporary problems (such as illness or an accident), ACF residents often have increasing care needs. Often such needs exceed the retention standards for the facility and require services ACF operators are not authorized to provide under DOH regulation. Experience has shown that many ACF residents with increased care needs can be safely and adequately cared for in the facilities, given appropriate medical services and community-based home care services such as those provided in the LTHHCP waiver.

LDSS may consider the use of an ACF with LTHHCP waiver services for individuals currently living at home but whose present living environment, cognitive impairment, or lack of informal support jeopardizes their health and safety. (For example, when the individual's private home is considered substandard and a barrier to service delivery, or when the resident is cognitively impaired and unable to function independently) Admission of such an individual to an ACF with needed waiver services may make it possible for the individual to avoid nursing facility placement.

The ACF operator retains the primary responsibility for determining whether to accept or retain a resident with increasing health care needs. In some instances, an ACF operator will recognize that a resident cannot or can no longer be adequately cared for in the facility, even with the provision of home care services. Since the protection of resident health and safety is of primary importance, the resident must then be transferred to a nursing facility by an ACF.

ACF and LDSS staff must maintain an effective working relationship with regard to the referral of residents for admission to an ACF and community-based home care services. To facilitate this working relationship, it is recommended that the LDSS identify a staff person to serve as a home care liaison who ACF operators may contact for information and requests for service.

This Section describes the aspects of care in an ACF that specifically relate to offering LTHHCP waiver participation to residents, including the ADIS Home Care Program. Other community-based home care services are available to ACF residents. (See *Appendix C: 92 ADM-15, Provision of Title XIX Home Care Services in Adult Care Facilities and Implementation of Retention Standards Waiver Program in Adult Homes and Enriched Housing Programs, March 27, 1992*)

Background Note: Historically, regulations (18 NYCRR §360.21) have defined an ACF as being an individual's home and have permitted the provision of personal care and CHHA service to its residents. Chapter 854 of the Laws of 1987 permitted ACF residents to be participants in the LTHHCP waiver. The statutory change was consistent with the generally held belief that social models of congregate care, i.e., adult care facilities, in combination with medical service components can provide appropriate long term care options. Chapter 165 of the Laws of 1991 eliminated a six month residency requirement that had been imposed by Chapter 854 so that an ACF resident may be eligible for the LTHHCP waiver regardless of his/her length of stay in the ACF.

## **ACF Type and the LTHHCP Waiver**

There are currently four ACF types where LTHHCP waiver services may be provided:

1. Adult homes providing long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator;
2. Enriched housing programs providing long-term residential care to five or more adults, primarily individuals sixty-five (65) or older, in community-integrated settings resembling independent housing units and providing or arranging for the provision of room, board, housekeeping, personal care, and supervision;
3. Residences for adults providing long-term residential care, room, board, housekeeping, and supervision for five or more adults unrelated to the operator; and
4. Family-type homes for adults providing long-term residential care and personal care and/or supervision to four or fewer adults unrelated to the operator.



## **Waiver Eligibility Criteria for ACF Residents**

To be eligible for the LTHHCP waiver, an ACF resident must meet all these criteria:

1. The resident must fulfill all the admission and retention criteria established for the type of ACF in which he or she is residing;
2. The resident must be medically eligible for nursing home level of care that requires the services of the LTHHCP; and
3. The services provided under the waiver must not duplicate ACF services.

The ACF operator must identify those individuals for the waiver who may be appropriate and has primary responsibility for determining that ACF admission criteria are met. The ACF operator also has continuing responsibility for decisions about the ongoing ability of facility staff and services to meet the resident's needs.

The LDSS and the LTHHCP agency must conduct the waiver assessment process for the ACF resident together, using the same process used to determining eligibility for individuals in the community.

Individuals who need to stabilize a medical condition (such as hypertension or diabetes) with adjustments to medication, or those who need coordination of health care services, or those who are undergoing rehabilitation for a serious condition (such as a fracture or stroke) would be examples of ACF residents who might benefit from waiver participation. LTHHCP services must not duplicate those the ACF is required to provide.

### **When the Needs of an ACF Resident Cannot Be Met**

If the ACF operator determines a resident's needs cannot be met within the facility, even with the support from LTHHCP services, the operator must make persistent efforts to secure appropriate alternative placement for the resident, including:

1. assisting the resident (or the resident's representative) with filing no less than five applications for appropriate facilities;
2. conducting telephone follow-up with the facilities (every two weeks); and
3. appealing rejections from facilities.

The operator must regularly inform the LDSS and the LTHHCP agency about progress in finding another suitable placement. The ACF operator may contract with the LTHHCP agency to complete the DOH authorized form used by nursing facilities to determine the care needs of an individual.

### **Assessment Process**

The process for assessing an ACF resident for the waiver is otherwise the same as for an applicant to the program. Once a resident has been identified as possibly needing

and wanting waiver participation, and the physician agrees, the LDSS must be contacted to request an assessment of the individual's appropriateness for the waiver. If enrolled, the LDSS representative provides the ACF operator with a copy of the completed assessment, the monthly budget, and the Plan of Care.

Note: The Alternate Entry provisions of the waiver do **not** apply to the ACF population. The LTHHCP agency cannot initiate services to ACF residents prior to the completion of the home assessment and authorization for waiver participation from the LDSS.

## **Budget Considerations**

Social Services Law §367-c(5), which provides for waiver services in an ACF, recognizes that a significant portion of the service normally required in an individual's home is provided by ACF staff. When a participant resides in an ACF, expenditures for the waiver are limited to 50 percent of the cost of care in an SNF/HRF. The 50 percent cap applies only to those services provided by the LTHHCP.

In practice, it is useful to develop a Plan of Care that reflects all of the resident's assessed service needs, as provided through both the waiver and the ACF. The assessors then delete from budget cap consideration all the services determined to be the responsibility of the ACF.

As with other LTHHCP participants, items that represent unusual expenditures not normally included in the nursing facility rates may be excluded from the budget. Such items include kidney dialysis, radiation therapy, chemotherapy, and the cost of medical transportation to the services.

Note: The LDSS determines whether continuous oxygen is included in the local nursing facility rate.

Annualization and "paper credit" provisions of the waiver apply to residents of an ACF. (See Section IV for more information.)

## **ACF and LTHHCP Waiver: Service Responsibilities**

The waiver **cannot** duplicate services the ACF is required to provide. The ACF must assure all of the resident's needs are met. In general, the ACF is responsible for room, board, supervision, and environmental and nutritional functions, as well as specified amounts of personal care services. The ACF is responsible for the "some assistance" level of personal care service, while the LTHHCP waiver is responsible for the "total assistance" level of personal care service. In the case of enriched housing facilities, the waiver can provide the "some assistance" level of personal care to residents.

The LTHHCP waiver is responsible for case management and medically related services including nursing, home health aide, medical transportation, medical supplies and equipment and therapeutic services (such as radiology, dentistry, audiology, and

physical, speech and occupational therapies) for individuals in an ACF. The LTHHCP waiver may provide a personal emergency response system (PERS) only in enriched housing.

The LDSS and LTHHCP agency nurse are responsible for case management of the resident as it relates to the provision of LTHHCP services. The ACF operator retains the final responsibility for assuring all of the resident's needs are met.

For more information about personal care agency and CHHA responsibilities, see 92 ADM-15 (March 27, 1992), *Provision of Title XIX Home Care Services in Adult Homes and Enriched Housing Programs*.

## **Case Management Responsibilities**

As noted previously, the ACF operator has primary responsibility for determining the appropriateness of an individual for ACF admission and retention and for identifying individuals appropriate for LTHHCP waiver referral. For those individuals judged appropriate for the waiver, it is ACF operators and LTHHCP agencies who are expected to work closely to coordinate their respective services to individual residents. This effort is intended to supplement (rather than supplant) those case management services provided by the LTHHCP agency and the LDSS.

The coordination responsibilities of the ACF operator include participation in the assessment and reassessment of a resident and attendance at regular discussions about the resident with the resident and the LTHHCP agency representative. This coordination is important for many reasons. The ACF operator can provide information concerning facility operation and services (such as meal and activity scheduling). The operator can also provide important information regarding the resident's needs, the facility's ability to meet those needs, and other factors that must be considered in developing the Plan of Care. On reassessment, the operator's input will be crucial in evaluating the effectiveness of the Plan of Care.

The case management responsibilities for the three parties (the LDSS, ACF and LTHHCP agency) involved in the process of determining whether waiver services can appropriately be delivered to ACF residents are best understood by using a functional definition of case management, including these five types of activities:

1. intake and screening;
2. assessment and reassessment;
3. comprehensive services planning;
4. service acquisition; and
5. monitoring and follow-up.

## **Reporting Questionable Practices**

LDSS staff should be attentive to the quality of care received by ACF residents with whom they are in contact. At times it may be appropriate for LTHHCP agency staff to alert the LDSS or to request assistance from NYSDOH staff about questionable practices in an ACF.

LDSS or LTHHCP agency staff should contact the NYSDOH Regional Office whenever circumstances warrant, such as:

- the practices of an ACF seem to be questionable;
- there are problems regarding the provision of resident care;
- the presence of inappropriate residents who do not appear to meet the ACF admission criteria;
- there is an unusual number of LTHHCP waiver referrals or a significant number of referrals for individuals inappropriate for the waiver; or
- Community-based home care services are found to have been used to duplicate or replace services required of the ACF.

## **Summary of Key Points**

1. ACF residents who meet LTHHCP eligibility criteria may participate in the waiver program.
2. The waiver assessment process for ACF residents is the same as that use for individuals living in the community, with the input from the ACF operator/staff.
3. The budget for a waiver participant in an ACF cannot exceed 50 percent of the approved HRF/SNF budget cap.
4. The LDSS or the LTHHCP agency should report any concerns they may have about an ACF to the DOH Regional Office.

## **Associated Medicaid Policy Directives (Appendix C)**

- 88 INF-20, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in Adult Care Facilities*, March 24, 1988
- 90 ADM-25, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in Adult Care Facilities*, August 24, 1990
- 92 ADM-15, *Provision of Title XIX Home Care Services in Adult Homes and Enriched Housing Programs*, March 27, 1992

## **Associated Laws and Regulations**

- *Social Services Law §367-c(5)*
- Social Services Law §460 and §461
- *18 NYCRR §505.21*
- *18 NYCRR §487.4*

# Section VIII: Fair Hearing Notices

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## **When Applicants/Participants Must Be Informed of Fair Hearing Rights**

A Fair Hearing is a formal procedure provided by the Office of Administrative Hearings, upon a request made by an applicant or recipient, to determine whether an action taken or the failure to act by a local district was correct.

At the time an individual applies to participate in the LTHHCP, LDSS staff must provide the LTHHCP Consumer Information Booklet that includes an explanation of his/her fair hearing rights.

## **Situations Requiring a Fair Hearing Notice**

MA recipients applying for or currently receiving services under the LTHHCP waiver are entitled to notice and a fair hearing when one of the following situations occurs:

1. An application for participation in the waiver is denied;
2. LTHHCP services are to be discontinued and the participant discharged from the program;
3. A change is made from an SNF-level budget to an HRF-level budget, thus reducing the budget cap;
4. There is a prospect to reduce or discontinue the number of hours of MA funded services previously authorized under a care plan contrary to the treating physician's orders, but without discontinuing the individual's participation in the LTHHCP waiver; and/or
5. MA funded services are denied contrary to the treating physician's orders, but without discontinuing the individual's participation in the LTHHCP waiver.

6. All MA recipients, including LTHHCP waiver participants, are also entitled to a fair hearing when they believe their MA is inadequate.

## **Content of the Fair Hearing Notice**

The fair hearing notice includes a brief description of the action the LDSS intends to take and the specific reasons for such action. Refer to 18 NYCRR Part 358 for more information on the notices and fair hearing requirements.

The notice also informs individuals of the rights to which they are entitled, including their rights to all the following:

1. legal representation
2. a local conference (which does not affect their right to a fair hearing)
3. the opportunity to cross-examine adverse witnesses
4. the opportunity to present evidence, documents, and/or witnesses in their own behalf

The fair hearing must be requested within sixty (60) days from the date of receipt of the notice. If the individual is currently receiving waiver services and desires services to continue (called “aid to continue”) pending a fair hearing, the hearing must be requested before the effective date of the proposed reduction or discontinuance of waiver services as contained in the notice. The LDSS must mail the notice at least (10) days before the effective date of the proposed reduction or discontinuance.

## **Fair Hearing Notices**

Depending on the situation involved, one of five standard notices is used for informing individuals of their fair hearing rights in the LTHHCP waiver. Each of the fair hearing notices has an AIDS Home Care Program (AHCP) equivalent. To provide the applicable Fair Hearing contact information, the notices also come in two versions, New York City and Upstate.

***1. Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program*** – used to notify the LTHHCP applicant or recipient that a decision has been made to authorize, reauthorize, or deny his or her application to participate in the LTHHCP.

***2. Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program*** – used when participation in the LTHHCP is discontinued.

***3. Notice of Intent to Reduce Your SNF Level Budget to an HRF Budget in the Long Term Home Health Care Program*** – used when the budgeting level used to determine the budget cap for an individual changes from Skilled Nursing Facility (SNF) to Health-Related Facility (HRF Level).

**4. Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program (LTHHCP) Contrary to Physician's Orders** - used when the LDSS or the LTHHCP provider proposes to reduce or discontinue services contrary to the participant's physician's orders (or when the physician has not sent a written response to the physician's confirmation form). The nature of the reduction or discontinuance does not affect the individual's participation in the LTHHCP; however, a specific process must be followed as outlined below:

- The LDSS and LTHHCP agency must communicate with the individual's treating physician regarding to the proposed changes.
- The Physician Confirmation Form must be sent to the treating physician by the LDSS (or by the LTHHCP agency, (if it agrees to do so).
- If the physician does agree with the proposed change, the LTHHCP agency may implement the change; and no fair hearing notice is necessary, although the LTHHCP agency must advise the participant of the change in his or her services.
- If the participant requests a hearing with aid continuing, the LTHHCP agency cannot implement the reduction or discontinue services until the fair hearing decision is issued.

**5. Notice of Intent to Deny Services in the Long Term Home Health Care Program Contrary to Physician's Order's** - used when services will be denied on the LTHHCP waiver contrary to the treating physician's orders, but the individual's participation in the LTHHCP will not be terminated.

All local districts must use the appropriate version from among the five fair hearing notices listed previously in order to inform LTHHCP waiver applicants and participants of their fair hearing right, unless prior permission to use a local equivalent form has been previously requested and obtained.

## **Required Procedures for Notices and Fair Hearings**

The fair hearing notices *must be reproduced as two-sided notices* (and *not* as two-page notices) when sent to applicants/participants.

For an explanation of the fair hearing notices and related procedures applicable to the LTHHCP waiver, consult 02 OMM/ADM-4-Notice and Fair Hearing Procedures for the Long Term Home Health Care Program, which is included here. Case examples illustrating use of the LTHHCP Notices follow the text of 02 OMM/ADM-4, in addition to the full text of each of the notice variations.

11 OLTC/005, Revisions to Long Term Home Health Care Program/AIDS Home Care Program (LTHHCP/AHCP) Notices of Decision, advised LDSS of revisions made to the Long Term Home Health Care Program/AIDS Home Care Program (LTHHCP/AHCP)



fair hearing notices. Current notices are available on the DOH website at <http://health.state.nyenet/revlibrary2.htm>

## **Fair Hearing Forms for AIDS Home Care Program**

While all LTHHCP Fair Hearing policy and procedures apply to AIDS Home Care Program (AHCP) participants, there are certain separate required forms are required. In 1992, the former New York State Department of Social Services issued an administrative directive, 92 ADM-25, entitled "AIDS Home Care Program (Chapter 622 of the Laws of 1988)." Attached to this directive was a notice for use in the AIDS home care program. In 2002, the Department issued an administrative directive, 02 OMM/ADM-4, entitled "Notice and Fair Hearing Procedures for the Long Term Home Health Care Program." Attached to this directive were several notices for use in the LTHHCP waiver.

In 09 OLTC/ADM-1, LDSS staff were notified that they must cease using the notices appended to 92 ADM-25 for AHCP recipients. Instead, districts were directed to use the notices appended to 09 OLTC/ADM-1 when notifying MA recipients of action taken with respect to their AHCP participation. Use of these forms continues to be required.

In addition, LDSS and AHCP providers must follow the procedures set forth in the 09 OLTC/ADM-1 with respect to MA recipients who are applicants for, or recipients of, AIDS home care program services. These notice and fair hearing procedures are based on the notice and fair hearing procedures set forth in 02 OMM/ADM-4, which apply to MA recipients' notice and fair hearing rights within the LTHHCP waiver. LDSS staff must continue to follow 02 OMM/ADM-4 for guidance on notice and fair hearing rights of MA recipients who are applicants for, or recipients of, MA LTHHCP waiver services other than AHCP services.

The notices noted in the ADM are mandated and may be downloaded for use from the intranet Library of Official Documents at <http://health.state.nyenet/revlibrary2.htm> or from 'CentraPort' by selecting "Medicaid" from functional areas and then by going to "ADM".

## **Summary of Key Points**

1. The fair hearing notices must be issued whenever there is a change in the participant's services plan and include a brief description and specific reasons for such action, and information about the individual's rights.
2. While all LTHHCP Fair Hearing policy and procedures apply to AIDS Home Care Program (AHCP) participants, certain separate forms are required. Refer to 02 OMM/ADM-4 Notice and Fair Hearing Procedures for the LTHHCP waiver and 09 OLTC/ADM-1 Notice and Fair Hearing Procedures for the AHCP for a description of the above process.

## **Associated Forms**

*Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the Long Term Home Health Care Program*

*Notice of Intent to Discontinue Your Participation in the Long Term Home Health Care Program*

*Notice of Intent to Reduce Your SNF Level Budget to an HRF Level Budget in the Long Term Home Health Care Program*

*Physician Confirmation Form*

*Notice of Intent to Reduce or Discontinue Services in the Long Term Home Health Care Program Contrary to Physician's Orders*

*Notice of Intent to Deny Services in the Long Term Home Health Care Program Contrary to Physician's Orders\**

*Notice of Intent to Authorize/Reauthorize or Deny Your Participation in the AIDS Home Care Program*

*Notice of Intent to Discontinue Your Participation in the AIDS Home Care Program*

*Notice of Intent to Reduce or Discontinue Services in the AIDS Home Care Program Contrary to Physician's Orders*

*Notice of Intent to Deny Services in the AIDS Home Care Program Contrary to Physician's Orders.*

## **Associated Medicaid Policy Directives (Appendix C)**

- *02 OMM/ADM-4, Notice and Fair Hearing Procedures for the Long Term Home Health Care Program, May 28, 2002*
- *09 OLTC/ADM-1, Notice and Fair Hearing Procedures for the AIDS Home Care Program, October 9, 2009*
- *GIS 11OLTC/005, Revisions to Long Term Home Health Care Program/AIDS Home Care Program (LTHHCP/AHCP) Notices of Decision*

## **Associated Laws and Regulations**

- *18 NYCRR §358*

# Section IX:

## Quality Assurance

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### Quality Assurance

To assure effective services for participants, management of the LTHHCP waiver combines quality assurance and improvement strategies by which to continuously measure program performance, identify opportunities for improvement, and monitor outcomes. LDSS, LTHHCP agencies, waiver providers, participants and NYSDOH work collaboratively to identify and address problems through continuous open and effective communication.

NYSDOH is fully committed to the provision of optimal quality of care for waiver participants. The quality assurance (QA) process includes performance monitoring through data collection and analysis; remediation through guidance to providers and LDSS; and improvement strategies to assure success as measured through a variety of factors, including participant overall satisfaction and care/service outcomes.

Performance monitoring focuses on the ability to become aware of events that may compromise federal quality assurance requirements, as specified below. Policies and procedures ensure that issues of concern to the participant, provider, community or program are identified.

Remediation involves response to individual situations and, when necessary, to initiate improvements on a system-wide level. The remediation process must be carried out in a timely and efficient manner.

Improvement is essential to implementation of long term health care system change.

### Federal Assurances

The federal Centers for Medicare and Medicaid Services (CMS) requires that states operating HCBS waivers document continuous compliance with the following six assurances:

1. The waiver must have an adequate and effective system to assure appropriate level of care determinations with ongoing, systemic oversight of the level of care (LOC) determination process.
2. The waiver must maintain an effective system for reviewing the adequacy of service plans for waiver participants.
3. The waiver must have an adequate system for assuring all waiver services are provided by qualified providers.
4. The waiver must have an adequate system to protect the health and welfare of persons receiving services under the waiver.
5. The State must retain ultimate administrative authority over the waiver and administration must be consistent with the approved waiver application.
6. The waiver must maintain an adequate system for assuring financial accountability

## **Roles of the LDSS and LTHHCP Agency**

Each LDSS and LTHHCP agency plays a critical role in assuring quality of care under the waiver as detailed in this Manual. LTHHCP agencies, subject to federal and State requirements governing Certified Home Health Agencies, must also follow QA protocols set forth in the federal Medicare Conditions of Participation and State Health Regulations. These guidelines further enhance the quality of care provided to waiver participants. See Table IX-1 at the end of this section, for a list of LDSS and LTHHCP agency QA responsibilities.

## **Role of the NYS State Department of Health**

In addition to its long standing certificate of need and surveillance responsibilities over LTHHCP agencies, the Department has implemented increased administrative oversight of the waiver to comply with heightened federal and State requirements for quality assurance.

Lack of compliance with CMS quality assurances may be discovered through a range of methods, including a random retrospective review of plan of care, comparison of plan of care to paid claim data, provider surveillance, or information received from the NYSDOH operated Home Health Hotline with regard to waiver participant experiences with provision of services. When problems are identified NYSDOH staff follow-up with the identified LDSS and/or LTHHCP agency, and may initiate a survey and/or referral for audit, vendor hold to limit admission of new participants to the LTHHCP agency and, if the problems persist, termination of the agency's provider status. Staff work in conjunction with the LDSS, the LTHHCP agency, and the NYSDOH regional office to assure a safe transfer of the participant to appropriate alternate services or another LTHHCP agency, if available in the local district.

## Surveillance

NYSDOH surveillance staff monitor all LTHHCP agencies that operate in New York State by standard periodic inspections that include State certification surveys, federal initial certification surveys and recertification surveys to ensure the agency meets federal (Medicare) and State regulations. LTHHCP agencies are surveyed at a maximum interval of 36 months to determine the quality of care and services furnished by the agency, as measured by indicators of medical, nursing and rehabilitative care.

NYSDOH surveillance staff, upon LTHHCP agency survey, gathers information through participant and agency staff interviews, home visits to participants, and clinical record reviews to evaluate the quality of care provided.

Written inspection results are reported by NYSDOH surveillance staff to the LTHHCP agency operator within 10 days of completion of the survey. When regulatory requirements are not met, the deficiency is identified to the LTHHCP agency. The LTHHCP agency operator must submit a written detailed corrective action plan identifying how the specific findings are to be corrected.

NYSDOH surveillance staff reviews the corrective plan and must find the plan acceptable. The LTHHCP agency must implement the approved plan of correction and monitor its effectiveness in correcting the deficient practices. NYSDOH surveillance staff conducts a follow-up survey to ensure the agency has implemented the plan successfully and deficiencies have been corrected.

A major function of the Home Care Surveillance program involves the investigation of complaints concerning home care services, to ensure all patients are offered adequate and safe quality care. All complaints received by the State regarding the provision of services by a LTHHCP agency will be processed according to established complaint investigation procedures. Complaints may be initiated by a patient or by anyone on behalf of a patient. NYSDOH central office surveillance staff coordinates statewide complaint activities and maintains a tracking system on each complaint until it is resolved. Each NYSDOH regional office categorizes, investigates and resolves all home care complaints within its geographic region.

In accordance with protocols developed by NYSDOH, all significant issues/deficiencies identified by NYSDOH surveillance staff during survey or by complaint investigation are shared with NYSDOH waiver management staff. NYSDOH waiver management staff will notify LDSS staff of issues discovered through a survey and/or complaint process that require investigation or intervention by the LDSS with a LTHHCP participant who may be at risk. NYSDOH waiver management staff provides necessary follow up/technical assistance. A summary of issues identified, remediation and follow up will be maintained in the NYSDOH Division of Long Term Care Technical Assistance database for analysis.

## Administrative Oversight by NYSDOH Waiver Management Staff

The LTHHCP waiver is administered by the LDSS in accordance with their statutory role. NYSDOH waiver management staff oversee the LDSS in the fulfillment of their waiver responsibilities through administrative reviews and case record reviews, provide program policy guidance, technical assistance, monitor LDSS administration of the program, and identify/monitor needed corrective actions.

NYSDOH waiver management staff maintains an open line of communication with LDSS staff for technical assistance, complaint investigation, and quarterly conference calls with the LDSSs for issue discussion and information updates.

NYSDOH administrative reviews of the LDSS include an assessment of the LDSS staff understanding of its role and responsibilities and its administrative processes. Preceding the review, the LDSS must complete a self-assessment of its LTHHCP administration; this assessment will be reviewed and used as a tool in NYSDOH waiver management staff's discussion with the LDSS.

When problems are discovered during annual case record or LDSS administrative reviews, further investigation and remediation actions may be taken. Problem findings identified will be discussed with involved LDSS staff and provided in a written report to the LDSS Commissioner. Subsequent case record reviews will be planned for evidence of compliance with remediation.

NYSDOH waiver management staff may review LDSS case records whenever circumstances indicate the need, and to monitor the effectiveness of subsequent corrective actions/remediation.

## NYSDOH Home Health and Hospice Profile Website and Hotline

A NYSDOH Home Health and Hospice Profile website at <http://homecare.nyhealth.gov/> is available to provide consumers with information about home health agencies, including LTHHCP agencies in New York State. Such information includes the agency's services provided, counties served, inspection reports, and any enforcement actions that may have been taken against the agency. In addition, performance ranking and quality of care measurements are provided with an explanation of their limitations. Quality measure performance rankings are designed to show how LTHHCP agencies rank in relation to other similar agencies in New York State. Consumers are encouraged to use this information to begin conversations with their doctors and other health care professionals about their home care options, as well as with family members, friends, and associates who may have direct experience with a particular agency or program.

The Home Health Hotline (800-628-5972) was established to give Medicaid recipients and their families a toll free number to call in the event they want to lodge a complaint regarding the quality of care or other experience with their waiver service. LTHHCP agencies are required to provide, in writing, the telephone number of the hotline and the hours of operation at enrollment.

## **Role of State and Federal Audit Agencies**

The scope and frequency of audits will vary with each auditing entity based upon the mission and goal of the entity. For instance:

- The audit process by the State Office of the Attorney General (OAG) investigates billing fraud, and handles the recovery of resulting financial losses on an as needed basis. Criminal charges may be prosecuted.
- The Office of the State Comptroller monitors all facets of State government operations, including the MA program using data analysis techniques to identify high risk scenarios for potential fraud, under-achievement of program results, and operational inefficiency. The auditors identify the particular types of medical services and medical service providers to be audited. A full audit may be scheduled to examine questionable billing patterns and determine whether corrective actions and/or financial recovery are needed.
- The Office of the Medicaid Inspector General (OMIG) audits all MA enrolled providers on a periodic basis and conducts ongoing audits of LTHHCP agencies for evidence of billing or payment discrepancies. If billing fraud is suspected the OMIG refers the agency to the OAG.

## **Summary of Key Points**

- LDSS, LTHHCP agencies, other waiver providers, participants, and NYSDOH staff must work collaboratively to identify and address problems. The waiver combines quality assurance and improvement strategies to assure a system by which to measure program performance, identify opportunities for improvement and monitor outcomes.
- To retain federal approval and financial participation, CMS requires all HCBS Medicaid waivers to comply with the following six assurances: level of care; service plans; qualifications of providers; participant health and welfare; administrative authority; and financial accountability.
- Compliance by LDSS staff and providers with these assurances is required. Respective responsibilities are summarized in Table X-1

**LONG TERM HOME HEALTH CARE PROGRAM WAIVER**

**CMS QUALITY ASSURANCES**

Table IX-I

<b><u>CMS QUALITY ASSURANCE</u></b>	<b><u>LDSS RESPONSIBILITIES</u></b>	<b><u>LTHHCP AGENCY RESPONSIBILITIES</u></b>
<p><b>I. The waiver must have an adequate and effective system to assure appropriate level of care determinations with ongoing, systemic oversight of the <u>level of care</u> determination process.</b></p> <ul style="list-style-type: none"> <li>• <b>An evaluation for level of care must be provided to all applicants for whom there is reasonable indication services may be needed in the future.</b></li> <li>• <b>The level of care of enrolled participants must be reevaluated as frequently as specified in the approved waiver.</b></li> <li>• <b>The process and instruments used to determine participant level of care must be applied appropriately and according to the description in the approved waiver application.</b></li> </ul>	<p>The LDSS must:</p> <ul style="list-style-type: none"> <li>• Assure each applicant for whom there is reasonable indication services may be needed has had his/her need for nursing home level of care (LOC) assessed and, if accepted into the waiver, has that LOC reassessed at least every 180 days or more frequently if circumstances warrant.</li> <li>• Obtain physician's recommendation and level of care assessment (DMS-1) from the LTHHCP agency.</li> <li>• Review every LOC instrument, i.e., The Long Term Care Placement Form, Medical Assessment Abstract (DMS-1) submitted and completed by the licensed medical professional assessor to assure all sections are complete, the form is signed and dated appropriately, and all indicators are scored accurately.</li> <li>• Confer with the assessor to discuss and remediate all identified issues.</li> <li>• If agreement can not be reached, request review by the LDSS local professional director who will review the case and make the LOC determination.</li> <li>• Contact State waiver management staff for technical assistance if needed in resolving</li> </ul>	<p>The LTHHCP agency must:</p> <ul style="list-style-type: none"> <li>• Have staff RN examine /interview /assess an applicant/participant in a face to face visit to complete the Long Term Care Placement Form, Medical Assessment Abstract (DMS-1) and sign it, attesting to the validity of the assessment. (Alternatively, this may be done by the applicant/participant's attending physician or a facility RN if the individual is hospitalized or residing in a nursing home.)</li> <li>• Forward the assessment to the LDSS in a timely manner and confer with the LDSS to discuss and remediate all identified issues, accepting the determination of the LDSS local professional director if agreement can not be reached with LDSS staff.</li> </ul>



<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
	<p>disputes.</p> <ul style="list-style-type: none"> <li>Track and report timeliness of application processing information related to LOC assessments/determinations, using specifications provided by DOH.</li> </ul>	
<p><b>II. The waiver must maintain an effective system for reviewing the adequacy of <u>service plans</u> for waiver participants.</b></p> <ul style="list-style-type: none"> <li><b>Service plans must address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or other means.</b></li> <li><b>Service plan development must be monitored in accordance with policies and procedures.</b></li> <li><b>Service plans must be updated/revised as set forth in the waiver application but, at minimum, at least annually or when warranted by changes in the participant's needs.</b></li> <li><b>Services must be delivered in accordance with the service plan, including the type, scope, amount and frequency specified in the service plan.</b></li> <li><b>Participants must be afforded choice between waiver services and institutional care and between/among waiver services and providers.</b></li> </ul>	<p>The LDSS must:</p> <p><b><u>Plan of Care Development</u></b></p> <ul style="list-style-type: none"> <li>Authorize initial home assessment.</li> <li>Conduct an assessment of the home environment, the individual's psychosocial status and availability of support systems using the Home Assessment Abstract (HAA) tool which is used with the DMS-1/PPRI to provide a full assessment of the individual's strengths and needs. This is done in cooperation with the LTHHCP agency.</li> <li>Use the full assessment to develop a Plan of Care which includes the range of services, both waiver and non-waiver, necessary to allow the individual to remain in the community, addressing his/her health, welfare and personal goals. This is done with the LTHHCP.</li> <li>Identify risk factors and safety considerations; incorporating interventions into the Plan of Care with consideration of the participant's assessed preferences.</li> <li>Include necessary back-up arrangements such as availability and use of family members or other informal supports to assist the participant.</li> <li>Include the applicant/participant, his/her family, significant others, legally designated</li> </ul>	<p>The LTHHCP agency must:</p> <p><b><u>Plan of Care Development</u></b></p> <ul style="list-style-type: none"> <li>Conduct a DMS-1 assessment or obtain one from the medical professional who conducted the assessment (as noted above under the first assurance) to be used with the HAA tool completed with the LDSS to provide a full assessment of the individual's strengths and needs.</li> <li>Use the full assessment to develop a Plan of Care which includes the range of services, both waiver and non-waiver, necessary to allow the individual to remain in the community, addressing his/her health, welfare and personal goals. This is done with the LDSS.</li> <li>Identify risk factors and safety considerations, incorporating interventions into the Plan of Care with consideration of the participant's assessed preferences.</li> <li>Include necessary back-up arrangements such as availability and use of family members or other informal supports to assist the participant.</li> <li>Include the applicant/participant,</li> </ul>

<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
<p><b>Note:</b> Federal Medicaid waiver terminology uses “service plan;” in the LTHHCP waiver this is referred to as the “plan of care.”</p>	<p>representative(s) and/or other representatives of his/her choosing in Plan of Care development.</p> <ul style="list-style-type: none"> <li>• Maintains a positive relationship with the individual and family by clearly identifying the names and telephone numbers and by explaining the responsibility of the LDSS personnel who will be contacting the individual and supporting the family’s involvement in the program.</li> <li>• If disagreements occur in Plan of Care development, confer with the LTHHCP agency for remediation; if agreement can not be reached refer the case for review to the local professional director who will determine appropriate adjustments.</li> <li>• Review the proposed Plan of Care and compare it to the physician’s orders to ensure all needs are met and services provided.</li> <li>• Investigate all unmet needs and, if found, contact the LTHHCP agency for discussion and resolution.</li> <li>• Develop the individual’s budget based on the agreed upon the Summary of Service Requirements; annualize the individual’s budget, as appropriate, to effectively address fluctuations in his/her service needs. Gives final approval on budgets proposed by the LTHHCP provider.</li> <li>• Maintains and authorizes use of “paper credits” for individual.</li> <li>• Approve for waiver participation each individual whose needs, goals, health and welfare can be served within his/her individual</li> </ul>	<p>his/her family, significant others, legally designated representative(s) and/or other representatives of his/her choosing in significant others in Plan of Care development.</p> <ul style="list-style-type: none"> <li>• Maintains good working relationships with the family and other caregivers. Notifies LDSS of any changes in family or caregiver support.</li> <li>• If disagreements occur in Plan of Care development, confer with the LDSS for remediation; if agreement can not be reached, comply with decisions of the local professional director who determines appropriate adjustments.</li> <li>• Assist LDSS staff in determining necessary services and costs. May propose budget for individual for LDSS approval.</li> <li>• Discuss and resolve with the LDSS any findings regarding unmet needs.</li> <li>• Assist LDSS in referring ineligible individuals to alternate services.</li> <li>• Provide all applicants approved for waiver participation with a copy of the bill of patient’s rights, documenting in the clinical record that this has been given to the participant.</li> </ul>

<b><u>CMS QUALITY ASSURANCE</u></b>	<b><u>LDSS RESPONSIBILITIES</u></b>	<b><u>LTHHCP AGENCY RESPONSIBILITIES</u></b>
	<p>limit. Authorize provision of LTHHCP services and participation; and notify provider concerning admission dates.</p> <ul style="list-style-type: none"> <li>Assure the individual is referred to other appropriate resources if the Plan of Care can not meet the individual's needs to assure health and safety.</li> </ul>	
	<p><b><u>Plan of Care Update/Revision</u></b></p> <ul style="list-style-type: none"> <li>Repeat the Plan of Care process at least every 180 days or more frequently when circumstances warrant. Review all subsequent Plans of Care for completeness and timeliness.</li> <li>Approve of any change in the Summary of Service Requirements arising from changes in the individual's health status, and agree or disagree with any proposed changes to the services specified in the Plan of Care.</li> <li>Use the range of available options to continue to meet the individual's service needs, e.g. use of paper credits, budget annualization, use of appropriate alternative waiver/non-waiver services, maximization of third party resources, increased use of informal supports, including other community resources. Also, coordinate (with provider RN) any changes in services with the family/caregivers to help them understand the changes.</li> <li>Seek appropriate alternatives when decreasing services or referring to alternative community based services or for institutionalization; provide comprehensive information to any agency to which individual referred.</li> </ul>	<p><b><u>Plan of Care Update/Revision</u></b></p> <ul style="list-style-type: none"> <li>Repeat the Plan of Care process at least every 180 days or more frequently when circumstances warrant.</li> <li>In accordance with Medicare Conditions of Participation, review the Plan of Care at least every 60 days or more frequently when there is a significant change in the individual's condition and promptly alert the physician of any need to alter services requiring the physician's order.</li> <li>Use the range of available options to continue to meet the individual's service needs, e.g. use of paper credits, budget annualization, use of appropriate alternative waiver/non-waiver services, maximization of third party resources, increased use of informal supports, including other community resources. Also, coordinate (with the LDSS representative) any changes in services with the family/caregivers to help them understand the changes.</li> <li>Notify LDSS concerning hospital</li> </ul>

<b><u>CMS QUALITY ASSURANCE</u></b>	<b><u>LDSS RESPONSIBILITIES</u></b>	<b><u>LTHHCP AGENCY RESPONSIBILITIES</u></b>
	<ul style="list-style-type: none"> <li>Send notice to the individual/family regarding: proposed discontinuance of the individual's participation in the LTHHCP; proposed reduction, denial, discontinuance of service contrary to treating physician orders or when level of budget cap changes from SNF to HRF.</li> </ul>	<p>admissions and other changes in status that might indicate the need for discharge from the LTHHCP.</p> <ul style="list-style-type: none"> <li>Seek appropriate alternatives when decreasing services or referring to alternative community based services or for institutionalization; provide comprehensive information to any agency to which individual referred</li> </ul>
	<p><b><u>Service Delivery</u></b></p> <ul style="list-style-type: none"> <li>Assist LTHHCP provider in arranging for delivery of services not available from the LTHHCP (adult protection, legal counseling, recreational therapy, financial counseling, friendly visitors and/or telephone reassurance) as well as in making referrals to LDSS programs (such as Food Stamps, HJEP, and PA).</li> <li>Maintain regular contact with the waiver participant to discuss the delivery of services in the approved initial or revised Plan of Care.</li> </ul>	<p><b><u>Service Delivery</u></b></p> <ul style="list-style-type: none"> <li>Implement and oversee the Plan of Care, coordinating and monitoring the provision of LTHHCP services. With the LDSS representative) arranges for the non-LTHHCP services.</li> <li>Conduct aide supervision as required by applicable regulations.</li> <li>Address with the LDSS any issues identified during LDSS home visits.</li> </ul>
	<p><b><u>Participant Choice</u></b></p> <ul style="list-style-type: none"> <li>Offer all potential waiver participants informed choice between community-based services and institutional care.</li> <li>For those choosing community-based care, discuss and offer choice of MA waiver programs and non-waiver services/programs such as the Personal Care Services Program or Managed Long Term Care.</li> <li>Notify all potential individuals or their families</li> </ul>	<p><b><u>Participant Choice</u></b></p> <ul style="list-style-type: none"> <li>When "alternate entry" is initiated for an individual: (a) offer all potential waiver participants informed choice between community-based services and institutional care; and (b) for those choosing community-based care, discuss and offer choice of MA waiver programs and non-waiver services/programs such as the Personal Care Services Program or</li> </ul>

<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
	<p>about availability of LTHHCP services (verbal and written notification).</p> <ul style="list-style-type: none"> <li>• Offer choice of providers of such services/programs from among qualified/participating providers.</li> <li>• Provide applicants/participants with the <i>LTHHCP Consumer Information Packet</i>, customized to include a list of LTHHCP agencies serving the county.</li> </ul>	<p>Managed Long Term Care</p> <ul style="list-style-type: none"> <li>• Offer choice of waiver services providers from among qualified/participating providers. The applicant/participant has the right to choose from among the available providers.</li> </ul>
<p><b>III. The waiver must have an adequate system for assuring all waiver services are provided by qualified providers.</b></p> <ul style="list-style-type: none"> <li>• <b>All providers must initially and continually meet required licensure and/or certification standards and adhere to other state standards prior to furnishing waiver services.</b></li> <li>• <b>All non-licensed providers/non-certified providers must be monitored to assure adherence to waiver requirements.</b></li> <li>• <b>Provider training must be conducted in accordance with state requirements and the approved waiver.</b></li> </ul>	<p>The LDSS must:</p> <ul style="list-style-type: none"> <li>• Use only those agencies certified by DOH and approved for enrollment in eMedNY as the applicant's/participant's LTHHCP agency.</li> <li>• Participate in provider training and technical assistance opportunities at the request of DOH.</li> <li>• Contact DOH and/or call the Home Health Hotline if there is a concern related to the quality of services provided by the LTHHCP agency and the agency is not remediating the problem.</li> </ul>	<p>The LTHHCP agency must:</p> <ul style="list-style-type: none"> <li>• Remain in compliance with all federal and State certification and survey requirements, including: <ul style="list-style-type: none"> <li>- orientation and ongoing training of staff and an annual performance evaluation which includes an in home visit to observe interaction with participants;</li> <li>- maintenance of appropriate contracting policies and procedures to fulfill the LTHHCP agency's responsibility for assuring all contracted staff are appropriately licensed, certified and in compliance with established qualifications for providing LTHHCP services;</li> <li>- maintenance of an agency quality management process which includes an annual overall evaluation of its total program by professional personnel.</li> </ul> </li> <li>• Comply with applicable State</li> </ul>

<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
		<p>fingerprinting requirements for prospective employees.</p> <ul style="list-style-type: none"> <li>• Enroll in eMedNY, submitting and annually updating all required certification statements.</li> <li>• Participate in provider training and technical assistance opportunities at the request of the LDSS or DOH.</li> </ul>
<p><b>IV. The waiver must have an adequate system for identifying, addressing and preventing instances of abuse, neglect and exploitation.</b></p> <ul style="list-style-type: none"> <li>• <b>Abuse, neglect and exploitation must be identified, addressed and prevented on an ongoing basis.</b></li> </ul>	<p>The LDSS must:</p> <ul style="list-style-type: none"> <li>• Monitor the health and welfare of individual participants.</li> <li>• Assure staffs involved with assessment, reassessment and service delivery or oversight under the waiver comply with all NYS requirements for reporting abuse and/or neglect applicable to their professional status.</li> <li>• Refer cases as appropriate to the LDSS' Protective Services for Adults or Child Protective Services programs; document such referrals in the case record; and, work with those programs as appropriate on resolution of issues.</li> <li>• Monitor follow-up activity to assure corrective action.</li> <li>• Comply with DOH reporting specifications regarding identification of significant occurrences of abuse, neglect and/or exploitation and corrective actions.</li> <li>• As provided in for in the <i>Consumer Information Booklet</i>, provide participants with the DOH Home Health Hotline phone number.</li> </ul>	<p>The LTHHCP agency must:</p> <ul style="list-style-type: none"> <li>• Monitor the health and welfare of individual participants.</li> <li>• Assure staffs involved with assessment, reassessment and service delivery or oversight under the waiver comply with all NYS requirements for reporting abuse and/or neglect applicable to their professional status.</li> <li>• Comply with federal and State requirements for policies and procedures which support the prevention, identification and/or remediation of abuse, neglect and exploitation, e.g. requirements for agency quality management processes to report adverse incidents/outcomes for investigation, action and quality improvement.</li> <li>• Refer cases as appropriate to the LDSS' Protective Services for Adults or Child Protective Services programs; document such referrals in the case record; and, work with those programs</li> </ul>

<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
		<p>as appropriate on resolution of issues.</p> <ul style="list-style-type: none"> <li>• Provide participants with the DOH Home Health Hotline phone number</li> </ul>
<p><b>V. The State must retain ultimate administrative authority over the waiver and administration must be consistent with the approved waiver application.</b></p> <ul style="list-style-type: none"> <li>• <b>The State Medicaid agency must retain ultimate administrative authority by exercising oversight of the performance of waiver functions by other State and local/regional non-State agencies and contracted entities.</b></li> </ul>	<p>The LDSS must:</p> <ul style="list-style-type: none"> <li>• Participate as requested by DOH in State waiver management staff review of case records, including completion of any self-assessments required prior to State on-site review and implementation of any identified corrective actions.</li> <li>• Participate as requested by DOH in quarterly technical assistance advisory calls and/or other training activities.</li> <li>• Maintain accurate and complete case documentation and comply with all DOH specified tracking/reporting requirements.</li> </ul>	<p>The LTHHCP agency must:</p> <ul style="list-style-type: none"> <li>• Participate as requested by the LDSS and DOH in State waiver management staff review of case records, including completion of any self-assessments required prior to State on-site review and implementation of any identified corrective actions.</li> <li>• Comply with all State survey requirements, including implementation of any corrective actions that must be implemented pertaining to the assurances, e.g. LOC assessments/determinations. For LTHHCPs which are Certified Home Health Agencies, these surveys serve as a primary mechanism for the State to assure that the agencies are complying with all Medicare Conditions of Participation pertaining to the assurances, e.g. components of plan of care development.</li> <li>• Participate as requested by the LDSS and/or DOH in technical assistance advisory calls and/or other training activities.</li> <li>• Maintain accurate and complete case documentation and comply with all tracking/reporting requirements specified by the LDSS and/or DOH.</li> </ul>

<u>CMS QUALITY ASSURANCE</u>	<u>LDSS RESPONSIBILITIES</u>	<u>LTHHCP AGENCY RESPONSIBILITIES</u>
<p><b>VI. The waiver must maintain an adequate system for assuring financial accountability.</b></p> <ul style="list-style-type: none"> <li>• <b>Claims must be coded and paid for in accordance with reimbursement methodologies specified in approved waiver application.</b></li> </ul>	<p>The LDSS must:</p> <ul style="list-style-type: none"> <li>• Compute each individual’s monthly MA expenditures based upon the Summary of Services Requirements and assure expenditures will be within the approved monthly budget cap before authorizing the individual’s participation in the waiver.</li> <li>• Give final approval on budgets proposed by LTHHCP provider. Maintain and authorize use of “paper credits” for participants.</li> <li>• Review the participant’s Plan of Care and monitor expenditures at least every 180 days as part of the reassessment process.</li> <li>• Incorporate any changes in the Summary of Service Requirements into monthly budget and adjust paper credits. Authorize any changes that exceed the approved budget by more than 10%.</li> <li>• Identify an approved participant’s authorization for the waiver by entering Code 30 in the Welfare Management System’s Restriction/Exception Code.</li> <li>• When authorizing State Plan services for an applicant/participant such as PERS, assure that those services are not duplicated within the waiver Plan of Care.</li> <li>• Maintain necessary documentation and provide information requested by DOH and/or federal and State audit agencies necessary for program oversight.</li> </ul>	<p>The LTHHCP agency must:</p> <ul style="list-style-type: none"> <li>• Notify LDSS on the first working day following the noting of a change in an individual’s condition and concerning any changes in the authorized Summary of Service Requirements.</li> <li>• Seek prior authorization for any service change that exceeds the spending cap for the individual by 10% or more when the level of service changes from SNF to HRF.</li> <li>• Comply with eMedNY enrollment and billing requirements.</li> <li>• Bill Medicare and third-party insurance for services, when appropriate, prior to billing Medicaid. Inform LDSS of any third-party insurance coverage.</li> <li>• Submit claims only for individuals who have been authorized by the LDSS as LTHHCP participants.</li> <li>• Secure an independent audit of their financial statements attesting to the accuracy of their annual cost report submitted to DOH.</li> <li>• Maintain necessary documentation and provide information requested by DOH and/or federal and State audit agencies necessary for program oversight.</li> </ul>



# Section X:

## Recordkeeping Requirements

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### **LDSS Recordkeeping Responsibilities**

Compliance with federal and State recordkeeping requirements—from the point of an individual’s waiver application to service planning, delivery and outcomes—must be maintained to meet fiscal and programmatic accountability and quality assurance requirements for HCBS waivers.

#### **Waiver Specific Records**

In addition to the records required for any individual applying for participation in Medicaid state plan or other service programs, certain specified records must be maintained for each LTHHCP waiver applicant or participant in the individual’s case record.

These records must include, but are not limited to:

1. Freedom of Choice Form signed by applicants
2. Annual Satisfaction Survey response or documentation that survey was provided
3. Contact Information Form
4. Level of Care assessment tool (DMS-1), including documentation of any override of the DMS-1 score by a physician or the local professional director used for assessments and reassessments
5. Home Assessment Abstract (HAA)
6. Physician orders
7. Plan of Care
8. LTHHCP Waivered Services Prior Authorization form (LDSS Form 3394)
9. Documentation used in calculation of the applicant/participant’s monthly budget

10. Documentation of referrals to alternative services made for applicants found ineligible for the waiver, or dis-enrolled participants, and outcomes of those referrals as appropriate
11. Documentation of referrals made to other LDSS programs/services (e.g., Adult Protective Services (APS), Child Protective Services (CPS), Home Energy Assistance Program (HEAP) for applicants/participants and outcomes as appropriate
12. Documentation of LDSS interactions with LTHHCP agencies serving waiver participants
13. Documentation of the applicant/participant permission to discuss his/her case with family members and/or others designated by the applicant/participant

## **LDSS Quarterly Report**

To initiate improved tracking and quality assurance reporting requirements, the “Long Term Care Home Health Care Program LDSS Quarterly Report” was initiated effective April 1, 2009 via GIS 09 OLTC/002, and reissued as Attachment IV to 11 OLTC/ADM-1. The data collected and reported by district staff in the report is used by NYSDOH for monitoring and analyzing trends, and identifying quality improvement issues in compliance with CMS quality assurance requirements. The data collected for the LTHHCP LDSS Quarterly Report includes:

1. Number of LTHHCP waiver referrals and applicants
2. Average length of time between LTHHCP applications and/or referrals for the LTHHCP waiver and completion of the level of care determinations by the LTHHCP agency/facility
3. Number of LTHHCP waiver applications approved
4. Number of LTHHCP waiver applications denied
5. Number of participants disenrolled from the LTHHCP waiver and reason
6. Number of alleged occurrences of abuse, neglect and/or exploitation resulting in referral to Adult Protective Services (APS) or Child Protective Services (CPS)
7. Number of total participants surveyed during the quarter

## **LTHHCP Agencies and Other Waiver Providers**

Accurate and up-to-date recordkeeping is required of all MA providers to substantiate accurate billing. The need to maintain the necessary records is described in the Provider Agreement, the eMedNY Provider Manual (available at <https://www.emedny.org/>) and in this Program Manual. It is the responsibility of the provider to have clear and accurate documentation to support all claims submitted for MA payment.

In addition to meeting the MA and waiver recordkeeping requirements, LTHHCP agencies and other waiver service providers must meet additional recordkeeping

requirements set forth in 10 NYCRR 763.14, as well as those required under the Medicare Conditions of Participation 484.48.

## **HIPAA and Privacy Regulations**

LTHHCP agencies and other waiver service providers must adhere to all MA confidentiality and Health Information Portability and Accountability Act (HIPAA) requirements and ensure the privacy of the waiver participant.

LTHHCP agencies and other waiver service providers must maintain a policy and procedure that assures the appropriate safeguard of all records containing any identifiable information regarding waiver applicants and participants. These policies and procedures must be disseminated and otherwise made available for easy reference to all staff.

LTHHCP agencies are responsible for maintaining open communication with other waiver service providers when concerns or changes with the participant's condition occur that potentially affect the provision of services. However, each provider must be respectful of the participant's right to privacy and confidentiality regarding the sharing of information, and have in place policies and procedures that must include, but are not limited to:

- Maintaining records in a secured environment (e.g. locked files/room) when not in use
- Preventing inappropriate exposure of information when records are in use
- Identifying all information transferred or transmitted from one location to another as "confidential" and in an appropriately secured manner
- Obtaining prior authorization from the appropriate supervisory staff before records are taken outside the agency, and return of records within one (1) business day
- Properly informing applicants/participants of record collection procedures, access, utilization and dissemination of information
- Specifying procedures related to employee access to information
- Specifying disciplinary actions for violations of confidentiality statutes, regulations and policies

### **Medicaid Claim Records**

LTHHCP agencies and other waiver service providers must sign a Claim Certification Statement that includes certification that services were furnished and records pertaining to MA claims must be retained for at least six (6) years.

Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the MA agency, the operating agency (if applicable), and providers of waiver services for a minimum period of three years as required in 45 CFR §92.42.

## **Summary of Key Points**

- As with all other MA programs/services, LDSS staff, LTHHCP agencies, and other waiver service providers must maintain complete records to document interactions with applicants and participants.
- Required records reflect federal and State quality assurance requirements with regard to the health and welfare of waiver participants and MA reimbursement.

## **Associated Medicaid Policy Directives**

- GIS 09 OLTC/002, *Long Term Home Health Care Program (LTHHCP) DSS Quarterly Report*, March 24, 2009
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011

## **Associated Laws and Regulations**

- 10 NYCRR 763.14
- Medicare Conditions of Participation 484.48

# Appendix A:

## Glossary

**Adult Care Facilities (ACF):** residences that provide temporary or long term residential care and services to adults who, though not requiring continual medical or nursing care, by reason of physical or other limitations associated with age, physical or mental disabilities, other factors, are unable or substantially unable to live independently. There are five types of Adult Care Facilities: Adult Homes, Residences for Adults, Family-Type Homes for Adults, Enriched Housing Programs, and Shelters for Adults. The LTHHCP services cannot be provided in shelters for adults.

**Adult Day Health Care:** medically supervised services that may include nursing; transportation; leisure activities; physical, occupational, and speech therapies; nutrition assessment; medical social services; psychosocial assessment; rehabilitation; and socialization. Services must meet DOH standards (10 NYCRR Part 425) and require a physician order.

**Adult Homes:** facilities that provide long-term residential care, room, board, housekeeping, personal care, and supervision to five or more adults unrelated to the operator.

**Aid Continuing:** the term used to designate the right to have public assistance, medical assistance, food stamp benefits, or services continued unchanged until the fair hearing decision is issued. If a MA recipient wants to receive LTHHCP waiver services on an aid-continuing basis, he or she must request a fair hearing before the effective date of the proposed reduction or discontinuance as contained in the fair hearing notice.

**AIDS Home Care Program (AHCP):** the title of a coordinated plan of care and services provided at home to persons who are medically eligible for placement in a nursing facility and who (a) are diagnosed by a physician as having AIDS; or (b) are deemed by a physician, within his or her judgment, to be infected with the etiologic agent of AIDS, and who have an illness, infirmity, or disability which can be reasonably ascertained to be associated with such infection. A LTHHCP agency cannot provide AHCP services unless specifically authorized by NYSDOH.

**Alternate Entry:** the process used to admit individuals with immediate needs into the LTHHCP waiver following an initial assessment by a LTHHCP agency. With the documented approval of a physician, the agency can begin necessary services. The LTHHCP agency must inform such individuals of all long term care options, including use of general Medicare or MA home care services, other Home and Community Based Services waivers and Managed Long Term Care. The agency must also provide to the potential participant a copy of the Consumer Information Packet that must be signed by the consumer and the LTHHCP representative.

**Annualized Budget:** the process by which the costs of care for an individual are averaged over the year to allow items that may exceed the budget cap in one or more months do not limit use of the waiver. This process is used when the LDSS representative anticipates the total expenditures for a 12 month period will not exceed the budget cap.

**Assistive Technology:** a waiver service supplementing the MA State Plan Service of durable medical equipment and supplies which provides a broad range of special medical equipment and supplies. The Medicaid State Plan and all other sources must be explored before considering Assistive Technology. An Assistive Technological device may include a medically necessary item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of waiver participants.

**Budget Review:** the process used by the LDSS staff to determine whether the individual's monthly cost of care is within the budget cap allowed for that individual.

**Budget Cap:** the monthly spending limit for an individual is based on the level of care for which he/she is eligible. The budget cap is 75% of the cost of care in a SNF or HRF for most individuals, 100% of the cost of care in a SNF or HRF for Individuals with Special Needs, and 50% of the cost of care in an SNF or HRF for residents of Adult Care Facilities.

**Carve Out List:** the list of drugs excluded from nursing facility rates. Drugs included on the "care out list" are not included in the monthly MA expenditures and is not counted toward the monthly expenditure cap.

**Case Management:** a comprehensive approach to the assessment and reassessment for all needed medical, psychosocial, and environmental services, and the coordination, delivery, and monitoring of all services needed to support the LTHHCP waiver participant in the community within the individual's approved Plan of Care. This approach allows services to be tailored to address all individual needs and to be well-coordinated, assuring an appropriate and cost-effective Plan of Care. To be eligible for the LTHHCP waiver, the individual must require the case management services of a LTHHCP agency.

**CMS:** abbreviation for the federal Centers for Medicare and Medicaid Services which oversees Medicaid Home and Community Based Services waivers and sets the standards which must be met for a state's waiver to qualify for federal financial participation.

**Community Budgeting:** MA budgeting eligibility process used when individuals reside in the community. They are not eligible for spousal impoverishment budgeting or are not in permanent absence status.

**Community Spouse:** a person who is the spouse of an institutionalized person and who is residing in the community and not expected to receive home and community based services provided pursuant to a waiver under Section 1915(c) of the federal Social Security Act for at least 30 consecutive days or services under a PACE program as defined in sections 1934 and 1894 of the federal Social Security Act.

**Community Spouse Monthly Income Allowance:** The amount by which the minimum monthly maintenance needs allowance for the community spouse exceeds the otherwise available monthly income of the community spouse, unless a greater amount is established pursuant to a fair hearing or a court order for support of the community spouse.

**Community Spouse Resource Allowance:** the amount of resources that the community spouse is permitted to retain under spousal impoverishment budgeting. This amount is equal to the greatest of the following: the state minimum spousal resource standard; or the amount of the spousal share up to the federal maximum community spouse resource allowance; or the amount established for support of the community spouse pursuant to a fair hearing or court order.

**Community Transitional Services (CTS):** a waiver service defined as individually designed services intended to assist a participant to transition from a nursing home to living in the community. This service is only provided when the individual is transitioning from a nursing home. It must not be used to move the participant from his/her home in the community to another location in the community.

**Congregate and Home-Delivered Meals:** a waiver service which provides meals to participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when the provision of such meals will decrease the need for more costly supports to provide in-home meal preparation. These meals will assist the participant to maintain a nutritious diet. They do not, however, constitute a full nutritional regimen.

**Decubitus Care:** technical term used to designate the kind of care given to persons with a pressure sore (sometimes called a "bedsore").

**Disenrollment:** the process used to remove someone from a program (such as a Medicaid Managed Care Health Plan).

**Discharge Planning in the LTHHCP waiver:** process by which the LTHHCP agency and LDSS plan for a discharge of an individual from the LTHHCP waiver to other home care services, to institutional care, or to independence. The LDSS must provide written notice to the LTHHCP participant and/or the participant's representative regarding the proposed discharge, and a fair hearing notice must also be provided to the participant so he/she may appeal the proposed discharge.

**Dispute Resolution Process:** the procedure followed when there are disagreements among the persons performing the assessment of an individual seeking entry into the LTHHCP waiver. Such issues might include disagreement as to whether the individual should be admitted to the LTHHCP waiver, disagreement about the need or amount of service(s) to be provided, or concern about the possible problems in implementing the Plan of Care. In such instances, the LDSS and the LTHHCP agency have a conference to review the Plan of Care. If there is not resolution at the time of the conference, it is referred to the local professional director for review and resolution. The decision of the local professional director is final. The appropriate fair hearing notice must be sent to the individual as indicated (including LTHHCP authorize, reauthorization, denial or discontinuance). If the individual disagrees with the decision, he/she may request a Fair Hearing to appeal the local professional director's decision.

**DMS-1 Form:** the assessment form used in the LTHHCP waiver for individuals age 18 and older to evaluate whether an individual qualifies for the nursing facility level of care and, therefore, may be programmatically eligible for the LTHHC waiver. The full name of the form is the New York State Department of Health Long Term Care Placement Form Medical Assessment Abstract. The evaluation criteria include nursing care needs, incontinence status, functional status, mental status impairments, and rehabilitation therapy needs.

**DOH:** the abbreviation for New York State Department of Health.

**Enriched Housing Programs:** are facilities that provide long-term residential care to five or more adults, primarily persons age sixty-five (65) or older, in community-integrated settings that resemble independent housing units. The program provides or arranges for the provision of room, board, housekeeping, personal care, and supervision.

**Environmental Modifications (E-mods)** are internal and external physical adaptations to the home or vehicle necessary to assure the health, welfare and safety of the waiver participant. These modifications enable the waiver participant to function with greater independence and prevent institutionalization.

**Fair Hearing Notice:** the form sent by the LDSS to individuals when their application for services is denied, when services are to be discontinued, when a change from SNF to HRF is made in the Budget, when services are reduced or discontinued contrary to physician orders, or when participants request a review of the adequacy of their MA-funded services. The notice informs the individual of their rights to legal representation; to a local conference; to cross-examine witnesses; and to present evidence, documents, or witnesses in their own behalf. It also describes how to request a Fair Hearing.



**Family-Type Homes for Adults** facilities operated by the Office of Children and Family Services (OCFS) that provide long-term residential care, room, board, housekeeping, personal care, and/or supervision to four or fewer adult persons unrelated to the operator.

**Health Related Facility:** the term used in the LTHHCP waiver to indicate the need for a lower level of care than the Skilled Nursing Facility designation. This term is not currently applied to Residential Health Care Facilities in New York State but is still used in the waiver. An individual with a DMS-1 score between 60 and 179 is determined to need HRF level of care and has a budget cap at the HRF level.

**Home and Community Support Services (HCSS):** is a waiver service which is the combination of personal care services (ADL) and (IADL) with oversight/supervision services or oversight/supervision as a discrete service. HCSS is provided to a waiver participant who requires assistance with personal care services tasks and whose health and welfare in the community is at risk because oversight/supervision of the participant is required when no personal care task is being performed.

**Home Assessment Abstract (HAA):** the evaluation tool, completed jointly by the LTHHCP agency and a LDSS staff member, that is used to determine whether the individual's total health and social care needs can be met in the home environment and, if so, how they can be met. The Summary of Service Requirements and Plan of Care are developed from the HAA.

**Home Maintenance Services:** a waiver service that includes those household chores and services that are required to maintain a participant's home environment in a sanitary, safe, and viable manner. Home maintenance tasks/chores differ from those provided by personal care or home health aides. Environmental support functions in personal care includes such tasks as dusting and vacuuming rooms the patient uses, making and changing beds, or light cleaning of the kitchen, bedroom and bathroom. These chore services are provided on two levels:

- **Light Chores** – Services provided when needed for the maintenance of the home environment.
- **Heavy-Duty Chores** – Services provided to prepare or restore a dwelling for the habitation of a participant.

**Home Maintenance Tasks – Other** – These include those essential services required for the maintenance of the participant's home and home environment but which are not suitable for setting specific rates because of the variety of case situations or individuals involved. For a full definition of the service, including limitations, refer to Section III, Waiver Services.

**Household Budgeting:** the process of combining the cost of care for two persons, both living in the same household and both medically eligible for the LTHHCP waiver so the cost of care remains under the computed combined budget caps for both members of the household.

**Housing Improvement:** See the definition of Environmental Modifications. The former waiver service of Housing Improvement has been incorporated in that updated service.

**Individuals with Special Needs:** the term used to designate those persons with one of the following conditions: mental disability, AIDS or dementia; or those in need of care including (but not limited to) respiratory therapy, insulin therapy, tube feeding, or decubitus care which cannot be appropriately provided by a personal care aide. Such individuals have a 100% budget cap of assessed level of care for services. Local districts are limited in the number of special needs individuals they may have in the LTHHCP to 25% of the total capacity (15% in NYC); however, districts may request DOH to increase the district's capacity.

**Institutionalized Spouse** - is a person:

- in a medical institution or nursing facility and is expected to remain in such a medical institution or nursing facility for at least 30 consecutive days; or
- in receipt of home and community-based waiver services, and expected to receive such services for at least 30 consecutive days; or
- receiving institutional or non-institutional services under a Program of All-Inclusive Care for the Elderly (PACE); or
- in a medical institution/nursing facility or in receipt of home and community-based waiver services, and expected to receive a combination of institutional services and home and community-based waiver services for at least 30 consecutive days; **AND**
- married to a person who is not described in items (a) through (d).

**LDSS:** the abbreviation for local department of social services.

**Long Term Home Health Care Program (LTHHCP) Waiver:** the New York State waiver that provides comprehensive coordinated care at home to those eligible for nursing facility care. The waiver offers intensive case management and services not normally covered under MA (such as social day care).

**Medicaid Managed Care Plans:** the umbrella term used to designate those programs in which MA pays a monthly capitation fee for health services, instead of fees for individual services. Individuals enrolled in a managed care program are restricted from participation in the LTHHCP waiver. Individuals who are eligible to participate in the LTHHCP waiver through the spousal budgeting provisions allowed under the State 1115 Managed Care Waiver receive services through the LTHHCP waiver not through managed care plans and are not considered managed care enrollees.

**Medical Social Services:** a waiver service that must be offered in the LTHHCP waiver. The service includes the assessment of social and environmental factors related to the participant's illness, need for care, response to treatment and adjustments to treatment; assessment of the relationship of the participant's medical and nursing requirements to his/her home situation, financial resources and availability of community resources; actions to obtain available community resources to assist in resolving the participant's problems; and counseling services. Such services shall include, but not be limited to: home visits to the individual, family or both; visits preparatory to transfer of the individual to the community; and patient and family counseling, including personal, financial, and other forms of counseling services. The service may also assist waiver participants who are experiencing significant problems in managing the emotional difficulties inherent in adjusting to a significant disability, integrating into the community, and on-going life in the community.

**Meals on Wheels:** a program that delivers nutritious, hot meals once or twice a day to those eligible (also called Home-Delivered Meals).

**Medicare Maximization:** the requirement that the LTHHCP provider must first bill Medicare for any costs eligible for Medicare payment before billing MA for those services, thus making MA the payer of last resort.

**Minimum Monthly Maintenance Needs Allowance (MMMNA):** the minimum amount of the couple's income the community spouse is allowed to retain when using spousal impoverishment budgeting. This amount is increased annually by the same percentage as the percentage increase in the federal Consumer Price Index. If the income of the community spouse is less than the MMMNA, the institutionalized spouse may make income available to the community spouse to bring the community spouse's income up to the MMMNA. If the community spouse's income is greater than the MMMNA, the community spouse is requested to contribute 25% of the excess amount toward the institutionalized spouse's cost of care. The community spouse's income may increase if an amount greater than the MMMNA is established as result of a court order or fair hearing due to exceptional expenses resulting in significant financial distress.

**Monthly Budget:** the estimated monthly cost of health and medical services reimbursed by MA for an individual in the LTHHCP waiver, based on the Summary of Service Requirements in the Home Assessment Abstract.

**Moving Assistance:** is a waiver service intended to transport a participant's possessions and furnishings when the participant must be moved from an inadequate or unsafe housing situation to a viable environment that more adequately meets the participant's health and welfare needs and alleviates the risk of unwanted nursing home placement. Moving Assistance may also be utilized when the participant is moving to a location where more natural supports will be available, and thus allows the participant to remain in the community in a supportive environment.

**Nutritional Counseling/Educational Services:** is a waiver service that includes the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.

**OHIP:** the abbreviation for the NYSDOH Office of Health Insurance Programs which has overall responsibility for the NYS Medicaid program, including responsibility for setting of MA rates for services and financial eligibility rules.

**OHSM:** the abbreviation for NYSDOH Office of Health Systems Management that licenses or otherwise certifies hospitals and clinics among other responsibilities.

**OLTC:** abbreviation for the former NYSDOH Office of Long Term Care now incorporated in the Office Health Insurance Programs, Division of Long Term Care.

**Paper Credit:** the difference between the actual MA costs of services for an individual and the applicable budget cap. The difference between the actual expenditures and the budget cap can be accumulated and used at a later date when an individual's costs exceed the cap. When calculating paper credits, a look-back period is used to determine available credits, using the previous 11 months and the current month. LDSS staff is responsible for tracking and authorizing use of paper credits.

**Payer of Last Resort:** the term used to describe the order of payment with regard to MA, in that all other third-party payers (such as Medicare and other insurances) are billed for services before MA is billed for services.

**Permanent Absence Status:** when an individual is not expected to return home or the individual is an institutionalized spouse. Permanent absence status will be presumed to exist for persons who are not institutionalized spouses if: a) a person enters a nursing or intermediate care facility; b) a person initially admitted to acute care in a hospital and is then transferred to an alternate level of care, pending placement in a nursing facility; or c) a person remains in an acute care in a hospital for more than six calendar months. Adequate medical evidence may overcome these presumptions.

**Personal Care Services (PCS):** the provision of partial or total assistance with personal hygiene, dressing, and feeding, nutritional, and environmental support functions. Such services are essential to the maintenance of the person's health and safety within the home, are ordered by the attending physician, based on an assessment of the person's needs, are provided by a qualified person in accordance with the Plan of Care, and are supervised by a registered professional nurse. In the LTHHCP waiver, personal care services are provided by the LTHHCP agency either directly or by subcontract.

**Personal Emergency Response System (PERS):** a technology available under the waiver service of Assistive Technology in the LTHHCP. A Personal Emergency Response System is an electronic device that enables certain high-risk individuals to secure help in the event of a physical, emotional, or environmental emergency.

**Personal Needs Allowance (PNA):** the amount of income that is set aside to meet the personal needs for persons who: are residing in a medical institution and are in permanent absence status; or have community spouses and are in receipt of home and community-based waiver services or receiving non-institutionalized PACE services.

**Physician Orders:** the written document through which a physician directs the care of an individual and which may include orders for nursing care, diagnostic services, treatment by therapists (such as physical therapists), medications, personal care services, and other services needed to promote the health or well-being of an individual.

**Physician Override:** the process through which a physician can authorize a change in the level of care (HRF/SNF) for which an individual is approved by sending a written explanation to the LDSS or LTHHCP agency. This process also can be used when an individual's DMS-1 score is not high enough for that individual to be determined eligible for the waiver but when that individual is still determined to be in need of nursing facility care.

**Plan of Care:** the internal, practical clinical document that describes the care to be given to the individual, under the physician's direction, and includes the goals and objectives for the individual along with the specific outline of methodologies and procedures that will be employed to reach those goals.

**Provider Notices:** the term used for the process used by LTHHCP agencies to notify the LDSS of changes in a participant's authorized Plan of Care. Instances in which such notices are required include any change(s) in the authorized summary of service, requests for authorization for any service change(s) that exceed the individual's budget cap by 10% or more, hospital admissions, change in budget level from SNF to HRF, or other change(s) in status that might indicate the need for discharge.

**Reassessment:** the process by which an individual in the LTHHCP is assessed by the LTHHCP provider and the LDSS every 180 days. This involves the use of the DMS-1 and the Home Assessment Abstract to determine the individual's current health status, service needs, and continuing need and qualification for the waiver.

**Residences for Adult:** Adult care facilities (ACF) that provide long-term residential care, room, board, housekeeping, and supervision for five or more adults unrelated to the operator.

**Residential Health Care Facility (RHCF):** a nursing home or a facility providing health-related services.

**Respiratory Therapy:** a waiver service that must be offered in the LTHHCP waiver. The service is specifically provided in the home, intended to provide preventive, maintenance, and rehabilitative airway-related techniques and procedures. Services include application of medical gases, humidity and aerosols; intermittent positive pressure; continuous artificial ventilation; administration of drugs through inhalation and related airway management; individual care; and instruction administered to the participant and natural supports.

**Respite:** a waiver service intended to provide relief to natural, non-paid supports who provide primary care and support to a waiver participant. The primary location for the provision of this service is in the waiver participant's home, or where appropriate, temporarily in an institutional setting. These services will be provided to family and other caregivers who ordinarily care for the individual, as temporary relief from these duties and are included in the physician-approved Plan of Care.

**RN:** the abbreviation for registered nurse. On LTHHCP forms, this designation usually refers to the LTHHCP agency nurse.

**Significant Financial Distress:** Exceptional expenses that the community spouse cannot be expected to meet from the monthly maintenance needs allowance amounts or from amounts held in resources. Such expenses may be of a recurring nature or represent major onetime costs. They may include, but are not limited to: recurring or extraordinary non-covered medical expenses of the community spouse or family members; amounts to preserve maintain or make major repairs on the homestead; and amounts necessary to preserve an income-producing asset. This determination is allowed only as a result of a court order or a fair hearing decision.

**Skilled Nursing Facility (SNF):** a residential care facility that provides convalescent, rehabilitative, or restorative services to residents at less intensive levels than would a medical acute care facility. This term is not currently applied to Residential Health Care Facilities in NYS, but it is used in the LTHHCP waiver to indicate the need for a higher level of care than the Health Related Facilities designation. An individual in the LTHHCP waiver with a DMS-1 score of 180 or greater is determined to be in need of SNF level of care and has a budget cap at the SNF level.

**Social Day Care:** a waiver service that makes available the opportunity for individual socialization activities, including educational, craft, recreational and group events. Such service may include hot meals, or other services that may be offered which are authorized in a Plan of Care approved by a physician. In some instances transportation between the individual's home and the location of the social day care may be included in the cost of the social day care service.

**Social Day Care Transportation:** a waiver service that includes providing transportation between the participant's home and the social day care facilities (within certain distance limitations). Social Day Care Transportation service is limited solely to

the purpose of transporting LTHHCP participants to and from approved social day care programs as discussed under that service section.

**Spenddown:** The use of medical expenses to reduce available net income and as appropriate, resources in excess of the medically needy income/resource levels. Spenddown is only available to Applicants/Recipients (A/R) whose eligibility is determined under the NYS medically needy income/resources levels. The A/R must submit paid or incurred bills equal to or greater than the amount of any excess. The A/R may also pay the amount of the excess income to the local district (Pay-In).

**Spousal Impoverishment Budgeting:** the treatment of income and resources of a couple when determining eligibility of an institutionalized spouse. Spousal Impoverishment Budgeting rules protect some of the income and resources of the couple for the community spouse. These rules allow the community spouse of a waiver recipient to retain more income and resources than he or she might under regular community MA budgeting.

**SSW:** abbreviation for social services worker. When this abbreviation appears in the Home Assessment Abstract (HHA) LTHHCP form, it usually refers to the LDSS representative.

**Summary of Service Requirements:** the section of the Home Assessment Abstract that lists the types, frequency, and amounts of services necessary to maintain the individual in the community, along with projected costs.

**Third-Party Payers:** insurance and other payment sources (including health plan insurance plans, Medicare, or health benefits from pensions, union membership, military service, or Veteran's benefits) responsible for an individual's health care expenses and which must be billed before MA.

**Waiver Services:** those services allowed by federal waiver to be offered in a Home and Community Based Services Waiver, including the LTHHCP waiver, and that are not usually covered under MA outside of a federal waiver program for home care.

# Appendix B: Sample Forms

Copies of the various forms used in the LTHHCP are included here for reference purposes and appear in the order that they are referred to in the manual, categorized by section.

## **Section II: Assessment**

*Long Term Home Health Care Program (LTHHCP) Checklist LDSS-3058*

*Long Term Home Health Care Program (LTHHCP) Checklist LDSS-3057*

*New York State Long Term Care Placement Form Medical Assessment Abstract (DMS-1)*

*New York State Health Department Numerical Standards Master Sheet*

*New York State Department of Health Guidelines for Completing the Long Term Care Placement Form Medical Assessment Abstract (DMS-1) Form*

*Physician Override Sample Form*

*Department of Health Office of Health Systems Management Home Assessment Abstract (LDSS-3139)*

*Office of Health Systems Management Instructions Home Assessment Abstract*

## **Section III: Waiver Services**

*Long Term Home Health Care Program Waivered Services Prior Authorization (LDSS-3394)*



**LONG TERM HOME HEALTH CARE PROGRAM  
(LTHHCP) - CHECKLIST**

**PATIENT AT HOME**

PATIENT'S NAME		MEDICAID NO.	This form is to be completed by the nurse from the LTHHCP or CHHA who is assessing the patient for level of care needs (DMS-1). The form is to be done on <u>all Medicaid Patients</u> who have been determined as <u>requiring SNF or HRF</u> level of care when there is a LTHHCP in the local social services district. It must be completed whenever the DMS-1 indicates SNF or HRF level of care is appropriate even if home care is <u>not</u> viewed as a viable alternative. This form will be used as an evaluation tool for the LTHHCP as well as assisting in meeting the requirements for notification to all SNF/HRF eligible individuals, of the alternatives in the LTHHCP Program.
HOME ADDRESS			
1	a. Date of initial contact with LTHHCP or CHHA		
	b. CONTACT (request for service/placement) MADE BY		
	c. ATTACH COPY OF DMS-1	DATE OF DMS-1	DMS-1 SCORE
2	Date <input type="checkbox"/> Patient <input type="checkbox"/> Family	Notified verbally and in writing of LTHHCP option _____	
	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	REASON FOR REJECTION	SIGNATURE/TITLE
3	Date LTHHCP option for this patient was discussed with physician _____		
	PHYSICIAN	REASON PHYSICIAN DISAPPROVES	NAME OF PHYSICIAN
	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		SIGNATURE/TITLE

*If numbers 2 and 3 are affirmative, number 4 **MUST** be completed.*

*If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.*

4	Date local social services notified of this potential LTHHCP patient (telephone notification is acceptable) _____	
	NAME OF LOCAL DSS STAFF NOTIFIED	SIGNATURE/TITLE
5	Date of completion of Home Assessment Abstract (HAA)	By Registered Nurse _____
		By DSS Caseworker _____
	COMMENTS	
6	DECISION ON PLACEMENT	DATE
	COMMENT	SIGNATURE/TITLE

*When completed, attach DMS-1 and send both forms to local social services office.*

**LONG TERM HOME HEALTH CARE PROGRAM  
(LTHHCP) – CHECKLIST**

**INSTITUTIONALIZED PATIENT**

PATIENT'S NAME _____		This form is to be completed by the discharge planner for patients who are <u>Medicaid recipients</u> and who have been determined as <u>requiring SNF or HRF level care</u> when there is a LTHHCP in the local social services district.
HOME ADDRESS _____		
PRESENT LOCATION _____		
Date admitted to present location _____		This form should be completed on <u>all</u> patients who meet the above criteria even if it has been determined that home care is not a viable alternative for the patient. The form will be used as an evaluation tool for the LTHHCP. When complete, it should be forwarded, together with the DMS-1, to the local social services office.
HOSPITAL NUMBER: _____	MEDICAID NUMBER: _____	

1	Date of DMS-1 completion indicating SNF/HRF level of care _____	
	DMS 1 Score (Attach form) _____	
2	<input type="checkbox"/> Patient Date _____ notified verbally and in writing of LTHHCP option _____ <input type="checkbox"/> Family	
	<input type="checkbox"/> Accepted <input type="checkbox"/> Rejected	REASON FOR REJECTION _____ SIGNATURE/TITLE _____
3	Date LTHHCP option for this patient was discussed with physician _____	
	<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved	REASON PHYSICIAN DISAPPROVED _____ NAME OF PHYSICIAN _____ SIGNATURE/TITLE _____

If numbers 2 and 3 are affirmative, number 4 **MUST** be completed

If either number 2 or 3 are rejections, forward this form and completed DMS-1 to LOCAL Department of Social Services.

4	Date local social services notified of this potential LTHHCP patient (telephone notification is acceptable) _____	
	NAME OF LOCAL DSS STAFF NOTIFIED _____	SIGNATURE/TITLE _____
5	Date of Patient Discharge _____	COMMENTS ON DISCHARGE _____
	DESTINATION _____	
	SIGNATURE/TITLE _____	

When completed, attach DMS-1 and send both forms to local social services office.

NEW YORK STATE DEPARTMENT OF HEALTH  
 LONG TERM CARE PLACEMENT FORM  
 MEDICAL ASSESSMENT ABSTRACT

CURRENT PAT. LOCATION

REASON FOR PREPARING FORM

PREDICTOR SCORE

HOSP DCF  
 SNF HOME CARE  
 HRF OTHER  
 SPECIFY \_\_\_\_\_

DISCHARGE/TRANSFER TO \_\_\_\_\_  
 ADMISSION FROM \_\_\_\_\_  
 REVIEW FOR PERIOD FROM \_\_\_\_\_ TO \_\_\_\_\_  
 MEDICAID REVIEW DEATH  
 OTHER. SPECIFY \_\_\_\_\_

PATIENT NAME LAST FIRST M.I. STREET CITY STATE ZIP SEX  
 MALE  
 FEMALE

PATIENT NUMBERS		PATIENT DATES		PROVIDER INFO	
S.S. NO.	_____	DATE OF BIRTH	_____ AGE	NAME	_____
MEDICARE NO.	_____	DATE OF LATEST HOSP. STAY	_____	ADDRESS	_____
MEDICAID NO.	_____	FROM	_____	MEDICAID NO.	_____
SOC. SERVICE DIST.	_____	TO	_____	MEDICARE NO.	_____
MEDICAL RECORD NO.	_____	DATE THIS ADMISSION	_____	DOES PATIENT HAVE PRIVATE INSURANCE?	_____
ROOM NO.	_____	RESPONSIBLE PHYSICIAN	_____	NO	YES

MEDICAL COVERAGE: PATIENT'S CONDITION AND TREATMENT REQUIRING SKILLED SUPERVISION (ALL ITEMS MUST BE COMPLETED)

1. A. DIAGNOSIS OCCASIONING CURRENT USE OF SERVICES: \_\_\_\_\_

2. LIST SIGNIFICANT MEDS/INJECTIONS: \_\_\_\_\_  
 (FOR PARENTERAL MEDS ALSO CHECK ITEM 3A)

PRIMARY	MED	DOSE	FREQUENCY	ROUTE
OTHER	_____	_____	_____	_____
OTHER	_____	_____	_____	_____
OTHER	_____	_____	_____	_____

B. NATURE OF SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

C. IF PATIENT HAD CVA/MI SPECIFY \_\_\_\_\_ DATE \_\_\_\_\_

D. ALLERGIES OR SENSITIVITIES, SPECIFY \_\_\_\_\_

3. A. NURSING CARE & THERAPY (SPECIFY DETAILS IN 3D, 3E, OR ATTACHMENT)

	FREQUENCY			SELF CARE		CAN BE TRAINED	
	NONE	DAY SHIFT	NIGHT/EVE SHIFT	YES	NO	YES	NO
PARENTERAL MEDS							
INHALATION TREATMENT							
OXYGEN							
SUCTIONING							
ASEPTIC DRESSING							
LESION IRRIGATION							
CATH/TUBE IRRIGATION							
OSTOMY CARE							
PARENTERAL FLUID							
TUBE FEEDINGS							
BOWEL/BLADDER REHAB							
BEDSORE TREATMENT							
OTHER (DESCRIBE)							

3. D. IS THE PATIENT'S CONDITION UNSTABLE SO THAT AN R.N. MUST DETECT/EVALUATE NEED FOR MODIFICATIONS OF TREATMENT/CARE ON A DAILY BASIS?

NO YES

IF YES, DESCRIBE INSTABILITY AND SPECIFIC NEED FOR NURSING SUPERVISION, VITAL SIGNS RANGES, LAB VALUES, SYMPTOMS, ETC.

E. IS THERE HIGH PROBABILITY THAT COMPLICATIONS WOULD ARISE IN CARING FOR THE PATIENT WITHOUT SKILLED NURSING SUPERVISION OF THE TREATMENT PROGRAM ON A DAILY BASIS?

NO YES

IF YES, DESCRIBE (a) PATIENT'S CONDITION REQUIRING SKILLED NURSING SUPERVISION (b) THE AGGREGATE OF SERVICES TO BE PLANNED AND MANAGED IN THE TREATMENT PROGRAM. INDICATE SERVICES NEEDED AND POTENTIAL DANGERS OF COMPLICATING CLINICAL FACTORS.

B. INCONTINENT

URINE: OFTEN\* SELDOM\*\* NEVER FOLEY

STOOL: OFTEN\* SELDOM\*\* NEVER

C. DOES PATIENT NEED SPECIAL DIET? NO YES

IF YES, DESCRIBE \_\_\_\_\_

\*MORE THAN ONCE A WEEK \*\*ONCE A WEEK OR LESS

F. CIRCLE THE MINIMUM NUMBER OF DAYS/WEEKS OF COMPLEX SKILLED NURSING SUPERVISION:

REQUIRES	RECEIVES
0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7

4. FUNCTION STATUS	SELF CARE	SOME HELP	TOTAL HELP	CAN NOT	REHAB* POTEN.
WALKS WITH OR W/O AIDS					
TRANSFERRING					
WHEELING					
EATING/FEEDING					
TOILETING					
BATHING					
DRESSING					
5. MENTAL STATUS	NEVER	SOME-TIMES	ALWAYS		REHAB* POTEN.
ALERT					
IMPAIRED JUDGEMENT					
AGITATED (NIGHTTIME)					
HALLUCINATES					
SEVERE DEPRESSION**					
ASSAULTIVE					
ABUSIVE					
RESTRAINT ORDER					
REGRESSIVE (BEHAVIOR)					
WANDERS					
OTHER (SPECIFY)					
6. IMPAIRMENTS	NONE	PARTIAL	TOTAL		REHAB* POTEN.
SIGHT					
HEARING					
SPEECH					
COMMUNICATIONS					
OTHER(CONTACTURES,ETC)					
SPECIFY					

7. SHORT TERM REHAB THERAPY PLAN  
(TO BE COMPLETED BY THERAPIST)

A. DESCRIPTION OF CONDITION (NOT DX) NEEDING INTERVENTION      SHORT TERM PLAN OF TREATMENT AND EVALUATION & PROGRESS IN LAST 2 WEEKS      ACHIEVEMENT DATE

B. CIRCLE MINIMUM NUMBER OF DAYS/WEEK OF SKILLED THERAPY FROM EACH OF THE FOLLOWING:

	<u>REQUIRES</u>		<u>RECEIVES</u>
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7	0 1 2 3 4 5 6 7

8. DO THE WRITTEN ORDERS OF THE ATTENDING PHYSICIAN AND PLAN OF CARE DOCUMENT THAT THE ABOVE NURSING AND THERAPY ARE NECESSARY?      NO       YES

9. A. SHOULD THE PATIENT BE CONSIDERED FOR ANOTHER LEVEL OF CARE?      NO       YES       IF YES: WHEN? \_\_\_\_\_  
WHAT LEVEL? \_\_\_\_\_

B. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR AS AN OUTPATIENT?      NO       YES

C. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR UNDER HOME CARE? IF YES TO ANY OF ABOVE, ATTACH A DISCHARGE PLAN.      NO       YES

10. SHOULD THE PATIENT/RESIDENT BE MEDICALLY QUALIFIED FOR SNF CARE?      COVERED       QUESTIONABLE       NON-COVERED \*\*\*

11. ADDITIONAL COMMENTS ON PATIENT CARE PLAN/REHAB POTENTIAL: \_\_\_\_\_

12. I CERTIFY, TO THE BEST OF MY INFORMATION AND BELIEF, THAT THE INFORMATION ON THIS FORM IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

\_\_\_\_\_  
(SIGNATURE OF DESIGNATED R.N. AND TITLE)      \_\_\_\_\_  
DATE ASSESS. COMPLETED

TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW

13. ADDITIONAL INFORMATION BY U.R. REPRESENTATIVE      15. U.R. REPRESENTATIVE: PLACEMENT \_\_\_\_\_  
\_\_\_\_\_  
SIGNATURE      \_\_\_\_\_      DATE      \_\_\_\_\_

14. NEXT SCHEDULED REVIEW DATE \_\_\_\_\_      16. U.R. PHYSICIAN: PLACEMENT \_\_\_\_\_  
\_\_\_\_\_  
SIGNATURE      \_\_\_\_\_      DATE      \_\_\_\_\_

\* CHECK THE BOX CORRESPONDING TO APPROPRIATE CRITERION IF THERE IS A LIKELIHOOD THAT THE PATIENT WILL RESPOND UNDER A COORDINATED PLAN OF RESTORATIVE TREATMENT (INDICATE PLAN IN ITEM 3E OR 11).      \*\*\* IF CHECKED "NON-COVERED", SNF PLACEMENT CANNOT BE APPROVED BY MEDICAID.

\*\* IF PATIENT HAS SEVERE DEPRESSION, PSYCHIATRIC CONSULTATION SHOULD BE OBTAINED.      A. ITEMS 1, 2, 3, 4, 5, 6 SHOULD BE COMPLETED BY NURSE.  
B. ITEM 7 SHOULD BE COMPLETED BY THERAPIST.  
C. ITEMS 8, 9, 10, 11, 12 TO BE COMPLETED IN CONSULTATION WITH THE HEALTH TEAM.

**NEW YORK STATE HEALTH DEPARTMENT NUMERICAL STANDARDS MASTER SHEET  
 NUMERICAL STANDARDS FOR APPLICATION FOR THE LONG TERM CARE PLACEMENT FORM  
 MEDICAL ASSESSMENT ABSTRACT  
 (DMS-1)**

**3.a.**

Nursing Care and Therapy (Specify details in 3d, 3e or attachment)	Frequency			Self Care		Can Be Trained	
	None	Day Shift	Night/Eve. Shift	Yes	No	Yes	No
Parenteral Meds	0	25	60	-15	0	0	0
Inhalation Treatment	0	38	37	-20	0	0	0
Oxygen	0	49	49	-4	0	0	0
Suctioning	0	50	50	-1	0	0	0
Aseptic Dressing	0	42	48	0	0	+1	0
Lesion Irrigation	0	49	49	-20	0	0	0
Cath/Tube Irrigation	0	35	60	-1	0	+4	0
Ostomy Care							
Parenteral Fluids	0	50	50				
Tube Feedings	0	50	50				
Bowel/Bladder Rehab.	0	48	48				
Bedsore Treatment	0	50	50				
Other (Describe)	0	0	0				

**b.**

**1. Incontinent**

Urine: Often\* [ ] 20 Seldom\*\* [ ] 10 Never [ ] 0 Foley [ ] 15  
 Stool: Often\* [ ] 40 Seldom\*\* [ ] 20 Never [ ] 0

**c.**

Does patient need a special diet? No [ ] Yes [ ]

If yes, describe \_\_\_\_\_

**4.**

Function Status	Self Care	Some Help	Total Help	Cannot
Walks with or w/o aids	0	35	70	105
Transferring	0	6	12	18
Wheeling	0	1	2	3
Eating/Feeding	0	25	50	
Toileting	0	7	14	
Bathing	0	17	24	
Dressing	0	40	80	

5.

Mental Status	Never	Sometimes	Always
Alert	40	20	0
Impaired Judgement	0	15	30
Agitated (nighttime)	0	10	20
Hallucinates	0	1	2
Severe Depression			*
Assaultive	0	40	80
Abusive	0	25	50
Restraint Order	0	40	80
Regressive Behavior	0	30	60
Wanders			
Other (Specify)			

6.

Impairments	None	Partial	Total
Sight	0	1	2
Hearing	0	1	2
Speech	0	10	20
Communications			
Other (Contractures, etc.)			

7.

Short Term Rehab. Therapy Plan (To be completed by Therapist)

a. Describe Condition (not Dx)                      Short Term Plan of Treatment &                      Achievement Date  
       Needing Intervention                              Eval. and Progress in last 2 weeks

b. Circle Minimum number of days/week of skilled therapy from each of the following:

REQUIRES

RECEIVES

0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	SPEECH	0 1 2 3 4 5 6 7

+ 37 for skilled rehab/therapy (received & required both>0)

**NEW YORK STATE DEPARTMENT OF HEALTH  
GUIDELINES FOR COMPLETING THE  
LONG TERM CARE PLACEMENT FORM  
MEDICAL ASSESSMENT ABSTRACT (DMS-1) FORM \***

The DMS-1 (Long Term Care Placement Form) has been developed to assure placement at the appropriate level of care by assisting in the proper assessment of the medical care needs of patients requiring alternate level of care placement.

For ease in identification of items on the DMS-1 form in the following discussion, each item has been denoted by a number as indicated. Therefore, #1 refers to the item 1 on the inset diagram – (Predictor Score). These numbers appear only in these guidelines and do not appear on the DMS-1 form.

**Box #1**            Predictor Score –

Upon completion of the medical assessment of the DMS-1 form, the correct assignment of numerical weights should be assigned to each item checked from the master score sheet attached. The total of these scores should be placed in Box #1.

**#2** Current Patient Location

The appropriate box should be checked to accurately indicate the patient’s current location. For example, if the patient is presently in an acute care setting, the box “Hospital” should be checked. “Other” should be used if no other category listed applies such as a hotel, private boarding house, etc., in which the patient has no facilities other than sleeping arrangements.

**#3** Reason for Preparing Form

- Discharge/transfer to \_\_\_\_\_
- Admission from \_\_\_\_\_
- Review for period from \_\_\_\_\_ to \_\_\_\_\_
- Medicaid Review \_\_\_\_\_  Death
- Other – Specify \_\_\_\_\_

**#3-** The DMS-1 is a multi-purpose form. Its exact use must be indicated by checking the appropriate box to the left of the alternative given.

If the patient has been admitted to a facility from a hospital or another facility, a check mark should be put in the box next to “Admission from \_\_\_\_\_”. The complete name of the facility the patient was admitted from should be written in the blank space to the right.

---

**\* These Guidelines have been retyped from New York State Department of Health Hospital Memorandum 77-13 so they could be more easily read. Clarifications issued in 7/03 and 2/04 specific to the LTHHCP have been included in the instructions (in bold type). The references cited throughout the instructions referring to Appendix B are not included as they no longer apply.**

If the patient is in a long term care facility and is to be discharged with no follow-up in another setting, the box to the left of "Discharge/transfer to \_\_\_\_\_" should be marked with the patient's destination in the blank space to the right and only the identifying information needs to be completed. If the patient is to be transferred from one facility to another, the name of the institution to which the patient should be transferred should then be given in the space to the right.

If the patient is to be reviewed for Medicaid or for continued stay, then the appropriate box should be checked. For the "Continued Stay Review" be sure to include the dates in the space to the right.

If the patient for whom a DMS-I has been previously prepared dies, the box to the left of "Death" should be checked and only items 4-21 need to be completed.

<b>#4</b>			<b>#5</b>			<b>#6</b>	
Patient Name	Last	First	Street	City	State	Sex	
M.I.			Zip			<input type="checkbox"/> Male <input type="checkbox"/> Female	

Patient Numbers		Patient Dates		Provider Info	
S.S. No. _____	<b>#7</b> _____	Date of Birth	<b>#13</b> _____ Age _____	Name _____	<b>17</b> _____
Medicare No. _____	<b>#8</b> _____	Date Latest Hosp. Stay	From _____	Address _____	<b>18</b> _____
Medicaid No. _____	<b>#9</b> _____	From _____	<b>#14</b> _____	Medicaid No. _____	<b>19</b> _____
Soc. Service Dist. _____	<b>#10</b> _____	To _____		Medicare No. _____	<b>20</b> _____
Medical Record No. _____	<b>#11</b> _____	Date This Admission _____	<b>15</b> _____	Does Patient Have Private Insurance?	
Room No. _____	<b>#12</b> _____	Responsible Physician _____	<b>16</b> _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____	<b>21</b> _____

Item #4. The patient's name with the last name, first name, and middle initial given in that order.

#5. The patient's home address including the street, city, state, and zip code.

#6. The patient's sex.

#7. The patient's social security number.

#8. The patient's Medicare number.

#9. The patient's Medicaid number.

#10. The social service district is the county in which the patient resides.

#11. The Medical record number for the patient's record.

#12. The patient's room number in the facility originating this form.

#13. The date of birth of the patient and the patient's age.

#14. The dates of the most recent hospital stay.

#15. The date of admission to the facility originating this form.

#16. The physician presently in charge of the patient's treatment plan.

#17. Refers to the facility originating this form.

#18. The address of the facility originating this form.

#19. The provider's Medicaid number.

#20. The provider's Medicare number.

#21. If private insurance is available, indicate what policy.

**Items #4-21** identify the patient, provider, physician and social service district involved with the patient. Some of the information (primarily # 8, 13, 14, & 15) are important clues in determining technical eligibility under Title XVIII - Medicare. Age 65 or over (#13) is an important factor and many persons over the age of 65 are eligible to receive SNF Part A and possibly Part B benefits. Other persons who may be receiving Medicare benefits include these persons who are entitled to disability benefits for not less than 24 months consecutively are also entitled to Medicare though under the age of 65. Fully or currently insured workers or their dependents with end stage kidney disease are deemed disabled for purposes of Medicare coverage provided that hemodialysis or kidney transplantation are needed. The coverage begins the 3rd month after the month of onset of the condition and continues through the 12th month after the month in which the patient has a successful



transplant or dialysis ends. For further clarification, see regulations 405.101 - 405-105 in the Code of Federal Regulations.

Exploring for private health insurance is an important role of the discharge planner. There may be untapped resources such as Veteran's Benefits, Workman's Compensation or Health Plans by private insurance companies which have not been previously recognized as resources for the patient's care.

The second section of the DMS-1 form is used to document the patient's current medical condition and treatment requiring skilled supervision. All items in this section must be completed.

**#22: MEDICAL COVERAGE :** Patient's condition and treatment requiring skilled supervision.  
(All items must be completed)

<b>#22</b>	A. Diagnosis Occasioning Current Use of Services:		
	Primary	<u>    A    </u>	
	Other	<u>    B    </u>	
	Other	<u>    B    </u>	
	Other	<u>    B    </u>	
	B.	Nature of Surgery (if any) <u>    23    </u>	Date <u>    24    </u>
	C.	If patient had CVA/MI specify <u>    25    </u>	Date <u>    26    </u>
	D.	Allergies or sensitivities, specify <u>    27    </u>	

**#22** - refers to the diagnoses for which the patient is being treated.

**#22A.** - the primary diagnosis ..... that Disease (Syndrome or Condition) for which the patient was or is being treated in the hospital, the primary diagnosis is the diagnosis most responsible for the patient's need for medical care in the long term care facility. It may not be the actual admitting diagnosis but rather the present diagnosis which is the focus of the Medical Care treatment plan. For example, a patient who is admitted to the hospital with gangrene of the left foot and later had a below the knee amputation would have a primary diagnosis (**22A**) of BK amputation of left leg. Other diagnoses (**22B**) refer to those conditions which also continue to exist. They may have been present for some time and perhaps did not directly cause the hospitalization although they may have contributed to it or may influence the treatment plan. In the above example, the other diagnoses might include diabetes mellitus, arteriosclerosis, etc. The patient might also have other diagnoses for which he is receiving regular treatment but because of the present illness, the treatment program must be modified in some way to meet the present situation. For example, the patient may be receiving monthly injections of Vitamin B12 for his pernicious anemia. This must continue as he is no longer able to go to the physician's office and other plans to receive the injection must be made.

**#23-** as the patient did have surgery, this item should read "BK amputation left leg" and the date of this surgery should be in **#24**. It is also important to note if the patient has had either a CVA or an MI (or both) in the past and the approximate date when this (these) events occurred as they will most likely affect the treatment care program (**#25**). Items **22A and B, 23, 25, and 27** should be reflected in the treatment care program, and be evident in the patient's medical record. **Note:** Diagnoses occasioning current use of services must be pertinent and timely. Do not report items which have occurred a long time ago and do not affect the need for skilled nursing today.

**#28** - List Significant Meds/Injections

Medication	Dose	Route	Frequency
------------	------	-------	-----------

All significant medications (other than sedatives, laxatives, stool softeners, across the counter or medicine chest items) should be listed in **#28**. The information should include the name of the medication, the amount ordered, the route of administration and how frequently it is given to the patient. This information must have been

ordered by the patient's physician and be so documented on the patient's medical record. In the area of medications, Medicare views intravenous and intramuscular administration of medication as a skilled nursing service. The administration of an injection which can be self-administered by the patient is considered a skilled nursing service if the patient is in the training phases of self-administration and requires teaching and supervision by skilled nursing personnel or if the patient's condition because of medical complications requires skilled performance, supervision, or observation. The same is true of medications administered by any other route which normally is self-administered. If parenteral medications are given, they should be included here and indicated in **Item #29** under Nursing Care and Therapy.

**Note:** Fecal softeners, laxatives, sleeping pills, should not be included since they are not significant for purposes of SNF coverage in a stable patient or one who needs only custodial care. Indicate only those medications which require skilled nursing to administer or to evaluate the effects. Medications and diagnoses identified should be consistent with one another.

**Item #29**

3. A. Nursing Care & Therapy (Specify details in 3D, 3E or attachment)	Frequency			Self Care		Can Be Trained	
	NONE	DAY SHIFT	NIGHT/EVE. SHIFT	YES	NO	YES	NO
PARENTERAL MEDS							
INHALATION TREATMENT							
OXYGEN							
SUCTIONING							
ASEPTIC DRESSING							
LESION IRRIGATION							
CATH/TUBE IRRIGATION							
OSTOMY CARE							
PARENTERAL FLUIDS							
TUBE FEEDINGS							
BOWEL/BLADDER REHAB							
BEDSORE TREATMENT							
OTHER (DESCRIBE)							

**#29** delineates those nursing care services the patient receives. The importance of the frequency, self-care and can be trained areas must reflect the medical care plan, physician's orders, progress notes and nursing notes of the patient's medical record. Each item must be checked. If the patient is not receiving a particular therapy or nursing care item, the column none should be checked. The columns Self Care and Can be Trained, should be used only when the Frequency column indicates the item is being given to the patient on either the Day Shift and/or the Night/Evening Shift. Specific services which are delineated as skilled nursing services, as cited in (FR Regulation Sec. 405.127 is as follows.) (See ATTACHMENT B.)

The specific details of the nursing treatment including, for example, the size and location of the decubitus ulcer and treatment regimen and progress should be given in 3D and E, or 11 on the DMS-1 or in an attachment.

**The treatments listed in Section 3A. should only be checked and scored if the LTHHCP provides the treatment. If the treatments listed are self administered, then the frequency should be checked “none”. Self administered means that the recipient (or his/her caregiver) gives him or her self the injection, oxygen, nebulizer or other treatment. If the LTHHCP is providing the treatment, but training the recipient in self administration, then the “self care” and “can be trained” boxes should be appropriately checked, in addition to the frequency. Please note: The use of an inhaler by a recipient for self administration is not considered inhalation treatment.**

#30

B. Incontinent							
Urine: Often*	<input type="checkbox"/>	Seldom**	<input type="checkbox"/>	Never	<input type="checkbox"/>	Foley	<input type="checkbox"/>
Stool: Often*	<input type="checkbox"/>	Seldom**	<input type="checkbox"/>	Never	<input type="checkbox"/>		
* more than once a week					** once a week or less		

#30 - The patient's ability to control urinary and bowel excretion is another indication of the patient's condition and nursing needs. As indicated, "often" implies that the patient is unable to control excretory function more frequently than once a week while "seldom" implies once a week or less frequently. If the patient is incontinent, is a Bowel and Bladder rehabilitation program included in the nursing care plan? If so, is this item checked in #29? Be sure to describe the details of the plan of care in 3D, E, or 11 of the DMS-1 including the goals of the program, the patient's response to the plan and when achievement of goals is anticipated. If the patient has a Foley Catheter, is there an irrigation to be checked in #29? How frequent are the catheter changes for comment in 3D, E, or 11?

**If the recipient is scored as seldom or often incontinent, according to the instructions for Section 3B, there should be a corresponding strategy in the care plan to address the functional and health issues resulting from the incontinence.**

#31. C. Does Patient Need Special Diet?  No  Yes  
 If Yes, Describe \_\_\_\_\_  
 \_\_\_\_\_

#31 - The diet the patient needs may make a difference in the alternate care facility selected. Any SNF should provide any prescribed diet. Certain categories of diets may be obtained in an HRF (mechanical soft, low sodium, modified diabetic).

#32

3.D	Is the patient's condition unstable so that an R.N. must detect/evaluate need for modification of treatment/care on a DAILY basis?
NO <input type="checkbox"/> YES <input type="checkbox"/>	
If yes, describe instability and specific need for nursing supervision, vital signs ranges, lab values, symptoms, etc.	

#32- If "no" is checked, it is assumed that the patient's condition is stable and that skilled nursing care on a daily basis is not necessary. This does not necessarily disqualify a patient from receiving Medicare post hospital coverage (SNF Part A) as long as "yes" is checked for 3E. However, if both are "no", the patient most likely does not require SNF level of nursing care

If "yes" is checked, the comments should be pertinent to the diagnosis, medications and treatments given. The dimensions of the instability should be stated precisely with the inclusion of any modifications to be made because of the instability. For example, if the patient's Diabetes Mellitus has not stabilized and modifications of Insulin type and doses which are the fractional urines should be stated along with the changes in medication, diet and/or activity allowances that may be required.

Regulations Section 405.127 (c) (1) (ii) of the 20 Code of Federal Regulations (CFR) is in APPENDIX B and addresses this area.

#33

<p>B. Is there high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis?</p> <p style="text-align: center;">NO [ ]      YES [ ]</p> <p>If yes, describe (a) patient's condition requiring skilled nursing supervision (b) the aggregate of services to be planned and managed in the treatment program. Indicate services needed and potential dangers of complicating clinical factors.</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

#33- If "no" is checked, it is assumed that complications would be unlikely if the patient's treatment program was not supervised by skilled nursing personnel on a daily basis.

If "yes" is checked, the comments should be directed to the complications which might occur if skilled supervision was not available even though the services given may not require a skilled nurse to perform them. For example, the Diabetic patient who requires fractional urines, special diet, skin care and foot care may have these services performed by unskilled personnel. However, the planning, the effect and the results must be supervised by skilled nursing personnel to avoid hyper or hypoglycemia, gangrene of extremities, prevention of injury or immediate attention to incurred injury to prevent infection. The skilled service is directed to the interrelationships of the patient's conditions and effects each part has on the other. Regulations Section 405.127 (c) (1) (i) the 20 Code of Federal Regulations addresses this area and can be found in APPENDIX B.

#34

F.	Circle the minimum number of days/week of complex skilled nursing supervision:				
	<table> <tr> <td style="text-align: center;"><u>Requires</u></td> <td style="text-align: center;"><u>Receives</u></td> </tr> <tr> <td style="text-align: center;">01234567</td> <td style="text-align: center;">01234567</td> </tr> </table>	<u>Requires</u>	<u>Receives</u>	01234567	01234567
<u>Requires</u>	<u>Receives</u>				
01234567	01234567				

#34-If the patient requires 7 days of skilled nursing care and/or supervision, the number "7" should be circled. If he receives 7 days of skilled nursing care/supervision the number 7 should be circled under the column RECEIVES. Regulation Section 405.128 of the 20 CFR addresses this area and can be found in APPENDIX B.

**Page 2 of the DMS-1:**

#35

Patient Last Name	First	M.I.	Patient S.S. No.	Medical Record No.	Room No.
-------------------	-------	------	------------------	--------------------	----------

#35- serves to identify the patient and should be the same as the front page of the DMS-1. It is important that these boxes be completed as xerox copies made of the DMS-1 may fail to identify the correct patient if these boxes on the 2nd page are not completed.

#39

4. FUNCTION STATUS	SELF CARE	SOME HELP	TOTAL HELP	CANNOT
WALKS WITH OR W/O AIDE				
TRANSFERRING				
WHEELING				
EATING/FEEDING				
TOILETING				
BATHING				
DRESSING				

#39 – Further describes the patient’s condition and functional status and will help to support the decision of the nurse in determining the level of care needed by the patient. The Functional Status reflects the patient’s custodial care requirements as they are assessed on the day the form is completed. The "cannot" column refers to not being physically able to walk, etc., rather to "not applicable for this patient." The definitions and parameters found in APPENDIX A should be used when checking the box.

**The category “some help” should only be checked if the assistance of another person is needed. If the recipient uses medical equipment (cane, walker or other adaptive devices), but performs the ADL without the assistance of another person, then the recipient should be scored as independent.**

#40

5. MENTAL STATUS	NEVER	SOMETIMES	ALWAYS
ALERT			
IMPAIRED JUDGMENT			
AGITATED (NIGHTTIME)			
HALLUCINATES			
SEVERE DEPRESSION			
ASSAULTIVE			
ABUSIVE			
RESTRAINT ORDER			
REGRESSIVE BEHAVIOR			
WANDERS			
OTHER (SPECIFY)			

#40 - The patient's Mental Status should be marked according to the definitions given for these items in APPENDIX A. If the total score in this box is high or if the patient is severely depressed, wanders, is assaultive or abusive a DMH-103 or a Psychiatric consultation may be needed to determine the appropriate placement for the patient and/or a treatment program to manage the problem may be needed.

**If the behaviors listed in the mental status section are observed in the recipient, they should only be scored if the behavior occurs frequently enough to be considered when planning care. Intervention strategies/services should be clearly identifiable on the care plan. Impaired judgment is described in the instructions as “a mental state marked by the mingling of ideas with consequent disturbance of comprehension and understanding and leading to bewilderment, inaccurate or unwise decision making, and unsafe self direction.” LTHHCP recipients who refuse services, or who have behaviors that are unhealthy (e.g. smoking), AND who understand the consequences of their behaviors/decisions, would not be considered to have impaired judgment. Individuals have a right to make choices about care and lifestyles.**

#41

6. IMPAIRMENTS	NONE	PARTIAL	TOTAL
SIGHT			
HEARING			
SPEECH			
COMMUNICATIONS			
OTHER (Contracture, etc.)			

#41 - The Definitions and parameters of IMPAIRMENTS can be found in APPENDIX A.

#39, 40, and 41 describe the patient's functional level and will help to support the decision determining the level of care necessary for the patient. These functional levels should be reflected in the total plan of care in Items 3D, and 3E. For example, the patient with an Organic Brain Syndrome may require Some or Total Help in many other areas in 39, 40, 41, and without this help, may develop decubiti, malnutrition, etc. The patient might also require reality orientation and close supervision of the total care plan.

#42

7. <b>SHORT TERM</b> Rehab Therapy Plan (To Be Completed By Therapist)		
a. Description of Condition Needing Intervention (NOT DX)	Short Term Plan of Treatment and Evaluation & Progress in last 2 weeks	Achievement Date
b. Circle number of days/week of skilled therapy from each of the following:		
<u>Requires</u>		<u>Receives</u>
0 1 2 3 4 5 6 7	PT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	OT	0 1 2 3 4 5 6 7
0 1 2 3 4 5 6 7	Speech	0 1 2 3 4 5 6 7

#42 - Items 7a and 7b should be completed by the Therapist(s) providing the service(s) if it is being provided. The current plan or treatment and evaluation should refer to short term stage of plan and should be very specific, not general. The achievement date should refer to date projected or anticipated when the short term plans will be accomplished. An achievement date years into the future should not be considered within this placement time-span. The therapy plan should tie-in to the nursing care in 3D and E, if possible to show continuity.

Patients requiring less intense and/or frequent therapy may receive such therapy in an HRF if institutional placement is indicated for the patient.

20 CFR Regulation Section 405.128 in APPENDIX B defines skilled rehabilitation services which must be required and provided on a "daily basis."

**Physical therapy, occupational therapy or speech therapy should be scored if the therapy is skilled, rehabilitative therapy provided on a short term basis to improve functioning. Recipients who receive a therapy evaluation only or may need long term maintenance therapy should also be scored.**

#44

8. Do the written orders and plan of care of the attending physician document that the above Nursing and Therapy are necessary? No [ ] Yes [ ]
---------------------------------------------------------------------------------------------------------------------------------------------------

#44 - Calls for the reaffirmation that the medical record and physician orders indicate that the Nursing Care and Rehabilitation Therapy plans are being carried out under the physician's overall orders and treatment plans. A "no" answer in this box would raise serious doubt about the validity of the patient's care, or that the care given is medically necessary and would automatically disqualify the patient from SNF Part A Benefit coverage.

#45

9. A. Should the patient be considered for another level of care:	No [ ]	Yes [ ]
B. As a practical matter, could patient be cared for as an outpatient ?	No [ ]	Yes [ ]
C. As a practical matter, could patient be cared for under home care?	No [ ]	Yes [ ]
If yes to any of above, attach a DISCHARGE PLAN.		

#45 - If 9A. is checked "yes", the patient should be evaluated for the correct level and date for transfer. Items (9B) and (9C) refer to the practical matter of outpatient care or Home care. "Practical" refers to the availability of the services, the patient's ability to leave his home to seek services or the suitability of the home setting in relation to needs and available services. If "yes" is answered in 9C above, a discharge plan, including the need for care, who will provide the care, and when it is available, should be attached to the DMS-1.

**Note:** the phrase "as practical matter" in items 9B and 9C referring to outpatient or home care means that the home care or outpatient treatment is either not cost-effective, (e.g., the patient would have to be transported by ambulance over a long distance) or that it is medically harmful to the patient. It does not mean that outpatient facilities or a home setting is not available.

#46

10. Should the patient/resident be medically qualified for SNF care? Covered [ ] Questionable [ ] Non-Covered [ ]
----------------------------------------------------------------------------------------------------------------------

#46 - This indicates that, in the best judgment of the Health Team, the patient meets the necessary requirements for SNF placement. An indication of "Not Covered" implies that the patient does not require SNF level of care and that he is not eligible to receive Medicaid benefits for SNF level of care

#47

11. Additional comments on patient care plan/rehab potential: _____
---------------------------------------------------------------------

#47 - Any additional comments or explanations can be put in #47. These comments should further clarify the patient's medical situation or condition and describe Nursing Plan items in addition to those in 3A, D, E.

#48

12. I certify, to the best of my information and belief, that the information on this form is a true abstract of the patient's condition and medical record.	
_____	_____
(Signature of Designated RN and Title)	Date

**#48** - Is self-explanatory as a documentation of the veracity of the information for which the designated RN has taken the responsibility to provide. It should be based upon Medical, Nursing, and Therapy Records of the patient.

**#49 TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW**

13. Additional Information by U.R. Representative _____	15. U.R. Representative: Placement Signature _____ Date _____
14. Next Scheduled Review Date _____	16. U.R. Physician Placement Signature _____ Date _____

**#49-** designed for use primarily in an SNF or HRF, i.e., the Utilization Review Process for the 30-60-90 and thereafter 90 day reviews of the SNF patient or the 6th month review for the HRF patient. This should contain any other information that the on-physician UR representative may have to support the level of care placement assigned. The UR physician, following review of the form, should then place his assessment of the patient's level of care needs followed by his signature and the date of his review. The date of the next scheduled CSR should be placed under 14.

If the UR committee, including at least one physician, decides that the patient no longer requires the level of care given in the facility, notification is sent to the patient's physician. An opportunity to clarify or present further information is given to the patient's physician. If this additional information does not meet the continued stay criteria as determined by two physicians, the two physicians suggest the proper level of care placement and sign their names in #49.

**Notes:** Items 13-16 - Date included in Item 13 through 16 of the form is administrative in nature reflecting UR Committee processing continued stay reviews. This information need not be completed when the LTC placement form is used to support specifications for medical coverage.

**Notes:**

- a. Items 1, 2, 3, 4, 5, & 6 should be completed by R.N.
- b. Item 7 should be completed by Therapist(s).
- c. Items 8-12 should be completed in consultation with the Health Team.
- d. If Item 10 is checked "non-covered", request for SNF placement cannot be approved by Medicaid.



## **APPENDIX A**

### **DEFINITIONS**

#### **Item 29 (3A)**

Parenteral Medications:	Any medication given by subcutaneous, intramuscular, intradermal, intrasternal and intravenous route.
Inhalation Therapy:	The administration and/or teaching of techniques or use of equipment to increase pulmonary capacity, liquify secretions, and/or facilitate the exchange of gases at the alveolir level.
Oxygen:	The administration of Oxygen by any method.
Suctioning:	The use of suction equipment in any body cavity using clean or aseptic technique as appropriate.
Aseptic Dressing:	The application of a sterile dressing using aseptic technique. This also includes the application of medicated ointments, creams, sprays or solutions under sterile conditions to an open lesion.
Lesion Irrigation:	The use of intermittent or continuous sterile or clean moist compresses or soaks, insertion of catheters or tubing into an open lesion for removal of secretions or instillation of medication or debridement of necrotic material.
Cath/Tube Irrigation:	Insertion of a catheter into the urinary bladder and the insertion of fluid through the catheter for the purpose of cleansing or insertion of medication into the urinary bladder using aseptic technique.
Ostomy Care:	The care of a colostomy, ileostomy, ureterostomy, tracheostomy, gastrostomy, or any such opening including the care of the surrounding skin, cleansing and observation of the stoma for patency, and the use of specialized equipment necessary to the maintenance of the "ostomy".
Parenteral Fluids:	The use of the intravenous of subcutaneous route for the administration of fluids used to maintain fluid and electrolyte balance and/or nutrition.
Tube Feedings:	The use of a nasogastric (including the insertion of) gastrostomy or jejunostomy tube for insertion of fluids for hydration, nutrition and medication.
Bowel/Bladder Rehab:	A planned program to gain or regain optimum bowel and bladder function.
Bedsore Treatment:	A planned program to treat decubiti including regular periods for turning, application of medication and/or the use of special equipment.

#### **ITEM 39 FUNCTION STATUS**

This refers to the ability of the person to carry out necessary activities of daily living and his degree of need for human assistance.

(a) Walks With Or Without Mechanical Aids:

<u>Independent-</u>	Walks with or without equipment or devices, either worn or not, but without the assistance of another person.
<u>Some Help-</u>	Walks with necessary assistance of another person.
<u>Total Help-</u>	Does not walk except with continuous physical support.
<u>Cannot-</u>	Is unable to walk even with assistance.

(b) Transferring:

This describes the process of moving horizontally and/or vertically between the bed, chair, wheelchair and/or stretcher.

<u>Independent-</u>	Means the patient receives no assistance or supervision from another person.
<u>Some Help-</u>	Includes guarding, guiding, protecting or supervising the patient in the process of transferring.
<u>Total Help-</u>	Means the patient is lifted out of bed, chair, etc. by another person or persons and does not participate in the process.
<u>Cannot-</u>	Is bedfast and may not be transferred.

(c) Wheeling:

The process of moving about by means of any device equipped with wheels.

<u>Independent-</u>	Means the patient receives no assistance or supervision from another person and is mobile independently in using the wheelchair.
<u>Some Help-</u>	Means another person helps the patient in getting through doorways, locking or unlocking the brakes, getting up and down ramps.
<u>Total Help-</u>	Means the patient is transported in a wheelchair but does not propel or guide it. (Patient may wheel a <u>few</u> feet within room or an activity area but this alone does not constitute wheeling.)
<u>Cannot-</u>	May sit in chair but is incapable of any maneuvering it.

(d) Eating/Feeding:

Is the process of getting food from the receptacle into the body.

<u>Independent-</u>	Means the patient does not receive assistance from another person. He cuts food, butters bread, pours beverages and conveys food to mouth.
<u>Some Help-</u>	Means another person helps the patient in cutting food, opening cartons, pouring liquids.
<u>Total Help-</u>	Means the patient is spoon-fed; patient does not bring food to his mouth.

(e) Toileting:

Refers to getting to and from the toilet room, transferring on and off the toilet, cleansing self after elimination and adjusting clothes.

<u>Independent-</u>	Means the patient receives no assistance or supervision from another person.
<u>Some Help-</u>	Means the patient receives assistance from another person or persons in getting to and from the toilet room, transferring on and off the toilet seat, adjustment of clothes.
<u>Total Help-</u>	Means patient uses other means such as urinal, bedpan, or commode.

(f) Bathing:

Describes the process of washing the body or body parts, including getting to or obtaining the bathing water and/or equipment.

<u>Independent-</u>	Means the patient receives no assistance or supervision from another person.
---------------------	------------------------------------------------------------------------------

- Some Help- Means the patient receives help from another person in such ways as filling the tub, towel drying, bringing water to him, assistance in washing or helping patient in and out of tub.
- Total Help- Means patient is bathed by another person.

(g) Dressing:

Describes the process of putting on, fastening and taking off all items of clothing, braces, and artificial limbs worn daily by the person; and obtaining and replacing these items from their storage area in the immediate environment.

- Independent- Means the patient receives no assistance or supervision from another person.
- Some Help- Means another person helps the patient in such things as obtaining the clothing, fastening hooks, buttons, zippers, putting on clothes, putting braces or artificial limbs on.
- Total Help- Means the patient is completely dressed by another person.

**ITEM 40 MENTAL STATUS**

The characteristics are used in their usual dictionary meaning. The degrees indicated should reflect observation of patient's actions rather than personality characteristics.

- Always- Occurs enough of the time, i.e., more than once a week, to constitute a regular pattern.
- Sometimes- Occurs frequently less than once a week, enough as to need to be taken into consideration when planning care.
- Never- Never or almost never.

(a) Alert:

This describes the patient who is able to communicate and provide feed back. Is watchful, able to perceive and react.

(b) Impaired Judgment:

This describes a mental state marked by the mingling of ideas with consequent disturbance of comprehension and understanding and leading to bewilderment, inaccurate or unwise decision making, and unsafe self direction.

(c) Agitated (nighttime):

This refers to the increased activity, restlessness, anxiety, fear and tension that occurs in some persons during the night leading to excited or disturbing behavior.

(d) Hallucinates:

This describes the activity where sense perception is not based upon objective reality.

(e) Severe Depression:

Refers to that abnormal behavior in which the patient remains withdrawn without cause; disinterested in surroundings and in self; refuses to eat or participate in social events and/or speaks of self destructions or makes suicidal attempts.

(f) Assaultive:

This refers to the act or attempt of physical violence upon another person.

(g) Abusive:

This refers to verbal attack of another person.

(h) Restraint Order:

Restraints are defined as physical articles attached to or put about the person to prevent freedom of motion, and usually requiring a physician's order and responsible supervision in their use. Bedside rails and geriatric chairs are not considered restraints in this sense.

(i) Recessive Behavior Signs:

Signs of regressive behavior may occur transiently in persons who are ordinarily stable in a closely supervised setting but who are unable to cope in a less supportive setting, or under stress or threat of change. Such regressive behavior signs include: onset or resumption of incontinence; refusal to eat or feed self; refusal to come out of room or withdrawal from others; attempts to appear sick with assumed nausea or vomiting; developing behavior changes as with agitation or belligerence.

(j) Wanders:

Leaves area boundaries with no particular plan or destination in mind and with no concern for the hazards within the environment (weather, adequate clothing, dangerous terrain, etc.).

**ITEM 41 IMPAIRMENTS**

(a) Sight

None - Has adequate visual acuity to see in the distance and the near vision to do close work with or without glasses.

Partial - Can perceive hazards in the environment with or without glasses but has sufficient loss of visual acuity and/or peripheral vision to reduce distance and near vision to a minimum.

Total - Visual acuity with glasses is less than 20/200.

(b) Hearing

None - Can hear the normal spoken voice with or without hearing aid. Can discriminate and identify sounds and voices in a group setting.

Partial - Can hear the normal spoken voice with the assistance of a hearing aid but is unable to identify sounds, direction of sound or discriminate voices in a group setting with a hearing aid. May require 2 hearing aids.

Total - Unable to hear and/or discriminate sounds even with the assistance of a hearing aid.

(c) Speech

None - Can speak clearly, distinctly and be understood by others who speak the same language.

Partial - May have some speech defect or indistinction of speech but can get verbal messages across to others most of the time.

Total - Is unable to speak clearly, distinctly, or not at all.

(d) Communication

- None - Can send and receive messages verbally, or in writing appropriately or in non-verbal ways.
- Partial - Can perceive and act upon messages received but has some problems expressing self verbally in writing appropriately or in non-verbal ways.
- Total - Is unable to receive or relay messages either verbally or in writing or in non-verbal ways.

-

## Physician Override Form

Date:

To:

From:

Subject:

Your patient's DMS-1 predictor score is \_\_\_ and does not adequately reflect the higher level of care that is needed to maintain him or her safely at home. A score of 60-179 indicates a Health Related Facility level and 180+ indicates a Skilled Nursing Facility level.

I have attached the DMS-1 form for your review and request you certify that a higher level of care is needed because of the following assessments:

Medical:

Psychosocial:

Rehabilitation:

Other:

I certify that this patient warrants a nursing facility level of care because of the above stated reasons.

\_\_\_\_\_  
Physician's name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
License #



**7. To be completed by S S W**

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.  
If none will assist explain in narrative.

	NAME	Age	Relationship	Days/Hours at Home	Days/Hours will Assist
1.					
2.					
3.					
4.					

**8. To be completed by S S W**

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

	Name	Address	Age	Relationship	Days/Hours Assisting
1.					
2.					
3.					
4.					
5.					

**9. To be completed by S S W**

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

	Organization	Type of Service	Presently Receiving	Contact Person	Tel No.
1.					
2.					
3.					
4.					

**10. To be completed by S S W and R.N.**

PATIENT TRAITS:

	Yes	No	?N/A	If you check No. ?N/A, describe
Appears self directed and/or independent				
Seems to make appropriate decisions				
Can recall med routine/recent events				
Participates in planning/treatment program				
Seems to handle crises well				
Accepts diagnosis				
Motivated to remain at home				



**11. To be completed by S S W and R.N. as appropriate**  
 FAMILY TRAITS:

	Yes	No	?	
a. Is motivated to keep patient home				If no, because _____
b. Is capable of providing care (physically & emotionally)				If no, because _____
c. Will keep patient home if not involved with care				Because _____
d. Will give care if support service given				How much _____
e. Requires instruction to provide care				In what – who will give _____

**12. To be completed by R.N.**

Home/Place where care will be provided:	Yes	No	?	If problem, describe
Neighborhood secure/safe				
Housing adequate in terms of: Space				
Convenient toilet facilities				
Heating adequate and safe				
Cooking facilities & refrigerator				
Laundry facilities				
Tub/shower/hot water				
Elevator				
Telephone accessible & usable				
Is patient mobile in house				
Any discernible hazards (please circle)				Leaky gas, poor wiring, unsafe floors, steps, other (specify)
Construction adequate				
Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly.				
Is patient's safety threatened if alone?				
Pets				

ADDITIONAL ASSESSMENT FACTORS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**13. To be completed by R.N.**  
 RECOVERY POTENTIAL ANTICIPATED

		COMMENTS
Full recovery	<input type="checkbox"/>	_____
Recovery with patient management residual	<input type="checkbox"/>	_____
Limited recovery managed by others	<input type="checkbox"/>	_____
Deterioration	<input type="checkbox"/>	_____

**14. To be completed by R.N. – S S W to complete “D” as appropriate  
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED**

WHO WILL PROVIDE

SERVICES REQUIRED	YES	NO	TYPE/FREQ/DUR	AGENCY/FAMILY	AGENCY FREQUENCY
A. Bathing					
Dressing					
Toileting					
Admin. Med.					
Grooming					
Spoon feeding					
Exercise/activity/walking					
Shopping (food/supplies)					
Meal preparation					
Diet Counseling					
Light housekeeping					
Personal laundry/household linens					
Personal/financial errands					
Other					
B. Nursing					
Physical Therapy					
Home Health Aide					
Speech Pathology					
Occupational Therapy					
Personal Care					
Homemaking					
Housekeeping					
Clinic/Physician					
Other 1.					
2.					
C. Ramps outside/inside					
Grab bars/hallways/bathroom					
Commode/special bed/wheelchair					
Cane/walker/crutches					
Self-help device, specify					
Dressings/cath. equipment, etc.					
Bed protector/diapers					
Other					
D. Additional Services (Lab, O <sup>2</sup> , medication)					
Telephone reassurance					
Diversion/friendly visitor					
Medical social service/counseling					
Legal/protective services					
Financial management/conservatorship					
Transportation arrangements					
Transportation attendant					
Home delivered meals					
Structural modification					
Other					

**15. To be completed by S S W and R.N**

DMS Predictor Score \_\_\_\_\_ Override necessary  Yes  No

Can patient's health/safety needs be met through home care now?  Yes  No

If no, give specific reason why not \_\_\_\_\_

Institutional care required now?  Yes  No If yes, give specific reason why.

Level of institutional care determined by your professional judgment:  SNF  HRF  DCF

Can the patient be considered at a later time for home care?  Yes  No  N/A

**16. To be completed by S S W**

**SUMMARY OF SERVICE REQUIREMENTS**

Indicate services required, schedule and charges (allowable charge in area)

Services	Provided by	Hrs./Days/Wk.	Date Effective	Est. Dur.	Unit Cost	Payment by			
						MC	MA	Self	Other
Physician									
Nursing									
Home Health Aide									
Physical Therapy									
Speech Pathology									
Resp. Therapy									
Med. Soc. Work									
Nutritional									
Personal Care									
Homemaking									
Housekeeping									
Other (Specify)									
Medical Supplies/Medication									
1.									
2.									
3.									
Medical Equipment									
1.									
2.									
3.									
Home Delivered Meals									
Transportation									
Additional Services									
1.									
2.									
	<b>SUBTOTAL</b>								
Structural Modification									
Other (Specify)									
1.									
2.									

SUBTOTAL \_\_\_\_\_

TOTAL COST \_\_\_\_\_

17. To be completed by S S W and R.N.

**Person who will relieve in case of emergency**

Name	Address	Telephone	Relationship
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Narrative: Use this space to describe aspects of the patients care not adequately covered above.

Assessment completed by:	_____	_____
	R.N.	Agency
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Local DSS Staff	District
	_____	_____
	Date Completed	Telephone No.
	_____	_____
	Supervisor DSS	District
	_____	_____
	Date	Telephone No.

Authorization to provide services: \_\_\_\_\_  
Local DSS Commissioner or Designee Date

HOME ASSESSMENT ABSTRACT  
FOR THE PERSONAL CARE SERVICES PROGRAM  
Instructions

**Purpose:**

The purpose of the Home Assessment Abstract is to assist in the determination of whether a patient's home environment is the appropriate setting for the patient to receive health and related services. This form is designed to provide a standardized method for all certified home health agencies and social services districts to determine the following questions essential to the delivery of home care services:

1. Is the home the appropriate environment for this patient's needs?
2. What is the functional ability of this patient?
3. What services are necessary to maintain this patient within this home setting?

**General Information:**

The assessment form includes an outline for the planning for the development of a comprehensive listing of services which the patient requires.

It is required that a common assessment procedure be used for the Long Term Home Health Care Program (LTHHCP), Home Health Aide Services and Personal Care Services. This procedure will apply to both initial assessments and reassessments. The Home Assessment Abstract must be used in conjunction with the physician's orders and the DMS-1 or its successor.

The assessment procedure will differ only in the frequency with which assessments are required. Assessments must be completed at the initial onset of care. Reassessments are required every 120 days for the LTHHCP and Home Health Aide Services. Reassessments for Personal Care Services are required on an as-needed basis, but must be done at least every six (6) months. At any time that a change in the condition of the patient is noted either by staff of the certified home health agency or the local social services district, that agency should immediately inform the other agency so that the procedures for reassessment can be followed.

The form has been designed so that certified home health agencies and local social services districts may complete assessments jointly, a practice which is highly recommended. When it is not possible to undertake assessments jointly, an indication of the person responsible for completing each section has been included on the form. If, while completing the assessment, a nurse or a social services worker believes they have

information in one of the other areas of the form, for which they are not responsible, they may include that information.

It is required that the local certified home health agency complete the assessment form within fifteen (15) working days of the request from the local social services district. Completed forms should be forwarded to the local social services district. Differences in opinion on the services required should be forwarded to the local Professional Director, for review and final determination by a physician.

### **Instructions:**

#### **Section 1 – Reasons for Preparation (RN and SSW)**

Check appropriate box depending on whether patient is being considered for admission to a LTHHCP, home health aide service provided by a certified home health agency, or personal care services.

For reassessment, include the dates covered by the reassessment and check whether the reassessment is for a LTHHCP patient, certified home health agency patient, or personal care service patient. If none is appropriate, specific under “other” why form is being completed.

#### **Section 2 – Patient Identification (RN and SSW)**

Complete patient’s name and place of residence. If the patient is or will be residing at a place other than his home address, give the address where he will be receiving care. Include directions to address where the patient will be receiving care.

The item “Social Services District” requires the name of the Social Services District which is legally responsible for the cost of the care. In large Social Services districts the number or name of the field office should be indicated.

#### **Section 3 – Current Location of patient (RN and SSW)**

Check the current location/diagnosis of the patient. If the patient is in an institution, give name of facility. If he/she is at home and receiving home care, give name of organization providing the service. Complete the “Diagnosis” on all cases.

#### **Section 4 – Next of Kin/Guardian (SSW)**

Complete this section with the name of the person who is legally responsible for the patient. This may be a relative or a non-relative who has been designated as power of attorney, conservator or committee for the management of the patient’s financial affairs.

#### **Section 5 – Notify in Emergency (SSW)**

Complete section with requested information on whom to call in an emergency situation.

**Section 6 – Patient Information (SSW)**

Complete all information pertinent to the patient. Use N/A if an item is not applicable. Specify the language(s) that the patient speaks and understands.

Check the category of living arrangements that best describes the living arrangements of the patient.

**Definitions of Living Arrangements:**

One family house – nuclear and extended family

Multi-family house – two or more distinct nuclear families

Furnished room – one room in a private dwelling, with or without cooking facilities

Senior citizen housing – apartments, either in clusters or high-rise

Hotel – a multi-dwelling providing lodging and with or without meals

Apartment – a room(s) with housekeeping facilities and used as a dwelling by a family group or an individual

Boarding House – a lodging house where meals are provided

If walk-up – when the living unit requires walking up stairs, specify number of flights

Lives with – specify with whom the patient lives. Members of household should be detailed in Section 7.

**Other Patient Information:**

Social Security Number	To obtain correct numbers, the interviewer should ask to see the patient's identification card for each item.
Medicare Numbers	
Medicaid Number	
Blue Cross Number	
Worker's Compensation	
Veterans Claim Number	

Veterans Spouse – patient may be eligible for benefits if a veteran's spouse.

Other – Identify insurance company and claim number if the patient has coverage in addition to those listed above.

Source of Income/other benefits – Include all sources of income and benefits. When the patient is receiving Medicaid or if Medicaid is pending, the local social services district will already have all necessary information.

Amount of available funds – Since many elderly people have little money left after payment of rent, taxes and utilities, an effort should be made to determine the amount available after payment of these expenses. This is especially important in evaluating whether or not the patient has adequate funds for food and clothing.

#### Section 7 – Others in Home/Household (SSW)

Indicate all persons residing in the house with the patient and indicate if and when they will assist in the care of the patient. Indicate in Section 14 what service this person(s) will provide. This information must be specific as it will be used to prepare a summary of service requirements for the individual patient.

#### Section 8 – Significant others Outside of Home – (SSW)

A “Significant Other” is an individual who has an interest in the welfare of the patient and may influence the patient. This may be a relative, friend, or neighbor who may be able to provide some assistance in rendering care. Indicate the days/hours that this person will provide assistance.

#### Section 9 – community Support – (SSW)

Indicate organizations, agencies or employed individuals, including local social services districts or certified home health agencies who have, or who are presently giving service to the patient; also indicate those services that have been provided in the past six months. Agencies providing home care, home delivered meals, or other services should be included if they have been significant to the care of the patient.

#### Section 10 – Patient traits – (SSW and RN)

Patient traits should help to determine the degree of independence a patient has and how this will affect care to this patient in the home environment. A patient’s safety may be jeopardized if he shows emotional or psychological disturbance or confusion. It is important to determine if the patient is motivated to remain at home, otherwise services provided may not be beneficial.

For all criteria check the “yes” column if the patient meets the standard of the criteria defined. If, in your judgment the patient does not meet the standard as defined,



check “no”. If you have insufficient evidence to make a positive or negative statement about the patient, check the box marked “?/NA” – unknown or not applicable. If you check a no or ?/NA, please explain the reason in the space to the right. Also indicate source of information used as basis for your judgment.

**Definitions:**

Appears self directed and/or independent – the patient can manage his own business affairs, household needs, etc., either directly or through instruction to others.

Seems to make appropriate decisions –n the patient is capable of making choices consistent with his needs, etc.

Can recall med. Routine/recent events – the patient’s memory is intact, and patient remembers when to take medication without supervision or assistance. Patient knows medical regimen.

Participates in planning/treatment program – the patient takes an active role in decision-making.

Seems to handle crisis well – this means that the patient knows whom to call and what to do in the event of an emergency situation.

Accepts Diagnoses – the patient knows his diagnoses and has a realistic attitude toward his illness

Motivated to remain at home – the patient wants to remain in his home to receive needed care.

Section 11 – Family Traits (SSW and RN as appropriate)

This section should be used to indicate whether the family is willing and/or able to care for the patient at home. The family may be able to care for the patient if support services are provided, and if required instruction and supervision are given, as appropriate, to the patient and/or family.

**Definitions:**

- a. Is motivated to keep patient home – this means that the family member(s) is (are) willing to have the patient stay at home to receive the needed care and will provide continuity of care in those intervals when there is no agency person in the home by providing care themselves or arranging for other caretakers.

- b. Is capable of providing care – the family member(s) is (are) physically and emotionally capable of providing care to the patient in the absence of caretaker personnel, and can accept the responsibility for the patient's care.
- c. Will keep patient home if not involved with care – the family member(s) will allow the patient space in the home but will not (or cannot) accept responsibility for providing the necessary services in the absence of Home Care Services.
- d. Will give care if support services given – this means that the family member(s) will accept responsibility for and provide care to the patient as long as some assistance from support personnel is given to the family member(s).
- e. Requires instruction to provide care – this item means that the family is willing and able to keep the patient at home and provide care but will need guidance and teaching in the skills to provide care safely and adequately.

Section 12 – Home/Place where care will be provided – (RN)

In order to care for a person in the home, it is necessary to have an environment which provides adequate supports for the health and safety of the patient. This section of the assessment is to determine if the home environment of the patient is adequate in relation to the patient's physical condition and diagnosis. Input from the patient and family should be considered where pertinent.

Specifically describe the problem if one exists.

**Definitions:**

Neighborhood secure/safe – refers to how the patient and/or family perceives the neighborhood, for example, in the assessor's perception, the neighborhood may not be safe or secure but the patient may feel comfortable and safe.

Housing adequate in terms of space – refers to the available space that the patient will be able to have in the home. The space should be in keeping with the patient's home health care needs, without encroaching on other members of the family.

Convenient toilet facilities – refers to the accessibility and availability of toilet facilities in relation to the patient's present infirmities.

Heating adequate and safe – refers to the type of heating that will produce a comfortable environment. Safety and accessibility factors should be considered.

Laundry facilities – refers to appliances that are available and accessible to the patient and/or family.

Cooking facilities and refrigerator – refers to those appliances that are available and accessible for use by the patient or family.

Tub/shower/hot water – refers to what bathing facilities are available and if the patient is able to use what is available. Modifications may have to be made to make the facilities accessible to the patient.

Elevator – refers to the availability of a working elevator and if the patient is able to use it.

Telephone accessible and usable – refers to whether or not there is a telephone in the home, or if one is available. Specify whether or not the patient is able to reach and use the telephone.

Is patient mobile in house – refers to the ability of the patient to move about in the home setting. Modifications may have to be made to allow mobility, for example, widening doorways and adding ramps for a patient in a wheelchair.

Any discernible hazards – refers to any hazard that could possibly have a negative impact on the patient's health and safety in the home.

Construction adequate – refers to whether or not the building is safe for habitation.

Excess use of alcohol/drugs by patient or caretaker – refers to whether or not the patient or caretaker uses those materials enough to endanger the patient's health and safety because of inadequate judgment, poor reaction time, etc.; smokes carelessly.

Is patient's safety threatened if alone – refers to situations that may cause injury to the patient. This includes situations such as physical incapacitation, impaired judgment to the point where the patient will allow anyone to enter the home, wandering away from home, and possibility of the patient causing harm to himself or others.

Pets – refers to if the patient has a pet(s) and if so, what problems does it present, for example, is the patient able to take care of the pet, is the pet likely to endanger the patient's caretaker, and what plans, if any, must be made for the care of the animal.

Additional Assessment factors – include items that would influence the patient's ability to receive care at home that are not considered previously.

### Section 13 – Recovery Potential (RN)

The anticipated recovery potential is important for short and long range planning.

Full recovery – the patient is expected to regain his optimal state of health.

Recovery with patient managed residual – the patient is expected to recover to his fullest potential with residual problem managed by himself, e.g., a diabetic who self-administers insulin and controls his diet.

Limited recovery managed by others – the patient is expected to be left with a residual problem that necessitates the assistance of another in performing activities of daily living.

Deterioration – it is expected that the patient’s condition will decline with no likelihood of recovery.

Section 14 – Services Required (RN, SSW to complete “D” as appropriate)

This section will serve as the basis for the authorization for service delivery. Fill in all services required, describing type, frequency and duration as pertinent. Specify whether the family or an agency will be providing services and frequency that the agency will be involved. It is necessary to determine the amount of services required to enable the local Social Services district to develop the summary of service requirements and to arrive at a total cost necessary to the Long Term Home Health Care Program. The local Social Services district will make the final budgetary determinations.

- A. This section determines that activities the patient can/cannot do for himself, also the frequency which the patient needs help in performing these activities.
- B. The RN should determine what level of services are needed or anticipated.

Example:

	Yes	No	Type/Freq. Dur.	Agency/Family Agency Freq.
Registered Nurse	X		1 hr.2xWk/1 mo.	V.N.S.
Physical Therapy		X		
Home Health Aide	X		4 hr/3xWk/ 1mo.	V.N.S.
Speech Pathology		X		
Occupational Therapy		X		
Personal Care	X		4 hr./5xWk/1 mo.	Homemaker Upjohn
Clinic	X		1xWk-Mondays 1 pm	

C. Equipment/Supplies

The nurse should determine what medical supplies and equipment are necessary to assist the patient. Consideration should be for the rehabilitation and safety needs of the

patient. Circle the specific equipment required and described in type/freq./dur. column, etc.

Example:

Dressing, cath equipment----#18 Foley/1xmo/6mo

D. Other Services

The RN should indicate any other health service needed for the total care of the patient. The SSW should complete the balance of the service needs.

Service needs will not be changed by the local social services district without consulting with the nurse. If there is disagreement, the case will be referred to the local professional director for review and final determination by a physician.

#### Section 15 – (SSW and RN)

#### DMS-1 Predictor Score

The predictor score must be completed. To be eligible for the LTHHCP, the patient's level of care needs must be determined and must be at the Skilled Nursing Facility (SNF) or Health Related Facility (HRF) level. The predictor score must be completed for home health aide and personal care services to assure adequate information for placement of personnel.

If the patient is institutionalized the predictor score should be obtained from the most recent DMS-1 completed by the discharge planner of that facility. If the patient is at home, it may be necessary for the nurse from the LTHHCP or certified home health agency to complete a DMS-1 form during the home assessment to ascertain the predictor score. Refer to the instructions for completing the DSM-1, if necessary.

#### Override necessary

An override is necessary when a patient's predictor score does not reflect the patient's true level of care. For example, a patient with a low predictor score may require institutional care due to emotional instability or safety factors. Either the institution's Utilization Review physician or physician representing the local professional director must give the override.

#### Can needs be met through home care?

Indicate if the patient can remain at home if appropriate services are provided. If the patient should not remain at home for health or safety reasons, be specific in your reply.

## Institutional Care

Give specific reason why institutionalization is required. Check the level of institutional care the patient requires. Indicate if the patient can be considered for home care in the future.

### Section 16 – Summary of Service Requirements – (SSW)

This information is to be used in correlation with services required for the patient to remain at home (Section 14). This section is to determine the cost of each individual service, source of payment, data services are effective and total monthly budget.

The SSW should complete this section including unit cost and source of payment. Subtotal and total costs will be determined by the local social services department.

### Section 17 – Person who will relieve in an emergency – (SSW and RN)

This should be an individual who would be available to stay with the patient, if required, in a situation where the usual, planned services are not available. An example would be, when an aide did not appear on schedule, and the patient could not be left alone.

### Narrative – (SSW and RN)

The narrative should be used to describe details of the patient's condition, not covered in previous sections, that will influence the decision regarding placement of the patient.

### Assessment completed by

Each professional should sign and date this form. Include agency and telephone number.

Authorization to provide services for the LTHHCP, Home Health Aide or Personal Care Services will be provided by the Local District Social Services Commissioner or his designee.



# Appendix C:

## Associated New York State Medicaid Policy Statements and Regulations

- New York Code of Rules and Regulations: Title 18 §505.21
- New York Code of Rules and Regulations: Title 10 §763.5

The following documents appear in chronological order.

- 78 ADM-70, *Implementation of Chapter 895 of the Laws of 1977: Long Term Home Health Care Program*, August 14, 1978
- 79 ADM-58, *Long Term Home Health Care Program Notification Requirements*, September 7, 1979
- 79 ADM-60, *Long Term Home Health Care Program Medicare Maximization Requirements*, September 7, 1979
- 80 ADM-77, *Long Term Home Health Care Program Federal Waivers Permitting the Expansion of the Medicaid Program's Scope of Service for Long Term Home Health Care Programs*, September 24, 1980
- 83 ADM-74, *Implementation of Chapter 895 of the Laws of 1977 and Chapter 636 of the Laws of 1980: Long Term Home Health Care Program*, December 30, 1983
- 85 ADM-26, *Long Term Home Health Care Program Budgeting*, July 12, 1985
- 85 ADM-27, *Long Term Home Health Care Program: Federal Waivers Permitting Expanded Medicaid Home and Community-Based Services for LTHHCPs*, July 15, 1985
- 86 INF-26, *Chapter 629 and the Laws of 1986: Demonstration Program*, October 22, 1986
- 86 INF-47, *Licensure of Home Care Services Agencies and Certification of Home Health Agencies*, December 29, 1986
- 88 INF-20, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in Adult Care Facilities*, March 24, 1988
- 89 INF-20, *Long Term Home Health Care Program: Annualization of Service Costs*, April 6, 1989
- 89 ADM-47, *Treatment of Income and Resources for Institutionalized Spouses/Individuals and Legally Responsible Relatives*, December. 5, 1989
- 90 ADM-25, *Chapter 854 of the Laws of 1987: Long Term Home Health Care Program Services Provided in Adult Care Facilities*, August. 24, 1990



- 91 LCM-198, *Use of Social Day Care in Long Term Home Health Care Programs*, November 4, 1991
- 92 ADM-15, *Provision of Title XIX Home Care Services in Adult Care Facilities and Implementation of Retention Standards Waiver Program in Adult Homes and Enriched Housing Programs*”, March 27, 1992
- 92 ADM-25, *AIDS Home Care Program (Chapter 622 of the Laws of 1988)*, June 15, 1992
- 93 ADM-29, *Documentation and Verification Requirements for the Medical Assistance Program*, September 21, 1993
- 96 ADM-8, *OBRA '93 Provisions on Transfers and Trusts*, March 29, 1996
- 96 ADM-11, *Spousal Impoverishment: Community Spouse Resource Amount*, May 28, 1996
- Letter from Robert Barnett, Director, Office of Continuing Care, NYS DOH, January 26, 1999
- 02 OMM/ADM-4, *Notice and Fair Hearing Procedures for the Long Term Home Health Care Program*, May 28, 2002
- 04 OMM/ADM-6, *Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)*, July 20, 2004
- 08 OHIP/INF-1, *Citizenship and Identity Requirements of the Deficit Reduction Act (DRA) of 2005: Final Guidelines*, January 28, 2008
- GIS 09 OLTC/002, *Long Term Home Health Care Program (LTHHCP) DSS Quarterly Report*, March 24, 2009
- 11 OLTC/ADM-1, *Long Term Home Health Care Program Waiver Renewal*, April 26, 2011
- GIS 11 OLTC/008, *Clarifications and Updates to Long Term Home Health Care Program (LTHHCP) 11OLTC/ADM-1*, June 22, 2011