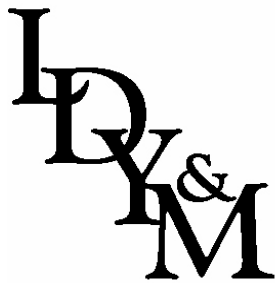


HOME AND COMMUNITY BASED SERVICES: AN EXPANSION OF THE CONTINUUM



LATSHA DAVIS YOHE
& MCKENNA, P.C.

ATTORNEYS AT LAW

PACAH 2010 SPRING CONFERENCE

April 20, 2010
State College, PA

Presented by
Kimber L. Latsha, Esq.

The information herein reflects the views of the authors. The information should be construed as general guidelines and not interpreted as legal advice. The materials should serve as a general reference to facilitate more thorough research and analysis with the assistance of a competent professional who would have an opportunity to consider the facts of any particular situation.

HOME AND COMMUNITY BASED SERVICES (“HCBS”): AN EXPANSION OF THE CONTINUUM

I. CORPORATE STRUCTURING FOR THE DELIVERY OF HCBS

A. Consideration of Separate Legal Entity

1. What type of HCBS will be provided?
2. Relationship of proposed HCBS operations to existing operations and corporate structure
3. Division of existing operating company or new entity

B. Liability Considerations

1. Isolation of potential liabilities
2. Insurance

C. Regulatory/Licensure/Reimbursement Considerations

1. Compliance considerations related to delivery of HCBS in licensed facilities
2. Reimbursement considerations

D. Tax Exemption Implications

1. Nature of business and anticipated revenue
2. Potential impact on tax exemption
3. Treatment of revenue

E. Selection of Legal Entity

1. Corporation, LLC or joint venture entity
2. Retaining control and relationship to existing corporate structure
3. Start-up costs and additional administrative and reporting

requirements

- a. Tax exemption application
- b. Form 990

II. REGULATORY CONSIDERATIONS IN THE DELIVERY OF HCBS

- A. Possible CON Requirements (other states)
 1. Application process
 2. Qualification criteria
- B. Licensure Requirements
 1. Application process
 2. Survey requirements
- C. Certification Requirements for Participation in Government Reimbursement Programs (Medicare/MA)
 1. Application process
 2. Survey requirements
 3. Reimbursement and payment issues
- D. Compliance Requirements
 1. Administrative requirements – administrator staffing and related costs
 2. Certification/licensing requirements
 - a. HIPAA
 - b. Advance directives
 - c. Resident rights (“Freedom of Choice”)
 3. Scrutiny by regulatory agencies

- a. Responding to complaints

III. HCBS PROGRAMS

A. Living Independence for the Elderly (“LIFE”)

- 1. Previously known as Long-term Care Capitated Assistance Program (“LTCCAP”)
- 2. Administered by Office of Long Term Living (“OLTL”)
 - a. National program known as Program of All-inclusive Care for the Elderly (“PACE”)
 - i. Risk-based and community-based service program
 - ii. Provides acute and long-term care services to a frail elderly population that meets nursing facility clinical criteria
 - b. First LIFE program implemented in Pennsylvania in 1998
 - c. All PACE providers in Pennsylvania have “LIFE” in their name
- 2. Provider enrollment process
 - a. May begin under Pre-PACE agreement with OLTL
 - i. Meet requirements in PACE Protocol
 - a) Describes minimum requirements for PACE providers and core operational procedures and processes
 - ii. Medicaid capitation payment and Medicare FFS
 - iii. Move to full PACE provider status within two years of becoming an operational Pre-PACE provider
 - b. May go to full PACE status immediately

- i. Complete PACE provider application
 - ii. Once approved as PACE provider, enter into program agreement with Centers for Medicare and Medicaid Services (“CMS”) and OLTL
 - iii. Execute provider agreement with OLTL
 - a) Supplements agreement with CMS and OLTL
 - iv. Comply with federal PACE regulations
 - v. Provider receives Medicare capitation payment in addition to Medicaid capitation payment
3. Consumer eligibility criteria
- a. Age requirement
 - i. Age 60 or older for Pre-PACE providers
 - ii. Age 55 or older for PACE providers
 - b. Certified Medicaid eligible by OLTL for LIFE, or able to pay privately
 - c. Determined by OLTL or its agent to meet clinical criteria appropriate for nursing facility care and is anticipated to require long-term services to meet needs
 - d. Determined by provider’s staff at time of enrollment to be capable of living in a community setting without jeopardizing consumer’s health or safety with services offered under plan
 - e. Enrolled by OLTL in LIFE
 - f. Enrolled in provider’s plan
 - g. Resides in provider’s service area (designated by OLTL) at time of enrollment

4. Types of services available
 - a. Multidisciplinary assessment and treatment planning
 - b. Primary care services including physician and nursing services
 - c. Social work services
 - d. Restorative therapies, including physical, speech and occupational therapy
 - e. Personal care and supportive services
 - f. Nutritional counseling
 - g. Recreational therapy
 - h. Transportation
 - i. Meals
 - j. Medical specialty services, including, but not limited to: cardiology, dentistry, internal medicine, oral surgery, pharmacy consulting services, psychiatry and radiology
 - k. Laboratory tests, x-rays and other diagnostic procedures
 - l. Drugs and biologicals
 - m. Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures, and repairs and maintenance for these items
 - n. Acute inpatient care
 - o. Nursing facility care
 - p. Additional services determined necessary by multidisciplinary team
5. Available in several counties in Pennsylvania

6. Is participation an economic opportunity?
 - a. Application costs
 - b. Feasibility study
 - c. Operational assessment
 - d. Is there an expected “margin”

B. Aging Waiver Program

1. HCBS to persons age 60 or older who are clinically eligible for nursing facility care
2. Waiver approved by Health Care Financing Administration (now CMS) pursuant to Section 1915(c) of the Social Security Act
 - a. Implemented as pilot project in Philadelphia County in November 1995
 - b. State-wide expansion in 1997
3. Provider enrollment process
 - a. Contact local Area Agency on Aging (“AAA”)
 - b. AAA assists providers in completing certification forms and submits them to OLTL
 - i. OLTL finalizes participation in program
 - c. Once enrolled, providers must notify AAA regarding any changes in enrollment, such as withdrawal from program
 - d. AAA conducts regular quality assurance monitoring visits of providers
4. Consumer eligibility criteria
 - a. Age 60 or older

- b. Income limit must be equal to or less than 300% of Federal Benefit Rate
 - c. Asset limit of \$8,000
 - d. Require services provided by a nursing facility, as determined by OPTIONS Assessment process
5. Role of AAA
- a. Care managers develop safe and adequate care plans for consumers
 - b. Reassessment of consumers' needs periodically and care plans adjusted accordingly
 - c. Consumers communicate satisfaction with services and providers under program
6. Types of services available
- a. Home support
 - b. Home health services
 - c. Personal care services
 - d. Respite care
 - e. Older Adult Daily Living Centers
 - f. Transportation
 - g. Specialized medical equipment and supplies
 - h. Personal Emergency Response Systems ("PERS")
 - i. Companion services
 - j. Home delivered meals
 - k. Counseling

- l. Environmental modifications
 - m. Attendant care
 - n. Extended state plan physician services
 - o. Transition services
7. Cost sharing
 - a. No cost to consumers
 - b. Medicaid covers services provided
 8. MA reimbursement limitations
 - a. Cost not to exceed 80% of the average (statewide) MA payment for institutional NF services.
 9. Is it an economic opportunity?
 - a. Possible feasibility study
 - b. Qualification as a provider
 - c. Contracts at county level
 - d. "Negotiated Rates" for unbundled services
 10. Is it a strategic opportunity?
 - a. New revenue source
 - b. Follow future anticipated direction of government reimbursement
 - c. Marketing/recognition in "community"
 - d. Referral base for institutional services
 11. Impact on NF MA reimbursement and census

- a. Does the program divert NF residents to HCBS in a non-institutional setting or does the program create a “wood-work” effect?
- b. Will dollars be diverted from the NF MA allocation or will an expansion of the program be based on new sources of fundings?

C. Community Choice

- 1. Began as a demonstration project in Philadelphia and Fayette, Green and Washington Counties
- 2. Accelerated method of assessment for entry to HCBS programs
 - a. Many of the steps in determining eligibility have been removed
 - b. Streamlined functional and financial eligibility process
 - c. Consumers receive HCBS quickly
- 3. Functional eligibility
 - a. Determine eligibility for Medicaid
- 4. Financial eligibility
 - a. Self-declaration by consumer that income and resources meet eligibility guidelines for HCBS programs
 - i. Income limit must be equal to or less than 300% of Federal Benefit Rate
 - ii. Resource limit of \$8,000
 - b. County Assistance Office (“CAO”) makes initial financial eligibility determination based on self-declared income and resources within 24 hours

- c. If consumer is financially eligible, payment for covered services will be made
 - d. Within 60 days, CAO will follow-up and verify self-declared financial information with consumer and/or through collateral sources
 - e. Determination of eligibility for initial service(s) and continued service(s) based on verification received
 - i. Consumer provided with written notice of ineligibility
 - ii. If determined to be ineligible, consumer has right to quickly appeal decision
 - f. Financial liability for services received if determined to be ineligible
- 5. Consumer receives services under HCBS program enrolled in
 - 6. Presently available in Allegheny, Chester, Cumberland, Dauphin, Perry, Delaware, Lancaster, Montgomery, Philadelphia, Fayette, Green and Washington Counties

IV. HOME CARE SERVICES

- A. Home care agencies arrange for or provide home care services to individuals in their homes or other independent living environments
 - 1. Home care services include personal care services, assistance with instrumental activities of daily living, companionship services, respite care, and specialized care services.
- B. History of Home Care Regulations
 - 1. In July of 2006, Governor Edward Rendell signed Act 69 of 2006 (“Act 69”), which amended the Health Care Facilities Act to include home care agencies as a new category of licensed health care providers.
 - a. At the heart of Act 69 is consumer protection, which is achieved by:

- i. Establishing oversight.
 - ii. Requiring criminal background checks and TB screenings for individuals employed by home care agencies to provide care.
 - iii. Ensuring the physical health and competency of individuals employed by home care agencies to provide care.
 - b. Home care agencies, traditionally unregulated by the Commonwealth, are now subject to governmental scrutiny and oversight by the Department of Health (“DOH”).
2. In accordance with Act 69, DOH has developed and implemented regulations governing licensure of home care agencies.
 - i. Regulations published in final form on December 12, 2009.

C. Applicability of Home Care Regulations

1. A licensed nursing facility or personal care home may provide home care services to its residents, within the institutional setting, without needing to obtain a separate home care license from DOH.
2. However, should nursing or personal care staff provide such services to individuals outside of the licensed institutional setting, then a home care license would be required.

D. Regulatory Scheme

1. Licensure of Home Care Agencies
 - a. Only those home care agencies that submit an application for a license to DOH and receive a license may continue to operate.
 - b. A home care agency may continue to operate while an application for a license is pending.

- c. An entity that is established after the effective date of the regulations must obtain a license prior to providing home care services.
- d. Licensure application packet consists of the following documents:
 - i. Application for Home Care Agency or Home Care Registry License
 - ii. Civil Rights Survey
 - iii. Disclosure of Ownership and Control Interest Statement
 - iv. Initial Home Care Agency/Registry Licensure Application Checklist
 - v. Home Care Agency/Registry Licensure Survey Form
 - vi. Information Requested of Health Care Providers
- e. Licensure application is due to DOH no later than April 30, 2010.

2. Inspection and Survey Activities

- a. DOH will ensure compliance with the regulations by conducting on-site surveys, interviewing office staff, direct care workers, consumers and other individuals providing care, and reviewing relevant documentation.

3. Sanctions and Corrective Actions

- a. Imposition of sanctions for deficiencies
- b. Notice of imposition of a sanction by DOH

4. Governance and Management

- a. Home care agencies must conduct criminal background checks and TB screenings and obtain child abuse clearances.

- i. A criminal background check is required for each applicant for employment or referral as a direct care worker, each applicant for employment as a member of the office staff for a home care agency or home care registry, and the owner(s) of the home care agency or home care registry.
 - ii. If a home care agency serves persons under 18 years of age, a ChildLine verification is required for each applicant for employment as a direct care worker and each applicant for employment as a member of the home care agency office staff.
 - a) A ChildLine verification confirms whether an applicant for employment or referral by a home care agency or home care registry is named in the Statewide Central Register as the perpetrator of a founded or indicated report of child abuse.
 - iii. A TB screening is required for each direct care worker and other office staff or contractors with direct consumer contact.
- b. The regulations require home care agencies to provide consumers with an informational packet in advance of the commencement of services.
- i. The informational packet includes, among other items, a listing of the available home care services that will be provided, the hours when those services will be provided, and the fees and total costs of those services.

E. Contractual Relationship with Consumer

- 1. Regulations do not require a home care agency and a consumer to sign a formal contract.
- 2. However, home care agencies that do not currently utilize a contract should consider implementing one in order to:

- a. Clearly define the relationship between the parties; and
- b. Address important risk management issues.

V. MANAGING OPERATIONAL RISKS OF HCBS DELIVERY SYSTEM

A. Defining the Relationship with Participant/Client/Patient/Resident

1. Regulatory, contractual or both
2. Reasons for the development of Admission Agreement or enrollment/participation requirements
 - a. Establish payment obligations
 - b. Disclosure of costs and participation requirements (use of "Handbook")
 - c. Define the "Rules" in the relationship
 - d. Address risk management issues

B. Identification of Potential Liability Exposure and Plan to Minimize Risk

1. Financial or other abuse of participant
 - a. Screening/"Background Check" of employees
 - b. Periodic review of participant/care-giver relationship
 - c. Structuring relationship with employees
 - i. Consequences for misuse of participant funds
 - ii. Transportation /liability issues
2. Dependability of Care-giver/Employee
 - a. Managing a "No Show"
 - b. Expectations of participant

- c. Back up or covering support
- 3. Distinguish Case Management Services
 - a. Expectations of participant
 - b. Defining obligations of agency for intervention and response to care needs
 - c. Can a participant buy “monitoring” or case management? If so, what is the nature of the program and how is it defined?
- 4. Minimize Risk in the Delivery of Services
 - a. Clarify the type(s) of services to be provided
 - b. Assess ability to meet participant’s needs in the HCBS setting
 - c. Assess liability insurance needs and obtain adequate coverage
- 5. Participant/ Client Grievance Procedure
 - a. Availability of complaint process
 - b. Timely response to complaints
 - c. Avoidance of litigation
- 6. Plan for Responding to Participant/ Client Injury/ Abuse
 - a. Response to regulatory agencies
 - b. Response to plaintiff’s counsel
 - c. Response to potential media coverage
 - d. Response to other “investigators”
- C. Conclusion – The Direction of Long-Term Care Services and Reimbursement