TO: Local District Commissioners, Medicaid Directors, Long Term Home Health Care Program Coordinators

FROM: Mark Kissinger, Deputy Commissioner
Office of Long Term Care

SUBJECT: Long Term Home Health Care Program (LTHHCP) and AIDS Home Care Program (AHCP) Consumer Information Booklet

EFFECTIVE DATE: Immediately

CONTACT PERSON: Office of Long Term Care
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The purpose of this GIS is to advise district staff of the requirement for issuing the attached Long Term Home Health Care Program Consumer Information booklet and forms to all individuals seeking nursing home placement, applicants for and participants of LTHHCP/AHCP, as well as other individuals who may be interested in the LTHHCP/AHCP.

The purpose of the consumer booklet and forms is to:

- Provide information about the LTHHCP which includes the AHCP;
- Provide brief information on other available Medicaid waiver programs for which an individual may be eligible;
- Provide and document the individual's choice of Medicaid home care services and/or other available Medicaid waiver programs;
- Provide pertinent contact information to enrolled LTHHCP/AHCP participants;
- Survey participant satisfaction as required for the LTHHCP/AHCP LDSS Quarterly Report; and,
- Comply with Centers for Medicare & Medicaid Services (CMS) waiver assurance requirements.

The documents attached to this GIS must be reproduced by the LDSS. The Department will notify local districts when the forms and informational materials become available online as electronic documents posted to the Office of Health Insurance Program's intranet site.

For questions regarding the LTHHCP/AHCP Consumer Information Booklet and/or instructions, contact OLTC LTHHCP waiver management staff at 518-474-5271.

Attachments

Long Term Home Health Care Program (LTHHCP)
AIDS Home Care Program (AHCP)

Instructions for Issuance and Completion
LTHHCP Consumer Information Booklet and Forms

LTHHCP Consumer Information Booklet (LDSS and LTHHCP provider use)

This booklet (OLTC/LTHHCP Form 2009-01) provides:

- Pages 2-4 - general information about the LTHHCP and AHCP including program goals, eligibility criteria, authorization process and required assessments, list of LTHHCP/AHCP services, discharge from the LTHHCP/AHCP including notice of decision and fair hearing rights.
- Page 4 – space for LDSS contact information.
- Pages 5-8 - additional information about each of the Medicaid waiver programs available in NYS.

This booklet must be provided to all LTHHCP/AHCP applicants/participants, individuals seeking nursing home placement, and may be provided to any individual who may be interested in the LTHHCP/AHCP. The provision of this information to an applicant, participant, or family member/designated other must be documented in the individual's case record.

The booklet may be downloaded; printed double sided and folded for distribution.

Freedom of Choice Form (LDSS and LTHHCP provider use)

This form (OLTC/LTHHCP Form 2009-02) provides documentation that the LTHHCP/AHCP applicant/participant has been provided with information about waiver programs for which the individual may be eligible and provided choice of available waiver programs and Medicaid home care services.

New Applicants: The completion of this form is required for all individuals applying for the LTHHCP/AHCP. To demonstrate that an applicant for the LTHHCP/AHCP has been informed of his/her right to choose program, provider and services, the LTHHCP/AHCP applicant and/or legal guardian must select his/her choice and verify that choice by signature and date. LDSS staff or LTHHCP agency staff (for alternate entry cases) must indicate the waiver program(s) for which the individual may be eligible, sign and date the form verifying that the information was provided and choice made. In Alternate Entry cases the LTHHCP agency must provide copies to the applicant and/or legal guardian and a copy to the LDSS for its case records.

Current Participants: This form must be completed and signed for all individuals currently participating in the LTHHCP/AHCP at the next reassessment visit for continued participation, but no later than nine (9) months following the issuance date of

this GIS. To demonstrate that a participant of the LTHHCP/AHCP has been informed of his/her right to choose program, provider and services, the participant and/or legal guardian must select his/her choice and verify that choice by signature and date. LDSS staff must indicate the waiver program(s) for which the individual may be eligible, sign and date the form verifying that the information was provided and choice made. When there is more than one LTHHCP agency available in the local district, the LDSS must create and provide a listing of all of the LTHHCP agencies in the district. This information is readily available from www.homecare.nyhealth.gov.

Change of LTHHCP agency: The Freedom of Choice form must be kept on file in the LDSS case record and is effective for the duration of the individual's participation in the LTHHCP/AHCP using the agency of choice. If a participant requests or is referred to an alternate LTHHCP agency for services, the information about waiver programs for which the individual may be eligible, choice of available waiver programs and alternative Medicaid home care services must be provided to the participant, along with the listing of available LTHHCP agencies in the local district. A new Freedom of Choice form must be completed, signed by the participant and/or legal guardian, and a copy is given to the participant to document that the participant was informed of his/her right to choose program, provider and services.

Disenrollment/Reapplication: If an individual is disenrolled from the LTHHCP/AHCP and reapplies at a later date, the information about waiver programs for which the individual may be eligible, choice of available waiver programs and alternative Medicaid home care services must be provided along with the listing of available LTHHCP agencies in the local district. The Freedom of Choice form must be completed and signed by the participant and/or legal guardian at the time of the individual's reapplication.

In all instances above, the completed signed form is given to the participant. A copy must be retained in the LDSS case record to document the applicant/participant was informed of his/her right to choose program, provider and services.

Consumer Contact Information (LDSS only use)

This form (OLTC/LTHHCP Form 2009-03) provides contact information regarding the LTHHCP/AHCP applicant/ participant's chosen LTHHCP agency, LDSS contact information, Home Health Hotline information and documentation that the applicant/participant and or designated other was afforded the opportunity to participate in the development of the plan of care and agrees with the plan of care. This is verified by date and signature of the participant/legal guardian.

New Enrollees: This form must be completed upon LTHHCP/AHCP enrollment for all new-LTHHCP/AHCP participants. A copy of the completed signed form is given to the participant.

Current Participants: This form must be completed for all individuals currently participating in the LTHHCP/AHCP at the next reassessment visit for continued participation, but no later than nine (9) months following the issuance date of the GIS and on an annual basis thereafter for all LTHHCP/AHCP participants.

Change of LTHHCP agency or local district: This form must be completed for all individuals participating in the LTHHCP/AHCP when there is a change of the LTHHCP agency providing services. When a participant moves from one local district to another local district whether there is a LTHHCP agency change or not, a form must completed with the updated contract information and documentation of the individual's participation in the new plan of care.

In all instances above, the completed signed form is given to the participant and a copy must be retained in the LDSS case record to document the applicant/participant's ability to participate in the process of developing his/her plan of care.

Consumer Satisfaction Survey (LDSS only use)

This form (OLTC/LTHHCP for 2009-04) is for the LDSS to survey the LTHHCP/AHCP participant regarding satisfaction with the LTHHCP/AHCP, the services in the LTHHCP/AHCP and the LTHHCP agency or staff providing care. The information/responses provided by the participant must be tracked by the LDSS and included on the LTHHCP LDSS Quarterly Report. Note: A "no" response requires follow up and notation by the LDSS or LTHHCP agency as appropriate.

This form is not applicable to the new applicant. The form must be completed on an annual basis for each LTHHCP/AHCP participant. The completed form is given to the participant and a copy must be retained in the LDSS case record.

The information gathered by this annual survey is intended to capture the participant and/or family/designated representative's views of the program and services provided. This information will be used to improve the program, services, and processes of the waiver program going forward. The opinions of the participant/family/designated representative are not to affect the individual's ability to participate in the LTHHCP/AHCP. Participants may choose to remain anonymous or may choose to provide identifying information. Inserting a date on the form, however, is important in monitoring participant satisfaction with potential changes in the future.

- ✓ Day Habilitation
- ✓ Family Caregiver Supports/Services
- ✓ Health Care Integration
- ✓ Skill Building
- ✓ Special Needs Community Advocacy/Support
- ✓ Supported Employment

Office of Mental Health (OMH) HCBS Waiver for Children with Serious Emotional Disturbance serves children and adolescents between the ages of five (5) and seventeen (17) with complex mental health needs. The program provides supports and services that enable children who would otherwise require an institutional level of care to live at home or in the community. OMH providers develop an individualized service plan for each child and family, and coordinate the mental health and health care services needed to enable children to remain in their homes. The program requires the child and family to be involved in all phases of planning and delivering the services. Services include:

- ✓ Crisis Response
- ✓ Family Support
- ✓ Individualized Care Coordination
- ✓ Intensive In-Home Services
- ✓ Respite Care
- ✓ Skill Building

New York State Department of Health
Office of Long Term Care
August 2009

Long Term Home Health Care Program

LTHHCP

New York State Department of Health
Office of Long Term Care

What is the LTHHCP?

The Medicaid **LTHHCP** waiver includes the AIDS Home Care Program (AHCP) and offers a variety of home and community services to assist people who wish to live in the community rather than a nursing home. The LTHHCP offers needed medical and non-medical support services to improve or maintain the health or daily functions of individuals who would otherwise require nursing home care. By providing coordination of care and monitoring of a person's health, it prevents or reduces hospital stays and prevents unnecessary nursing home stays.

Who can participate?

To be in the Medicaid LTHHCP/AHCP, you must meet the following basic eligibility criteria:

- be eligible for Medicaid so Medicaid will pay for the services;
- require nursing home care as determined by a medical assessment;
- wish to remain in the community;
- have needs that can be met safely at home and have your doctor's agreement; and
- be able to be cared for in the community at less cost to Medicaid than in a nursing home in your county.
- For the AHCP, you must have a diagnosis of AIDS or HIV infection.

What assessments and approvals are needed?

If you meet the basic LTHHCP/AHCP eligibility criteria as listed above and want to participate in the program, the Local Department of Social Services (LDSS) and a LTHHCP agency will complete an assessment at the time you apply for the program and **every 120 days** after that. You have the right to choose the LTHHCP agency from those available in your community. The LDSS can provide you with a list of available LTHHCP agencies.

The purpose of the assessment is to identify your abilities and needs and to identify available help from other programs, family and friends. You, your family/ representative or designated other may participate in developing your plan of care. The plan of care will include the services necessary and appropriate to support your

Office of Mental Retardation and Developmental Disabilities (OMRDD) Care at Home III, IV, and VI Waivers serve children under age eighteen (18) who are developmentally disabled and require Intermediate Care Facility level of care. These waivers are available for children with both developmental disabilities and complex health care needs. The CAH III, IV, and VI waiver services include:

- ✓ Assistive Technology
- ✓ Case Management
- ✓ Respite

Office of Mental Retardation and Developmental Disabilities (OMRDD) Waiver serves Medicaid eligible adults and children who are developmentally disabled, meet OMRDD eligibility criteria, and require an Intermediate Care Facility level of care. The OMRDD waiver services include:

- ✓ Assistive Technology
- ✓ Community Transition Services
- ✓ Consolidated Supports and Services
- ✓ Day Habilitation
- ✓ Environmental Modifications
- ✓ Family Education and Training
- ✓ Plan of Care Support Services
- ✓ Prevocational Services
- ✓ Residential Habilitation
- ✓ Respite
- ✓ Supported Employment

Bridges to Health (B2H) Waivers for Children in Foster Care is comprised of three (3) separate waivers: B2H for the Seriously Emotionally Disturbed, B2H for the Developmentally Disabled and B2H for the Medically Fragile. The B2H waivers serve children with significant unmet health care needs who are at an institutional level of care and provides home and community based services allowing such individuals to remain in the most integrated community setting. Children who are discharged from foster care can also remain in the B2H waivers up to age twenty-one (21), if they are otherwise eligible. In addition to Medicaid State Plan services, the B2H program offers the following waiver services:

- ✓ Accessibility Modifications
- ✓ Adaptive and Assistive Equipment
- ✓ Crisis Respite
- ✓ Crisis Avoidance, Management/Training
- ✓ Immediate Crisis Response Services
- ✓ Intensive In-Home Supports
- ✓ Planned Respite
- ✓ Prevocational Services

Services
- ✓ Home Visits by Medical Personnel
- ✓ Wellness Counseling Services

Traumatic Brain Injury (TBI) Waiver serves Medicaid eligible individuals who have experienced an acquired traumatic brain injury, are in need of nursing home level of care, and have needs that can safely be met in the community. The program provides supports and services to assist individuals towards successful inclusion in the community and strongly encourages maximum participant choice. The TBI waiver services include:

- ✓ Assistive Technology
- ✓ Community Integration Counseling
- ✓ Community Transition Services
- ✓ Environmental Modifications
- ✓ Home & Community Support Services
- ✓ Independent Living Skills Training/ Development
- ✓ Positive Behavioral Intervention/Support
- ✓ Respite Care
- ✓ Service Coordination
- ✓ Structured Day Program
- ✓ Substance Abuse Programs
- ✓ Waiver Transportation

Care at Home I/II Waiver serves children under age eighteen (18) and provides medical and related services to families who want to bring their physically disabled child home from a hospital or nursing home. Families who have already brought their child home can also apply. CAH Medicaid helps to pay for medically necessary in-home services to make it possible for physically disabled children to live at home with their families. Services available under this program include:

- ✓ Bereavement Services
- ✓ Case Management
- ✓ Expressive Therapies
- ✓ Family Palliative Care Education
- ✓ Home & Vehicle Modification
- ✓ Massage Therapy
- ✓ Pain and Symptom Management
- ✓ Respite

Other New York State HCBS Waiver Programs

individual needs and desires to continue to live in the community. The plan must be approved by your doctor.

Your initial and ongoing participation in the LTHHCP/AHCP must be authorized by the LDSS based on its review of the plan of care proposed for you and its estimated cost. The LDSS must send you a written notice of its decision regarding authorization, reauthorization or denial for the LTHHCP/AHCP.

What services are available?

The following home health services may be provided under the LTHHCP/AHCP:

- Nursing
- Physical, Occupational and Speech Therapies
- Home Health Aide
- Personal Care Aide
- Homemaking

The following waiver services may also be available:

- Assistive Technology (e.g. Personal Emergency Response Services)
- Community Transitional Services
- Congregate and Home Delivered Meals
- Environmental Modifications
- Home and Community Support Services
- Home Maintenance Services
- Medical Social Services
- Moving Assistance
- Nutritional Counseling/Education Services
- Respiratory Therapy
- Social Day Care
- Transportation to Social Day Care

The LDSS and the LTHHCP agency can discuss these services with you as they work with you to develop your plan of care. The LTHHCP agency is responsible for coordinating the specific care and services included in your approved plan of care.

Leaving the LTHHCP/AHCP

If you are no longer eligible for the LTHHCP/AHCP or choose not to continue to participate, a safe appropriate plan for discharge will be developed by the LTHHCP agency and the LDSS prior to your discharge. The LDSS will provide to you a written notice of decision regarding discontinuing participation prior to discharge.

Fair Hearing Rights

If you do not agree with a decision made regarding authorization, reauthorization, denial or discontinuance from the LTHHCP/AHCP, a fair hearing may be requested. Specific information regarding fair hearing rights and how to request a fair hearing is provided by the LDSS and included on the written notice of decision.

For further information of how to apply for participation in the program, contact your Local Department of Social Services (LDSS) at:

Contact information for your Local Department of Social Services is also available on the following website:
www.nyhealth.gov/health_care/medicaid/ldss

Information on LTHHCP agencies in your area is available through the LDSS or on the following website:
www.homecare.nyhealth.gov

NEW YORK STATE HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAMS

New York State Department of Health Sponsored HCBS Waiver Programs

Long Term Home Health Care Program (LTHHCP), (also known as *Lombardi Program*) including the AIDS Home Care Program (AHCP), serves seniors and individuals of all ages who have physical disabilities. Eligible individuals must be in need of nursing home level of care and have needs that can safely be met in the community. LTHHCP offers both medical and nonmedical support services to assist an individual in improving or maintaining their health and daily functioning. All regular Medicaid home care services are available and the following may also be available through the LTHHCP or AHCP:

- ✓ Assistive Technology
- ✓ Case Management by RNs
- ✓ Community Transition Services
- ✓ Congregate / Home Delivered Meals
- ✓ Environmental Modifications
- ✓ Home & Community Support Services
- ✓ Home Maintenance Services
- ✓ Nutritional Counseling/ Education
- ✓ Medical Social Services
- ✓ Moving Assistance
- ✓ Respiratory Therapy
- ✓ Respite Care
- ✓ Social Day Care
- ✓ Transportation to Social Day Care

Nursing Home Transition and Diversion (NHTD) serves Medicaid eligible seniors or individuals eighteen (18) years or older who have a physical disability. Eligible individuals must be in need of nursing home level of care and have needs that can safely be met in the community. All regular Medicaid home care services are available and the following waiver services are available:

- ✓ Assistive Technology
- ✓ Community Transition Services
- ✓ Community Integration Counseling
- ✓ Congregate / Home Delivered Meals
- ✓ Environmental Modifications
- ✓ Nutritional Counseling/ Education
- ✓ Home & Community Support
- ✓ Moving Assistance
- ✓ Independent Living Skills Training
- ✓ Positive Behavioral Interventions
- ✓ Peer Mentoring
- ✓ Respiratory Therapy
- ✓ Respite Services
- ✓ Service Coordination
- ✓ Structured Day Program

LONG TERM HOME HEALTH CARE PROGRAM
MEDICAID HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER

FREEDOM OF CHOICE

NYS DOH Sponsored HCBS Medicaid Waivers you may be eligible for:

- ☐ Long Term Home Health Care Program (LTHHCP) / AIDS Home Care Program (AHCP)
- ☐ Nursing Home Transition and Diversion (NHTD)
- ☐ Care at Home (CAH) I/II
- ☐ Care at Home (CAH) III; IV; & VI
- ☐ Traumatic Brain Injury (TBI)

Other NYS HCBS Medicaid Waivers:

- ☐ Bridges to Health (B2H)
- ☐ Office of Mental Retardation and Developmental Disabilities (OMRDD)
- ☐ Office of Mental Health (OMH) Children w/ Serious Emotional Disturbance (SED)

The following has been provided to me and/or my legal guardian:

1. Information about available HCBS waivers, other Medicaid home care services, services provided through a nursing home and my right to choose whether or not to apply for the LTHHCP/AHCP at this time.
2. The description and goals of the LTHHCP/AHCP.
3. The eligibility criteria for the LTHHCP/AHCP and available services.
4. The list of available LTHHCP agencies in my area and an explanation of my ability to select the LTHHCP agency of my choice and to change that choice at any time.

I have received information regarding the above and (check one below):

_____ I have chosen to apply for the LTHHCP/AHCP waiver.

_____ I have chosen to apply for other _____ (specify Medicaid home care services and/or another waiver).

_____ I have chosen **NOT** to apply for Medicaid home care services and/or another waiver at this time.

Applicant Name (Print)	Signature	Date
Legal Guardian Name (as applicable) (Print)	Signature	Date
LDSS Staff (Print) or LTHHCP Agency Staff *(For alternate entry cases)*	Signature	Date

Long Term Home Health Care Program (LTHHCP)
AIDS Home Care Program (AHCP)

Consumer Contact Information

NAME: _____ CIN#: _____ DATE: _____

☐ New Application: ☐ Reassessment:

From the available LTHHCP Agencies, I have selected the following:

Agency Name _____

Agency Address _____

Agency Phone # _____

Local Department of Social Services (LDSS)

Contact Name: _____

Phone # _____

Home Health Hotline Phone Number: **800-628-5972**

This toll free number may be used by you, your family or anyone to lodge a complaint regarding the quality of care or any type of complaint regarding home care services.

Your plan of care is based on an assessment by the LDSS and the LTHHCP agency and approved by your doctor. You, your family/representative or designated other may participate in developing the plan of care and choose the services necessary for your plan of care.

I have participated in the development and agree with my plan of care.

Signature of LTHHCP participant/legal guardian *Date*

Long Term Home Health Care Program (LTHHCP)
AIDS Home Care Program (AHCP)

Consumer Satisfaction Survey

NAME:_____ CIN#: _____ DATE: _____
(Optional) (Optional) (Required)

Please complete the following if you are currently enrolled in the LTHHCP/AHCP waiver.

Your opinions are important to help improve the program. Responses to these questions will ***not*** *affect your ongoing participation in the LTHHCP or AHCP.*

Are you satisfied with the LTHHCP or AHCP overall?
Yes ☐ No ☐ N/A☐

Are you satisfied with the services you have received in the LTHHCP or AHCP?
Yes ☐ No ☐ N/A☐

Are you satisfied with the LTHHCP agency/staff?
Yes ☐ No ☐ N/A☐

Comments: _____

_____

_____

_____

_____

_____

_____

_____

Thank you for your assistance. You may request a copy of this survey for your records.