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New York State Department of Health
Office of Primary Care and Health Systems Management
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Dear Mark:

Thank you for the opportunity to provide recommendations for reforms of State regulations that interfere with the ability of long-term/post-acute care (LTPAC) providers to deliver high quality care effectively and efficiently. We have interpreted your request broadly and included recommended changes in statutes and regulations that would:

- eliminate duplicative, unnecessary or obsolete requirements;
- align State and federal regulations;
- support high quality, cost-effective models of care and efficient use of increasingly scarce direct care staff;
- support value-based payment (VBP) arrangements; and/or
- ensure consistency and transparency in the interpretation and enforcement of regulations.

The proposed reforms set forth below seek to achieve these goals in five long-term/post-acute care service sectors: nursing homes, adult care facilities, adult day health care, home and community-based services, and managed long term care. Please understand that this is an initial set of recommendations. We have reached out to our membership for recommendations, and expect to receive additional proposals over the next few weeks. However, in order to respond to your request in a timely manner, we are providing the following initial proposals. We will follow up with any additional recommendations we receive.

I. Nursing Homes

Primary Care Services

- **Nurse Practitioners (NPs) and Physician Assistant (PAs) Services:** Success under VBP arrangements will require nursing homes to implement robust clinical protocols to avoid hospitalizations, re-hospitalizations and emergency department visits. Nursing homes will increasingly be expected to retain residents who experience an acute exacerbation to the extent medically appropriate and to care for higher acuity residents after discharge from the hospital. Active engagement of mid-levels in these activities will be valuable to these new models. However, outdated nursing home regulations prevent NPs and PAs in nursing homes from practicing within the full scope of their professional licenses. Specifically, the regulations should be amended to clarify

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that NPs and PAs are permitted to conduct the initial health history and physical for new residents and to sign nursing home admission orders.

- **Incentives for Use of Physician Extenders:** Encourage facilities to bring on physician extenders by allowing them to keep the Medicare Part B offset funds that would normally be taken from the Medicaid rate. Such staffing would support serving higher acuity residents and providing necessary treatments to avoid hospitalization and emergency room visits (See 18 NYCRR §540.6(4)).

- **Physician Services in Rural Areas:** Nursing homes located in rural areas can have significant difficulty securing physicians to provide medical direction. Regulations at 10 NYCRR §415.15 require facilities to designate a full-time or part-time physician to serve as medical director. However, limited physician availability on an in-person basis may make these requirements very difficult to meet. The regulations should be interpreted to allow certain duties identified in §415.15 to be undertaken remotely via telemedicine encounters, and possibly by physician extenders practicing within their scope of practice.

- **Revise Medicaid Reimbursement Rules to Permit Payment for Remote Consults with Psychiatrists and other Specialty Physicians.** This would improve the ability of facilities to meet the specialized needs of their residents in an expeditious manner and reduce emergency department visits and hospital admissions (See 18 NYCRR, Section 505.9 – for list of covered services; list is silent on this).

Patient Assessments

- **Eliminate the Patient Review Instrument (PRI):** Hospitals conduct the PRI assessment prior to discharge from the hospital to a nursing home. The PRI assessments tend to have minimal value due to hospital discharge staff's lack of familiarity with the patient and absence of a hospital purpose for the PRI. Upon admission to the nursing home, a complete assessment is conducted by the nursing home using the Resident Assessment Instrument. Under managed care and emerging VBP arrangements, there is significant pressure to reduce nursing home utilization. Accordingly, the PRI is no longer necessary to prevent inappropriate utilization.

- **Alternatively, Eliminate PRI Requirements in Certain Circumstances:** If elimination of the PRI is not possible, allow nursing homes to admit someone without requiring a PRI to enable more rapid admission under the following circumstances:
    - when a person who resides in a multi-level retirement community (with independent living and/or adult care facility/assisted living) is hospitalized and seeks to be admitted to the community's nursing home; and
    - in certain regions, where staffing and administrative challenges may delay the PRI and screen and thereby delay admissions to a nursing home. This is particularly common along borders with other states, where facilities commonly accept people from out of state, or repatriate residents from nursing homes in another state. While an assessment of appropriateness is still conducted, arranging for the appropriately trained person to conduct a PRI can stall an admission. Waiving this requirement would enable nursing homes to more rapidly accept people from the hospital, and/or bring them back to New York from other states.

Staffing

- **Modify Training Required of Paid Feeding Assistants:** New York regulations require feeding assistants who support nursing home residents at meals to undergo more extensive training than federal regulations require. As a result, many nursing homes continue to use certified nursing assistants (CNAs) to assist some residents at meals who might otherwise be fed by a paid feeding assistant. If State regulations were aligned with the federal requirements, nursing homes could expand their use of feeding assistants and allow CNAs to focus on higher level tasks. This would alleviate an unnecessary administrative burden and facilitate efforts to reduce the overall cost of care.

Specialty Services

- **Allow Nursing Homes to Offer Enhanced Services that Reduce Avoidable Hospital Use:** Nursing homes face reimbursement and other barriers to providing chemotherapy services. The unavailability of such services in nursing facilities can lead to more lengthy hospital stays and readmissions. Similarly, if nursing homes were permitted to offer hyperbaric services for wound care and other specialty services which can feasibly be provided in a nursing home, avoidable hospital use could be further reduced. Finally, the Restorative Care Unit demonstration program created in the SFY 2016-17 budget should be broadened to additional facilities.

Survey and Oversight

- **Address Ongoing Regional Variation in Citations:** As shown in the table below, there continue to be significant regional differences throughout the State in the incidence of survey deficiencies. This variation cannot reasonably be explained by variation in provider quality. It is important to recognize that survey findings do not merely result in plans of correction or fines; they are increasingly important to the financial health of every facility. Survey findings have a major effect on a facility's 5-Star rating, which in turn determines eligibility for quality payments; determines participation in managed care, hospital and ACO networks, and bundled payment arrangements; and influences consumers' selection of a nursing home. To encourage greater consistency in surveys and a common understanding of requirements among providers and surveyors, the Department should initiate statewide joint provider-surveyor training on new and existing requirements of participation. A potential source of funding for this initiative could be the available civil monetary penalties (CMP) funds.

Nursing Home Survey Deficiency Counts: Most Recent Periodic Health Survey for Each Home through September 2016

Region	Number of Homes	Number of Beds	Total Deficiencies Cited	Average Number of Deficiencies per Home	Average Number of Deficiencies per 100 beds	Median Number of Deficiencies Per Home	Number of Homes with 0 Deficiencies	Percent of Homes with 0 Deficiencies
Buffalo	73	10,244	701	9.6	6.8	8.0	2	2.7%
Rochester	60	8,794	458	7.6	5.2	7.0	0	0.0%
Central NY	81	12,312	808	10.0	6.6	9.0	0	0.0%
Northeastern NY	65	9,226	381	5.9	4.1	5.0	1	1.5%
NYC	171	45,292	447	2.6	1.0	2.0	58	33.9%
Hudson Valley	86	13,388	154	1.8	1.2	2.0	29	33.7%
Long Island	77	15,914	391	5.1	2.5	5.0	9	11.7%
Statewide	613	115,170	3,340	5.4	2.9	4.0	99	16.2%

Source: LeadingAge NY analysis of CMS Nursing Home Compare Data accessed Dec. 2016

- **Provide Real-Time Communication/Education on New Mandates:** As an example, the Department began enforcing an update of the nursing home Life Safety Code requirements during 2016, but has yet to provide written guidance or training to the field. Facilities should receive information and education on new regulatory/policy requirements prior to enforcement.

II. Adult Care Facility/Assisted Living (ACF/AL)

As you know, a work group has been convened to explore adult care facility regulatory reforms. LeadingAge New York is an active member of that work group and is working within that context on detailed regulatory updates and revisions. The below suggestions are offered as broader public policy reforms to help the ACF/AL sector evolve.

- **Allow ACF/AL Nurses to Perform Nursing Tasks:** Currently, many ACFs, Assisted Living Programs, Assisted Living Residences, and Special Needs Assisted Living Residences employ licensed practical nurses (LPNs) and/or registered nurses (RNs). Unfortunately, these nurses are not permitted to perform nursing tasks in these ACF settings due to statutory limitations in New York related to the corporate practice of professions. By allowing nurses in ACFs to perform tasks *within their scope of practice*, ACF residents would receive more proactive, preventive services that can prevent emergency department visits and hospital admissions. Nurses working in ACFs could also help to avert declines in health status that trigger nursing home placement, thereby saving money for the state, the federal government and the consumer. Like nurses employed by nursing facilities and hospitals, nurses employed by ACFs should be exempt from the corporate practice of the professions

prohibition and permitted to practice their profession in those settings. A.2736 (Gottfried)/S.4398 (Hannon) offers a legislative solution to this issue.

The case for allowing nurses to practice nursing in adult care facilities is particularly compelling in Assisted Living Programs (ALPs) and would require minimal adjustments to Department of Health policies or regulations. All ALPs must also operate a licensed home care services agency (LHCSA). The Department has interpreted its regulations to prohibit nurses employed by an ALP LHCSA from providing nursing services in the ALP itself, *even though they may provide nursing services anywhere else in the community*. Instead, ALP regulations point to contracted certified home health agencies or long term home health care programs to provide nursing services to ALP residents. Nurses working for ALP LHCSAs should be able to provide nursing services to the affiliated ALP's residents. It is our understanding that this change could be implemented through a modest change in DOH policy guidance. In addition, amendments to Title 18 NYCRR Part 494 would help to clarify that a LHCSA nurse could provide nursing services, particularly those services that would not be covered by Medicare.

- **Allow Access to Hospice Services in the Assisted Living Program (ALP):** Currently, DOH prohibits a Medicaid beneficiary from residing in the ALP and accessing the hospice benefit at the same time. This limits access to critical services and supports at the end of life and places the resident and his/her family in the impossible position of choosing between remaining in his/her assisted living home or moving to another setting to receive hospice care. We urge the Department to work with us to identify possible solutions to overcome this barrier. Aside from the clear quality of life benefits to the beneficiary, providing access to hospice is also likely to reduce hospitalizations and emergency room visits for ALP residents.

- **Allow ACFs and Assisted Living Facilities to Utilize Advanced Home Health Aides:** We urge the swift implementation of the advanced home health aide option, and suggest exploring how it could be used in the ACF and assisted living residence (ALR) settings.

- **Provide Expedited Process for Limited Additions to ALP Capacity**: Currently ACF and ALR providers can add beds through an expedited process if they meet certain criteria and are in good standing with the Department of Health. We recommend that existing ALPs have access to the same option. We recommend that an ALP provider be permitted to add up to nine (9) beds to its ALP operating certificate no more than once in a five-year period. An expedited application process should be available for those applications that do not require any construction beyond minor renovations. We believe DOH has the authority to implement this administratively.

- **Rationalize ALP Approval and Expansion Process:** We have long advocated for an expansion of the ALP program; creating more assisted living opportunities for Medicaid-eligible seniors has multiple benefits. To that end, we suggest that the State remove the cap on ALP beds, and create a process by which eligible entities can apply to create ALP beds, based on a demonstration of community need. Our objective in proposing a more rigorous demonstration of need is to provide a consistent logic that can be applied to the future growth of ALP beds to address rising demand in the

context of an aging population, while avoiding excess development that can compromise the viability of programs. S.5840 (Hannon) provides a legislative solution to this issue.

In addition to the aforementioned expansion, the ALP could be expanded in a way that supports other policy priorities, perhaps administratively and without instituting a need-based process:

- ALP beds could be awarded to Nursing Homes that want to decertify beds.
- ALP beds could be awarded to Special Needs Assisted Living Residences (SNALRs) to expand access to SNALR dementia units for Medicaid beneficiaries.
- ALP beds could be awarded in counties where there are 2 or fewer ALP options, so as to ensure choice in a managed care environment.

In the first two cases, the Department would have to provide guidance to the provider community about how to develop the new programs in a way that is compliant with the federal home and community based settings rule

- **Access to Assisted Living for Medicaid-Eligible People with Dementia:** Currently, there are limited options for Medicaid-eligible consumers in New York who have specialized and intensive care needs related to dementia. For those who can no longer live in their own homes, nursing homes are often the only option. We urge the state to find ways to expand assisted living options for low-income seniors with dementia.

  LeadingAge NY analyzed MDS data from 2011-2013 for long-stay residents in nursing homes, and found that 64 percent of the long-stay residents had a diagnosis of dementia or Alzheimer's disease, or were identified as otherwise severely cognitively impaired **.** Some segment of this population could be served in the ALP. Reducing the number of Medicaid eligible people with dementia and other cognitive impairments would save significant Medicaid dollars. In fact, if *just one percent* of this population (i.e., 770) were served in ALPs instead of in nursing homes for six months, the savings to the Medicaid program would exceed *$15 million per year*. Increasing ALP beds and making it more feasible for the ALP to serve people that need specialized services for dementia care can help achieve potential savings.

- **Adjust UAS Scoring of Cognitive Deficits and Behavioral Health Conditions:** We have consistently heard from members that they believe the UAS-NY does not adequately capture the true care needs of people with dementia and other cognitive impairments. A recent study commissioned by the Department and conducted by IPRO supports this contention. As a result of flaws in the UAS tool or assessment process, cognitive impairments are under-appreciated and ALP providers are not paid adequately to care for this population. Ensuring adequate payment will support growth in services for people with dementia in ALPs.

- **Making Dementia Care More Person-Centered:** We also need to find ways to provide services and supports that appropriately honor the preferences and autonomy of people with dementia, while supporting the people who care for them. For example, when a person requires specialized care outside of a private home for his/her dementia-related needs, there should be a setting in which a spouse who does not have dementia might be able to live with that person. Consumers, policy-

makers, and providers need to explore ways in which the family can have a meaningful role in caring for a loved one in a facility environment, such as assisted living or nursing home care. Currently, regulations limit that role. Enabling family members to live with disabled loved ones in residential settings would help to avoid unnecessary hospitalizations and improve the quality of life for both the consumer and the family member. We need to examine to examine and address the barriers to providing the most person-centered services and environment possible, across settings.

III. Adult Day Health Care

- **Home and Community-Based Services (HCBS) Settings Rule:** Several regulations governing ADHC programs may need to be modified to comply with the federal HCBS settings rule. We identified problematic regulations and wish to share our ideas for reform. Given the length of time it takes to amend regulations and the deadline for HCBS compliance, we request a meeting to discuss regulatory changes to ADHC, including new standards for care planning or person-centered service planning.

- **Allow fee-for-service Medicaid, Mainstream Managed Care (MMC), and private-pay to utilize unbundled services payment option (USPO):** The Department of Health adopted regulations to "unbundle" the all-inclusive adult day health care rate to permit managed long term care plans to contract for discrete services within the ADHC setting based on the needs of the registrant. However, only MLTC plans and Care Coordination Models are allowed to unbundle and purchase ADHC services in this innovative way. ADHC programs increasingly turn away younger individuals, and people with developmental disabilities and behavioral health conditions who would benefit from a structured and regulated ADHC environment, but may not need skilled services every day. By expanding USPO to additional Medicaid beneficiaries and private pay population, these functionally impaired individuals will receive services tailored to fit their needs in a safe and regulated setting.

- **Amend Part 425.4 (a)(1).** 425.4(a)(1) states: *An operator must provide services to registrants consistent with the requirements of this Title and Part* ***and other applicable statutes and regulations*** (emphasis added). As written, this regulation implies that ADHC programs must comply with any nursing home statute and regulation or any other regulation that could be considered "applicable" to ADHC. This phrase is too vague and creates confusion as to which regulatory requirements outside of Part 425 must be followed. ADHC providers should strictly comply with Title 10 Part 425 regulations and not be subject to "other applicable statutes and regulations."

- **Allow interdisciplinary care plan and UAS-NY to be completed during any day of the month it is due.** ADHC regulations state that the care plan and UAS-NY must be completed "every six months." This is difficult to arrange because this day may fall on the weekend or the registrant may have an unexcused absence from program. MLTC plans have the flexibility to assess on any day

during the month that the UAS is due. ADHC providers request this same flexibility to accommodate the registrant's unpredictable schedule and stay in compliance.

- **Allow nursing home medical director to sign orders for continued stay.** ADHC programs must rely on community physicians to sign orders every six months for continued stay. It is incredibly difficult to obtain these orders, particularly for large programs where every registrant may have a different physician. The medical director employed by the sponsoring nursing home currently supervises medical services, reviews a registrant's medical history and diagnostic services, diagnoses and orders for treatment, as well as several other responsibilities under section 425.9. The medical director should be allowed to determine the suitability and continued need for services in addition to the community physician.

IV. Home and Community-Based Services

- **Advanced Home Health Aide (AHHA):** The State should work to implement in a timely fashion the Advanced Home Health Aide (AHHA) legislation. This legislation, which enables home health aides (HHAs) to perform certain advanced tasks under the training and supervision of a registered nurse (RN), was signed into law in November 2016, with substantive provisions to take effect 18 months later. However, we are not aware of the commencement of any steps to implement this law or any stakeholder involvement. The Department of Health and Department of Education should resume the work of the AHHA workgroup in order to ensure proper and timely implementation of the law.

- **Cross-Certification of Aides**: The State should take steps to facilitate cross-certification of aides to promote a flexible and adaptive workforce. Rigid and inconsistent training requirements across service lines create career mobility issues for workers and staffing/cost issues for providers. Presently, these requirements demand expensive and duplicative training resources, including multiple curricula, oversight processes, and tracking mechanisms. In addition, existing training requirements cause artificial barriers for individuals who wish to work in more than one site of care, and/or transition between sites of care.

- **Facilitate cross-training and lateral transfers across health and long-term care settings:** Providers of health, LTPAC, behavioral health, and developmental disability services and unions should join with regulators and educational institutions to explore cross-training and inter-disciplinary service opportunities to alleviate workforce shortages. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.

- **Promote accessible education and training in rural areas**: The State should provide incentives and funding to nursing schools, community colleges, other training programs, and trainees to broaden participation in formal courses of instruction for nurses and aides in rural areas. Techniques such as satellite broadcasts, web-based courses, training stipends, flexible scheduling of courses, and on-the-job training opportunities should be pursued.

- **Reimbursement for Rural Home Care:** The State should enact legislation that would increase home care reimbursement under Medicaid to cover the disparate transportation costs associated with providing home health services in rural areas. (See S5479A – A6791).

- **Expedite the Processing of Certificate of Need (CON) Applications to Add Services or Expand Service Area:** As providers seek to implement value-based payment arrangements under both Medicare and Medicaid, and align their services and service areas with the needs of their network partners (e.g., DSRIP PPSs, ACOs, and hospitals), CHHA CON and LHSCA applications to expand services areas or add services need to be processed more quickly.

- **Adjust UAS Scoring of Cognitive Deficits and Behavioral Health Conditions:** The State should respond to the findings of the IPRO desk audit team by implementing improved training and procedures to identify and appropriately score cognitive deficits and behavioral health conditions.

V. Managed Long Term Care

- **Timely Contract Updates and Revisions:** Managed Long Term Care (MLTC) plans have been subject to retroactive contract revisions which can cause operational difficulties and expose plans to compliance audit findings because timing issues can be difficult to unravel when audits or surveys are done months or years after the fact. Partial capitation plans currently operate with a contract that expired at the end of 2016 and are uncertain about what provisions may be deleted or added when the contract is updated. The "regulatory" environment for plans would be significantly improved by timely contract updates and the elimination of retroactive requirements.

- **Contractual Requirements to Monitor Pass-Through Funding:** The expired contract for partial capitation plans, requires plans to monitor provider use of certain pass-through funding such as FLSA and wage parity-related funds. Ensuring that providers use dedicated funds in specified ways is a DOH responsibility that plans are not in a position to perform. This contract provision conflicts with current DOH guidance that suggests (appropriately) that such monitoring is NOT the responsibility of the plan. This uncertainty causes confusion and unnecessary administrative costs. DOH should be explicit that plans are not required to monitor provider use of pass-through funding, and that this provision will not be part of the 2017 contract.

- **OMIG Audit Protocols:** In consultation with State regulating agencies, the Office of Medicaid Inspector General (OMIG) has developed a series of audit protocols to assist the Medicaid provider community in developing programs to evaluate and ensure compliance with Medicaid requirements under federal and State statutes and regulations. Audit protocols are applied to specific providers or categories of service in the course of an audit and involve OMIG's application of articulated Medicaid agency policy and the exercise of agency discretion. Although there are more than 30 provider audit protocols, OMIG has issued no audit protocols for MLTC plans. This is particularly perplexing given plans' involvement in managing the bulk of Medicaid long term care funding and OMIG's growing emphasis on managed care audits. The absence of audit protocols detracts from

the consistency and transparency of audit processes. OMIG should develop, communicate and adhere to clear MLTC audit protocols in their MLTC plan reviews.

- **UAS Risk Adjustment Methodology Does Not Accurately Weigh Dementia:** Acuity or case mix adjustments that in other settings might be done pursuant to regulation are performed in the MLTC realm under the authority of DOH and its contracted actuary. It appears that plan concerns and documented evidence of UAS items and combinations of items that drive costs are not often considered. In particular, the risk scoring methodology appears to under-appreciate the risk associated with serving beneficiaries with dementia. DOH and its actuarial firm should engage in an open, transparent, and participatory process in developing and revising risk adjustment models. DOH should make deidentified UAS data to stakeholders for analysis.

Thank you again for soliciting our input. We look forward to working with you and your team to update and improve the regulations governing long-term/post-acute care.

Sincerely yours,

Karen Lipson

Executive Vice President for Innovation Strategies