



**OPTIMIZING INDEPENDENCE
AND QUALITY OF CARE FOR
SENIORS IN NEW YORK STATE:**
Cost-Effective Strategies for
Long-Term/Post-Acute Care Services

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Table of Contents

Introduction	4
I. The Long-Term/Post-Acute Care and Senior Services Continuum	7
A. Community-Based and Residential Services	9
B. Nursing Homes	10
C. Managed Care	11
D. Consumers of LTPAC Services	12
II. Goals and Key Strategies for New York's LTPAC and Senior Services System	13
III. Challenges	15
A. Demographic Challenges: A Shrinking Pool of Caregivers to Serve Growing Numbers of Seniors With High Rates of Chronic Disease	16
B. Financial Challenges: Public Funding of LTPAC and Senior Services Is Not Aligned With Growing Need and Costs	17
1. Medicaid and Medicare spending levels off, despite rising costs.	17
2. MLTC rates are depressed, and program features leave few opportunities for additional savings.	19
3. Lack of investment in affordable and appropriate housing and assisted living reduces opportunities for savings and community integration.	20
4. Bifurcation of Medicaid and Medicare funding and regulations impedes reform.	22
5. DSRIP and VBP are not expected to provide financial relief for LTPAC providers.	23
C. Operational Challenges: Proliferation of New Requirements and Programs, Workforce Shortages and Weak IT Infrastructure	24
1. Rapid pace and scope of change and a proliferation of new regulatory requirements are draining resources and diverting MLTC plans and providers from their core mission.	24
2. Workforce challenges hinder efforts to build capacity and offer services in the most integrated setting.	25
3. Health Information Technology (IT) infrastructure is lacking.	27

Table of Contents (continued)

IV. Strategies for Optimizing Quality of Life and Advancing the Triple Aim Through LTPAC and Senior Services	29
A. Promote Integration of Medicare and Medicaid Funding Streams	30
B. Expand Access to a Continuum of Community-Based and Residential Options for Seniors	31
1. Invest in affordable senior housing and services.	31
2. Expand ALP capacity and increase capital and operating funding for ALPs and ACFs.	32
3. Provide capital funding for LTPAC providers.	32
4. Provide additional funding for NORCs/NNORCs.	32
5. Support the development of the Village Model.	33
6. Promote expansion and utilization of medical-model adult day health care.	33
C. Invest in Information Technology and Health Information Exchange to Support Value-Based Payment and the Triple Aim	34
D. Expand the Continuing Care Workforce and Support Efficient and Effective Utilization of Workers	34
1. Implement the Advanced Home Health Aide legislation.	34
2. Allow for Advanced Certified Nursing Aides.	34
3. Expand the role of the nurse in the ACF.	35
4. Cross-certification of direct care workers.	35
5. Facilitate cross-training and lateral transfers across health and long-term care settings.	35
6. Promote accessible education and training in rural areas.	36
7. Expand the use of telehealth and remote patient monitoring.	36
8. Support informal caregivers.	36
E. Allocate Additional Funds to Quality Incentives for LTPAC Providers	36
F. Ensure That MLTC Rates Are Adequate to Cover the Costs of Care, Care Management and Administration	37
G. Encourage Self-Financing of Long-Term Care and Discourage Medicaid Divestiture	37
1. Expand access to social supports for seniors.	37
2. Modernize the CCRC statute.	37
3. Transfer estate recovery responsibility to OMIG and reinvest recoveries in LTPAC system.	38
4. Align NY Connects and HIICAP.	38
Conclusion	39
Contact LeadingAge New York Staff	39



INTRODUCTION



New York is home to approximately 3 million residents age 65 and older, representing 15 percent of the population. By 2025, 18 percent of New York's population is projected to be age 65 or older, up from 14 percent in 2010. Both the number and percentage of older New Yorkers is expected to continue to rise over the next 20 years. This growth will drive a corresponding increase in the number of New Yorkers with cognitive and functional limitations who need long-term care (LTC) services. However, by 2025, the availability of younger New Yorkers to care for seniors will be at its lowest point in a decade and declining.¹ Both informal caregivers and workers in the formal care delivery system to support the growing population of seniors will be in short supply. Moreover, with one-third of today's older New Yorkers living at or near the poverty level, it is reasonable to expect that a significant portion of our growing senior population will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs.

These demographic and socioeconomic challenges are not just problems for the future. Today, seniors and their families are already experiencing the impact of LTC workforce shortages, lack of access to home care services (especially upstate), and financial pressures associated with the high cost of LTC. Faced with current and future demographic challenges and their anticipated impact on the State budget, New York must take action now. The State must broaden its focus beyond high-cost Medicaid beneficiaries and begin to develop strategies that will prolong independence and encourage the use of private funds to delay entry onto the Medicaid rolls. It must invest in lower cost long-term services, supports and technologies that enable individuals to remain in their communities, and it must modernize regulations and provide funding to permit providers to address consumer preferences, optimize efficiencies, improve quality, and effectively deploy an increasingly scarce workforce.

For decades, the State has focused on curbing LTC spending by reducing provider reimbursement and more recently by shifting to a managed care payment system. Investments or regulatory changes that would support the development of new capacity or lower-cost models of LTC have not been a priority, nor has investment in programs that would help seniors to avoid or delay enrollment in Medicaid. On the contrary, as the State has pursued an ambitious effort to provide care management for all and reduce avoidable hospital use, only a minuscule

fraction of the billions of dollars invested in the health care delivery system has been invested in the long-term/post-acute care (LTPAC) sector. Instead, funds

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have been targeted at primary care and behavioral health care and compensating hospitals for lost volume. As currently structured, the State's Delivery System Reform Incentive Payment (DSRIP) program and value-based payment initiatives are unlikely to drive new investment in LTPAC and senior services. In fact, as discussed below, they are likely to have the opposite effect.

¹NYS Office for the Aging, County Data Book, New York State, Table 1, Demographics, <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/01NYS.pdf>, accessed Dec. 13, 2015.

Although LTPAC providers and managed long-term care (MLTC) plans have not been given a central role in the State's health care reform efforts, they are well positioned to contribute to New York State's initiatives to transform care and reduce avoidable hospital use. They serve medically-complex and frail elderly and disabled individuals, who experience high rates of hospitalization and frequent transitions between health care settings. In addition, LTPAC providers deliver basic, light-touch support services to community-dwelling seniors who might otherwise be one fall or illness away from nursing home care. The patients and residents served by LTPAC providers are at risk of sub-optimal outcomes and avoidable hospitalizations due to inability to access needed services and lack of clinical continuity.² With longstanding experience and clinical expertise in the care of seniors and people with complex conditions and functional limitations, LTPAC providers have been at the forefront of innovative models of coordinated and person-centered care, such as the Assisted Living Program (ALP), Programs of All-Inclusive Care for the Elderly (PACE), INTERACT, palliative care, and MOLST.³

This paper is intended to provide actionable strategies for meeting the Triple Aim of better health, better care, at lower overall cost for the State's growing elderly population. It proposes an array of legislative/regulatory changes and financial investments that would advance these goals, while enabling older New Yorkers to access services in the most integrated settings appropriate to their needs. The paper is organized

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in four parts: Part I provides a brief description of the long-term/post-acute care continuum⁴ and the patients and residents it serves; Part II presents a vision for a robust continuum of LTPAC services and senior housing in New York through goals and key strategies; Part III sets forth an analysis of the

challenges facing New York in relation to the services available for a growing population of seniors; and Part IV proposes a set of strategies to achieve the vision.

We recognize the fiscal challenges that the State is confronting; however, in the face of a growing population of older New Yorkers and workforce shortages, additional investment in the LTPAC sector is an imperative. New resources, coupled with the regulatory reforms needed to maximize the effectiveness and capacity of community-based models, will result in lower costs and better outcomes in the long-run.

² See "Medicare Nursing Home Hospitalization Rates Merit Additional Monitoring," U.S. Dept. of Health & Human Services, Office of Inspector General, 2013, Appendix C, available at <http://oig.hhs.gov/oei/reports/oei-06-11-00040.pdf>.

³ The Triple Aim: A Golden Opportunity for Geriatrics, Joseph G. Ouslander, M.D. J Am Geriatr Soc. 2013 Oct; 61(10): 1808–1809.

⁴ For purposes of this paper, the LTPAC continuum includes nursing homes, assisted living facilities, home care agencies, Hospice, adult day health care programs, continuing care retirement communities, and senior services providers. In addition, the paper covers senior housing providers and the long-term managed care plans that serve seniors, including Medicaid MLTC plans, PACE, Fully-Integrated Duals Advantage plans, and Medicaid Advantage Plus (MAP) plans.

I



THE LONG-TERM/POST-ACUTE CARE AND SENIOR SERVICES CONTINUUM



LTPAC spans a wide continuum of services comprised of two major segments – long-term care and post-acute care. Because the two segments are delivered to overlapping cohorts of consumers by overlapping categories of providers, and because health care stakeholders are working to eliminate provider silos, they are often described collectively as LTPAC services. Post-acute care is delivered on a short-term basis following a hospitalization, in order to return the consumer to his/her prior health and functional status. It is provided by home care agencies, nursing homes, and inpatient and outpatient rehabilitation facilities.

... the majority of LTC services is delivered by unpaid, informal caregivers. In New York, an estimated 2.5 million people are unpaid caregivers for elderly family members.⁶

LTC, by contrast, often involves custodial care and management of chronic conditions, rather than rehabilitation. Like post-acute care, it is often delivered by nursing homes and home care agencies. However, it involves a broad array of health care and residential services, including medical-model adult day health care services; adult homes and assisted living programs and residences; hospice programs; and continuing care retirement communities. It also includes social supports, such as home-delivered meals, transportation, companion services, environmental modifications, social adult day programs, and senior centers. And, it includes various types of housing that offer social supports to residents, including affordable senior housing, low-income HUD housing with in-house service coordinators, Naturally Occurring Retirement Communities (NORCs) and Neighborhood NORCs, and market-rate retirement communities.

Post-acute care is typically paid for by Medicare for individuals age 65 and over or by commercial health plans or mainstream Medicaid managed care plans for younger individuals. LTC, by contrast, is principally paid for by Medicaid, which covers 51 percent of all long-term care expenditures nationwide.⁵ It may also be reimbursed by LTC insurers

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or by consumers and their families, or supported by federal Title XX and New York State Office for the Aging (NYSOFA) funding or federal/state Supplemental Security Income (SSI) funding.

Unfortunately, neither Medicaid nor other LTC payers pay directly for housing, unless it is provided in a medical facility, such as a nursing home. Notably, the majority of LTC services is delivered by unpaid, informal caregivers. In New York, an estimated 2.5 million people are unpaid caregivers for elderly family members.⁶

⁵ Kaiser Family Foundation, "Medicaid and Long-Term Services and Supports: A Primer," Dec. 2015, available at: <http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/>.

⁶ AARP, "Family Caregivers Provide Staggering \$470 Billion in Unpaid Care According to AARP Study," July 16, 2015, available at <http://www.aarp.org/about-aarp/press-center/info-07-2015/family-caregivers-provide-470-billion-in-unpaid-care-aarp-study.html>.

A. Community-Based and Residential Services

In response to seniors' evolving expectations and desire to remain in their homes as they age, the focus of LTPAC has shifted from traditional nursing homes to community-based services, including home care, independent housing with supports, and residential options, such as adult homes and assisted living. New Yorkers may access a variety of community-based services funded through Medicaid, Medicare, NYSOFA programs, commercial insurance, and self-payment.

Home care is delivered in New York through certified home health agencies (CHHAs), licensed home care services agencies (LHCSAs), and consumer-directed personal assistants. CHHAs are reimbursed by Medicaid, Medicare, and commercial payers for skilled nursing, rehabilitation, and home health aide services. LHCSAs cannot be reimbursed directly by Medicaid or Medicare.⁷ They generally deliver personal care services to Medicaid beneficiaries through contracts with CHHAs or managed care plans. They may also deliver home care services to individuals who pay for their own care or whose care is insured by commercial payers. Rather than using aides and nurses hired by a LHCSA or CHHA, Medicaid beneficiaries may opt to hire, train, supervise, and fire their own "personal assistants," through consumer-directed personal assistant services (CDPAS). Individuals who do not qualify for Medicaid may access personal care through NYSOFA's Expanded In-Home Services for the Elderly Program (EISEP) and Community Services for the Elderly (CSE) program.

Medical-model adult day health care (ADHC) programs provide comprehensive health care services in a community-based, congregate day setting, in accordance with individualized plans of care developed and implemented by an interdisciplinary team of medical professionals. ADHC programs offer a variety of services, including skilled nursing; case and clinical management; medication management and pharmaceutical review; restorative and maintenance occupational, physical, and speech therapies; transportation; nutrition; therapeutic recreation; and personal care services on a routine or daily basis.

In addition to ADHC, home health care, and personal care, seniors in New York may access a number of community-based social supports. Through MLTC plans, Medicaid covers care management, home-delivered meals, medical transportation, and social and environmental supports. EISEP and CSE provide an array of community-based services to individuals who are not Medicaid eligible, including case management, respite, home-delivered meals, transportation, housekeeping and chore services,

and minor home repairs. Clients of the EISEP and CSE programs are typically required to share in the cost of their services, according to a sliding scale reflecting their income and the cost of the services they receive.

For seniors who need more extensive supports or more accessible housing, there are a variety of residential options in New York, although affordable units are in short supply.

Assisted Living Programs (ALPs) offer housing, meals, and a range of nursing, home care, and therapy services to Medicaid beneficiaries ... at a cost that is roughly 50 percent of the cost of a nursing home.

Assisted Living Programs (ALPs) offer housing, meals, and a range of nursing, home care, and therapy services to Medicaid beneficiaries who are clinically eligible for nursing home care, but do not require 24/7 skilled nursing, at a cost that is roughly 50 percent of the cost of a nursing home. Adult homes and enriched housing programs that are not licensed as assisted living offer another residential option for frail seniors, including those on SSI. These facilities offer personal care, supervision, and meals, but do not make available the array of services and skilled level of care offered by ALPs. For more affluent seniors, Assisted Living Residences (ALRs) and Special Needs Assisted Living Residences (SNALRs)

⁷ LHCSAs that contract with counties to provide personal care may bill Medicaid directly. However, with the growth of Medicaid managed care, this practice is shrinking.

offer similar services (including specialized services for people with dementia), while Enhanced Assisted Living Residences (EALRs) are permitted to provide nursing services and allow residents to age in place.

Affordable senior housing typically serves healthier and more independent seniors. State regulations prohibit senior housing operators from providing or arranging for LTC services, but operators often offer non-medical supports, such as transportation, social activities, exercise classes, resident advisors, and sometimes meals.

Over the last several years, providers report that the functional and cognitive limitations and medical complexity of individuals served in the community have grown considerably. This trend stems not only from consumer preferences, but also from payment methodologies that encourage early discharge from hospitals and rehabilitation facilities, managed care plans that support community-based care, and advances in health care and monitoring technology. Accordingly, not-for-profit LTC providers are developing innovative care models to serve increasingly frail and complex consumers. These often involve the deployment of technology to monitor medical conditions and to help consumers “age in place.” For example, with the help of a HEAL NY grant, Lutheran Social Services in Western New York has designed a new independent living model for seniors called the “Smartment” Building. The Smartment Building is a state-of-the-art senior living facility that includes fourteen apartments with built-in technology that helps people remain independent for as long as possible.

B. Nursing Homes

Despite the trend toward greater use of community-based services, nursing homes remain a critically important component of the LTPAC continuum. Nursing homes are increasingly dedicated to serving the most medically-complex individuals, whose conditions require 24-hour, skilled nursing care. As hospitals strive to reduce Medicare lengths of stay and readmissions in order to succeed under various payment arrangements, nursing homes are admitting residents earlier in an acute episode and retaining them if their condition declines, instead of transferring them to a hospital. Only 6 percent of nursing home residents statewide can be classified as “low-acuity.”⁸ These residents typically have no other place to live or require 24-hour supervision due to dementia or other cognitive impairment.

Like community-based care, nursing home care is evolving in response to consumer preferences and

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advances in medical technology. Nursing homes are striving to minimize the institutional character of their care through “culture change” efforts focused on resident engagement and satisfaction, environmental modifications, and changes to staff roles. For example, The Eddy in the Capital Region has adopted and created small-home style care modeled after

THE GREEN HOUSE™, which offers ranch-style houses – complete with private bedrooms and baths, family-style country kitchens with living/dining areas, and fireplaces – staffed by specially-training aides, known as Shahbazim, who provide a more holistic approach to care. In addition to creating more home-like environments, nursing homes are seeking to implement telehealth technologies to facilitate physician consultations, in order to reduce avoidable hospital use and improve outcomes.

⁸ LeadingAge New York analysis of Q4 2014 MDS 3.0 data for NYS nursing homes. “Low-acuity,” for purposes of this paper, means having a Resource Utilization Groups (RUG) patient classification system score, based on the MDS assessment, which places the resident in the Reduced Physical Functioning A, B, or C categories.

DATA POINT: *Nursing Homes: Despite some variation among homes and regionally, statewide nursing home occupancy has dipped only slightly over the past two years. Statewide mean occupancy remains at 93 percent, with median occupancy at 94.2 percent. Homes in New York City report the highest occupancy, with Hudson Valley, Central New York, and Buffalo homes reporting the most available beds. Anecdotally, we understand that Medicare bundled payment initiatives, accountable care organizations, and managed care are having an impact on nursing home utilization by Medicare beneficiaries. Data that fully reflects the impact of these programs is not yet available. Source: LeadingAge New York analysis of nursing home weekly bed availability report data through Aug. 2015.*

C. Managed Care

Managed care plans are playing an increasingly important role in authorizing, coordinating, and paying for LTPAC services. Over 168,000 Medicaid beneficiaries in New York are enrolled in some type of managed long-term care plan, and approximately 37 percent of New York's Medicare beneficiaries are enrolled in Medicare Advantage plans.⁹ In some counties, Medicare Advantage penetration exceeds 50 percent.¹⁰ A variety of plans provide coverage of long-term and/or post-acute care services in New York State:

- Medicare Advantage plans cover only Medicare benefits (including post-acute care) plus certain supplemental benefits, but do not cover LTC services. They include both standard plans and the “special needs plans” that serve residents of nursing homes, beneficiaries who require a nursing home level of care, beneficiaries with chronic diseases, and dual eligibles.
- Partially-capitated MLTC plans cover only Medicaid benefits – currently LTC, optometry, dental, and podiatry services. The State is moving to add all remaining Medicaid benefits into the MLTC benefit package (chiefly behavioral health services) and to require plans to assume the State's responsibility for paying the copayments and deductibles associated with Medicare benefits.
- PACE plans integrate the Medicare and Medicaid benefits under a single plan for individuals age 55 or older who require a nursing home level of care. PACE programs directly provide medical, therapy, and social services primarily in the program's health center, supplemented by in-home and other services as needed.
- Fully Integrated Duals Advantage (FIDA) plans integrate the Medicare and Medicaid benefits and cover a number of specialized services that were previously available only through Medicaid waivers. Only residents of New York City or Nassau County may currently enroll in FIDA; it is expected to be available in Westchester and Suffolk Counties later this year.
- Medicaid Advantage Plus (MAP) plans cover both Medicare and Medicaid benefits, although programmatic features are less integrated than under the FIDA program.
- Mainstream Medicaid Managed Care plans cover almost all Medicaid benefits, including LTC services, for individuals who are under age 65 or ineligible for Medicare.

⁹ Presentation by NYS DOH, June 9, 2016 at Managed Care Policy and Planning Meeting; Kaiser Family Foundation, “Medicare Advantage Enrollees as a Percent of Total Medicare Population 2015,” available at <http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/>.

¹⁰ Centers for Medicare and Medicaid Services, MA State/County Penetration, July 2016, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartIDEnrolData/MA-State-County-Penetration-Items/MA-State-County-Penetration-2016-07.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>.

DATA POINT: As of September 2015, five plans represented 48 percent of Medicaid-only MLTC (also referred to as “partially capitated” MLTC) enrollment in the State. Over 14,000, or 11 percent, of the State’s 131,300 enrollees were served by GuildNet. Senior Health Partners and VNS Choice each represented over 10 percent of Medicaid MLTC enrollment, while ElderPlan and ElderServe each accounted for more than 8 percent. FIDA enrollment was even more concentrated with 38 percent of the 8,300 enrollees associated with VNS Choice FIDA and 13 percent with GuildNet FIDA. Mainstream Medicaid managed care (for those not eligible for Medicare) was dominated by two plans: 24 percent of the 4.6 million enrollees are served by NYS Catholic Health Plan (Fidelis) and 21 percent by HealthFirst.

Geographically, 82 percent of all types of MLTC enrollment was concentrated in the downstate region in September 2015, comprised of NYC, Long Island, and Westchester County, with Erie and Monroe Counties each reporting about 2,350 beneficiaries enrolled. PACE enrollment stood at 5,500 individuals, of which 68 percent was in the downstate region. Two-thirds of the State’s PACE participants were served by Comprehensive Care Management. PACE enrollment was approaching 700 beneficiaries in Rochester and was up to nearly 500 beneficiaries in the Syracuse area. Source: NYS DOH Medicaid Managed Care Monthly Enrollment Reports.

D. Consumers of LTPAC Services

LTPAC services are used by a wide variety of consumers, whose needs vary greatly based on their health status and functional limitations, including the presence of cognitive deficits and/or comorbidities. Post-acute care, whether in a nursing home or at home, may be provided to individuals of all ages who need physical rehabilitation, usually after an acute episode (e.g., stroke, hip replacement, trauma). LTC services may be provided to older adults or people with disabilities who require social supports, nursing care, or custodial care to maintain a high quality of life.¹¹

Often, individuals move back and forth among the continuum of providers as their care needs change.

Often, individuals move back and forth among the continuum of providers as their care needs change. An acute hospital stay may trigger the need for short-term, post-acute rehabilitation. This rehabilitation may take place in a nursing home, at home through a certified home health agency (CHHA), or in an inpatient or outpatient rehabilitation facility. The focus of rehabilitative care is to improve functioning and return individuals to their prior condition and residence as soon as possible.

... for seniors with significant frailty, chronic conditions, and/or functional or cognitive limitations, it may be impossible to return to one’s prior level of function after an acute episode.

By contrast, for seniors with significant frailty, chronic conditions, and/or functional or cognitive limitations, it may be impossible to return to one’s prior level of function after an acute episode. A fall or the flu can lead to LTC needs. And, the unfortunate reality for the vast majority of individuals who need LTC is that their condition will not improve over time. While it may be possible for them to improve or maintain their current state for a period of time, ultimately they will decline as they age.

For these individuals, the focus of care is maintaining functioning for as long as possible, managing pain and symptoms, and optimizing quality of life.

Many seniors incorrectly assume that the federal Medicare program will finance their long-term care needs, whether in the community or a nursing home. Medicare, Medicaid, and private insurance coverage of the different service options varies greatly, and many consumers find they are financially unprepared to cover the costs of their long-term care.

While it may be possible for them to improve or maintain their current state for a period of time, ultimately they will decline as they age.

¹¹ This paper addresses only the long-term care services licensed or certified by the Department of Health or the State Office for the Aging. It does not address long-term care provided under the auspices of the Office for People with Developmental Disabilities or the Office of Mental Health.

II



GOALS AND KEY STRATEGIES FOR NEW YORK'S LTPAC AND SENIOR SERVICES SYSTEM



New York requires a high-performing, financially stable, and accessible LTPAC delivery system to address the needs of its growing population of seniors. It must also ensure that it has the capacity to serve people in the most integrated setting appropriate to their needs and preferences. New York has made great strides in rebalancing its LTC delivery system in recent years. Forty-seven percent of Medicaid spending for LTC for seniors and people with physical disabilities is spent on home and community-based services, up from 41 percent in 2009.¹² The implementation of mandatory MLTC enrollment has created strong incentives for further rebalancing. However, system capacity and access is unbalanced in many areas, particularly rural regions, where institutional reliance is greater due to a lack of home and community-based services, shortages of home care workers, insufficient ALP bed capacity, and a scarcity of safe and affordable housing.

In order to transition from where we are today to where we need to be in the future, the LTPAC and senior services sector must work together and in partnership with the State to develop and implement sustainable solutions. With that in mind, State and federal policies and spending and stakeholder activities should be directed toward the following goals:

- *Optimizing the quality of life and independence of older adults;*
- *Providing access to high-quality, accessible care at a lower overall cost; and*
- *Serving consumers in the most integrated setting appropriate to their needs, without needless institutionalization due to a lack of appropriate housing or caregivers.*

To achieve those goals, the State and federal governments should join with stakeholders to implement the following key strategies:

- *Promoting integration of Medicare and Medicaid funding streams;*
- *Expanding access to a continuum of community-based services and residential settings for seniors;*
- *Expanding the availability of non-medical social supports that allow seniors to remain in the community and delay or avoid the need for Medicaid, and linking those social supports with the health care delivery system;*
- *Strengthening outreach and education about LTC service options, especially lower cost social supports;*
- *Building a continuing care workforce that is properly trained and paid, in appropriate numbers to meet the demand, and eliminating regulatory barriers to the efficient and effective utilization of workers;*
- *Investing in information technology and health information exchange to support value-based payment and the Triple Aim;*
- *Allocating additional funds to quality incentives for LTPAC providers;*
- *Providing options that promote appropriate utilization of personal resources, and discouraging individuals from divesting assets to qualify for Medicaid; and*
- *Instituting a regional/community approach to LTPAC planning to ensure that available capacity and models of care meet the specific needs of the community.*

These strategies are discussed in more detail in Part IV.

¹² Eiken, S. Sredl, K. Burwell, B. & Saucier, P. "Medicaid Expenditures for Long-Term Services and Supports in Fiscal Year 2014," Mathematica Policy Research and Truven Analytics for Centers for Medicare and Medicaid Services, available at <https://www.medicaid.gov/medicaid/lts/index.html>.

III



CHALLENGES



New York's LTPAC and senior services sector and the consumers it serves are facing a variety of demographic, financial, and operational challenges that must be addressed in order to achieve the goals set forth above. These challenges demand sound policy interventions at the State and federal levels, a substantial investment of public dollars, and visionary leadership within government agencies, providers, health plans, and communities.

A. Demographic Challenges: A Shrinking Pool of Caregivers to Serve Growing Numbers of Seniors With High Rates of Chronic Disease

Individuals aged 65 and older are the fastest-growing segment of New York's population.¹³ By 2025, 18 percent of New York's population is projected to be age 65 or older.¹⁴

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The first Baby Boomers, who are hitting their seventies now, will be entering their eighties by 2025, triggering a surge in demand for LTPAC and senior services.

However, as these Boomers experience growing care needs, the availability of younger New Yorkers to care for them as informal caregivers or workers in the formal care delivery system is projected to shrink significantly. According to the NYS Office for the Aging, the Aged Dependency Ratio (the ratio of the population aged 18 to 64 to the population aged 65 and over) is expected to decline from 4.31 in 2015 to 3.05 in 2030 and continue declining through 2040.¹⁵ Reductions in the availability of informal caregivers will lead to increased reliance on the formal care delivery system. Moreover, a disproportionate number of this growing cohort of aged New Yorkers is likely to rely on public programs to pay for their care. Today, one-third of New Yorkers over age 65 have incomes at or below 200 percent of the federal poverty level. This economic reality has major implications for the Medicaid program, the predominant payer for LTC services.

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Not only is the population of older New Yorkers rising but New Yorkers on Medicare have higher rates of chronic disease than the national average. More than half of New York's Medicare beneficiaries have hypertension, nearly half have high cholesterol, and more than one-third have diabetes.¹⁶ Nationally, today's "pre-seniors" have rising levels of disability, in comparison with older seniors.¹⁷ And, despite high rates of chronic disease, older Americans are living longer than their parents did.^{18 19} As these seniors age, their health care and

¹³ NYS Office for the Aging, County Data Book, New York State, Table 1, Demographics, <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/01NYS.pdf>, accessed Dec. 13, 2015; see also Cornell University Program on Applied Demographics, <https://pad.human.cornell.edu/counties/projections.cfm>, accessed Dec. 13, 2015.

¹⁴ *Ibid.*

¹⁵ NYS Office for the Aging, County Data Book, New York State, Table 1, Demographics, <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/01NYS.pdf>, accessed Dec. 13, 2015.

¹⁶ Medicare Chronic Conditions Dashboard: State Level Comparison of Geographic Areas by Chronic Conditions, 2012, New York, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Chronic-Conditions-State/CC_State_Dashboard.html, accessed Dec. 15, 2015.

¹⁷ While disability among the oldest Americans (ages 85+) continued to decline between 2000 and 2008, disability trends have held steady among the elderly (ages 65 to 84) and have increased for those approaching late life (ages 55 to 64). Freedman, V.A. et al., "Trends in Late-Life Activity Limitations in the United States: An Update From Five National Surveys," *Demography*, 50, no. 2 (2013): 661-71.

¹⁸ *Health: United States 2014*, U.S. Dept. of Health & Human Services, Centers for Disease Control, Nat'l Center for Health Statistics, May 2015, Table 16, available at <http://www.cdc.gov/nchs/data/hestats/14.pdf>. See also Jiaquan Xu, M.D.; Kenneth D. Kochanek, M.A.; Sherry L. Murphy, B.S.; Elizabeth Arias, Ph.D. *Mortality in the United States 2012*, NCHS Data Brief, No. 168, U.S. Dept. of Health & Human Services, Centers for Disease Control and Prevention, Nat'l Center for Health Statistics, Oct. 2014, available at <http://www.cdc.gov/nchs/data/databriefs/db168.pdf>.

¹⁹ *Federal Interagency Forum on Aging-Related Statistics. Older Americans 2012: Key Indicators of Well-Being. June 2012.* <http://www.agingstats.gov/docs/PastReports/2012/OA2012.pdf>

supportive service costs can be expected to significantly eclipse those of prior generations. Moreover, given demographic trends, they will have difficulty finding younger adults to care for them informally or formally, and they can be expected to rely heavily on public programs to pay for their care.

B Financial Challenges: Public Funding of LTPAC and Senior Services is Not Aligned With Growing Need and Costs

1. Medicaid and Medicare spending levels off, despite rising costs.

As a growing number and percentage of New Yorkers enter their seventies and eighties, resources are needed to meet their escalating health and LTC needs. However, LTPAC services are funded predominantly by public programs – Medicare and Medicaid. In New York State, for example, Medicare represents 35 percent of CHHA revenue, while Medicaid comprises 44 percent. In 2014, Medicaid covered 74 percent of all non-specialty nursing home resident care days and provided 59 percent of nursing home revenue, while Medicare covered 14.5 percent of days and provided 24 percent of revenue.²⁰ State and federal budgets are already straining to keep pace with rising demand and costs.

Facing growing utilization and fiscal pressures, State and federal policymakers have sought to reduce LTPAC spending through a combination of rate cuts, promotion of managed care programs, and, more recently, value-based payment (VBP) initiatives.²¹ New York State has not made a cost-of-living adjustment to Medicaid

rates of payment for most LTC providers since 2008. Beginning in 2011, the State adopted an annual global cap on State Medicaid spending, delegating to the Commissioner of Health and the Division of the Budget extraordinary powers to cut spending if it threatens to exceed the cap. More recently, the State's decision to mandate the enrollment of Medicaid beneficiaries with LTC needs into managed care plans has exacerbated the financial pressures on LTC providers.

At the same time, the costs associated with delivering care are rising, due to increases in the costs of staffing, goods, and services; mandated wage increases; the rising acuity of the population served; and the administrative and infrastructure costs associated with the growth in managed care and VBP models. Examples of growing wage mandates include home care wage parity requirements in the New York City metropolitan area and new federal Fair Labor Standards Act requirements for personal care aides. In addition, wages in all LTPAC service lines will experience upward pressure statewide, due to minimum wage increases. Although the State has allocated targeted amounts intended to compensate for these additional expenses (e.g., QIVAPP), payment of those funds has been repeatedly delayed and has been directed only to providers that meet certain criteria. Moreover, even when Medicaid reimbursement is adjusted to address new wage requirements,

At the same time, the costs associated with delivering care are rising, due to increases in the costs of staffing, goods, and services; mandated wage increases; the rising acuity of the population served; and the administrative and infrastructure costs associated with the growth in managed care and VBP models.

New York State has not made a cost-of-living adjustment to Medicaid rates of payment for most LTC providers since 2008.

²⁰ T H Denison, "New York's Nursing Homes: Shifting Roles and New Challenges," United Hospital Fund, Aug. 2013, available at www.uhfnyc.org/assets

²¹ Medicare reimbursement for skilled nursing facilities has been cut by an estimated \$27.4 billion nationwide since 2010. American Health Care Assoc. analysis, available at http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/Medicare%20Cuts%20Timeline.pdf. Medicare payments for home health agencies have also been cut repeatedly, including a 14 percent reduction between 2014 and 2017.

the increases do not cover the additional wage expenses associated with services reimbursed by other sources, such as Medicare, area agencies for the aging, commercial payers, or consumers.

New regulatory requirements are further contributing to cost increases. These include the e-prescribing mandate; the use of the UAS assessment tool for ALPs, ADHC programs, and LHCSAs; and the requirement that MLTC plans contract with CHHAs (rather than LHCSAs) for skilled services.

LTPAC providers not only must fund new wage mandates and regulatory requirements, but they are also struggling to support new administrative processes and infrastructure associated with MLTC and VBP arrangements. These include expenses associated with managing plan contracts, claims

Approximately 70 percent of CHHAs incurred negative operating margins in 2013.²² ... In 2014, 40 percent of the State's nursing homes, and 58.3 percent of not-for-profit nursing homes, lost money on operations.

submission and billing, service authorizations, appeals and fair hearings, credentialing and reporting, and audits. They also include investments in data and analytics, electronic health records, and health information exchange necessary for VBP.

Stagnant reimbursement combined with increases in costs – especially labor, which represents the vast majority of operating expenses for LTC providers (e.g., over 80 percent for most

nursing homes) – is already having an impact on margins. Approximately 70 percent of CHHAs incurred negative operating margins in 2013.²² In the nursing home sector, flat funding and rising costs have resulted in a growing shortfall in Medicaid reimbursement, estimated to be \$48 per bed per day in 2015.²³ In 2014, 40 percent of the State's nursing homes, and 58.3 percent of not-for-profit nursing homes, lost money on operations. The median operating margin for all nursing homes in New York State was 1.5 percent in 2014 and negative 1.9 percent for not-for-profit nursing homes. The disparity in margins between the proprietary and not-for-profit homes is attributable at least in part to higher cost structures in public and not-for-profit homes related to higher wages, benefits, and staffing levels.²⁴

The dismal reimbursement picture has led many not-for-profit organizations to sell their nursing homes to for-profit operators, in order to subsidize other services. This has driven a significant change in the ownership composition of nursing homes in New York State, as shown below. This is unfortunate, as it is the not-for-profit sector that has led efforts to build continuing care systems and implement innovative models of care.

Distribution of NHs in New York

Change in Ownership Distribution: 2006-16

Sponsor	2006	2014	2016	Percentage Change: 2006-16
For-Profit	322	350	370	14.9%
Not-for-Profit	283	237	222	-21.6%
Governmental	53	37	34	-35.8%

Source: LeadingAge New York analysis of DOH data.

²² *Risk Factors: What You Need to Know about the Financial Condition of New York State's Home Care Community* Feb. 2016 by the Home Care Association of New York State, <http://hca-nys.org/wp-content/uploads/2016/01/RiskFactors2016HCAFinancialConditionReport.pdf>.

²³ *A Report on Shortfalls in Medicaid Funding for Nursing Center Care*, ELJAY, LLC & Hansen Hunter & Company, PC, Apr. 2016, https://www.ahcancal.org/research_data/funding/Documents/2015%20Medicaid%20Underfunding%20for%20Nursing%20Center%20Care%20FINAL.pdf

²⁴ LeadingAge New York analysis of 2014 RHCF-4 Medicaid cost report data.

2. MLTC rates are depressed, and program features leave few opportunities for additional savings.

MLTC plans are experiencing a similar trend in their margins, due to rates that lag behind program changes and that erroneously assume deep discounts for managed care utilization management and price reductions. The median premium margin among non-start-up MLTC plans has plummeted from positive 1.7 percent in 2012 to negative 5.1 percent in 2014.²⁵ Moreover, more than 70 percent of the non-start-up plans reported negative premium margins in 2014.²⁶ More than 80 percent of the non-start-up plans in New York City had negative margins in 2014.²⁷

Despite narrow to negative margins, managed care quality reports indicate that MLTC plans are, indeed, making available high-quality care through care management and contracted networks of providers. The plans' care coordination activities with physicians and hospitals are helping to reduce avoidable hospitalizations and improving outcomes. In addition, MLTC plans are making personal care available for the first time in many upstate counties.

However, MLTC plans' ability to achieve further Medicaid savings and participate effectively in VBP models is severely constrained by rates that are already depressed and by programmatic features. MLTC plans by definition serve

The median premium margin among non-start-up MLTC plans has plummeted from positive 1.7 percent in 2012 to negative 5.1 percent in 2014.²⁵

beneficiaries with multiple chronic conditions and functional limitations.²⁸ Most would qualify for nursing home placement. Unlike members in a mainstream managed care plan, all members in MLTC receive frequent (often daily) services from the plan. Given their health status, they can be expected to decline, and services must then increase to meet their changing needs. The expectation that plans can significantly reduce the LTC service utilization of this vulnerable population has not materialized in practice.

The sustainability of the MLTC program, and the stability of the providers that participate in it, depend on the development of MLTC rates that accurately reflect the policy parameters of the program and the health and functional status of the beneficiaries served.

²⁵ LeadingAge New York analysis of Q4 2014 MMCOR data. This analysis was conducted based on 2012-14 Q4 MMCOR reports, which typically include premium revenues received, rather than premium amounts owed under proposed rates. "Non-start-up plans" are those that have been in operation long enough to have 2012, 2013 and 2014 annual cost report data and report annual revenue in excess of \$4 million.

²⁶ *Ibid.*

²⁷ LeadingAge New York analysis of Q4 2014 MMCOR data.

²⁸ By definition, MLTC beneficiaries require at least 120 days of community-based long term care services annually or reside permanently in a nursing home.

3. Lack of investment in affordable and appropriate housing and assisted living reduces opportunities for savings and community integration.

The State and federal governments have repeatedly expressed the belief that Medicaid savings in LTC is available through the diversion and transition of beneficiaries from nursing homes to lower-cost settings in the community.²⁹ In

order to transition or divert

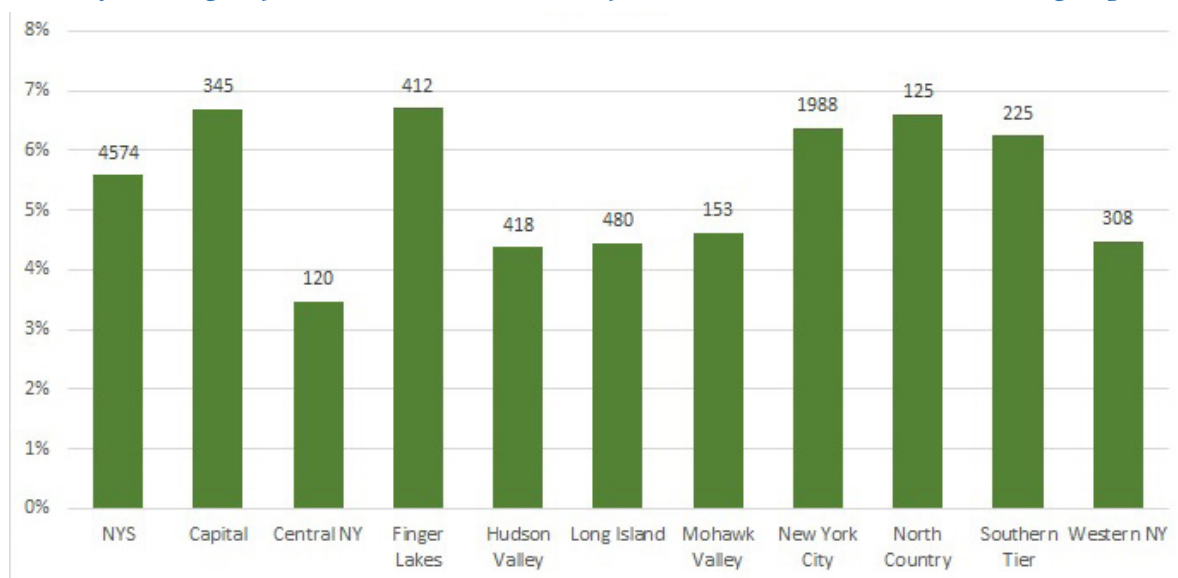
beneficiaries from nursing homes, however, appropriate housing and supportive services must be available in their communities. The lack of affordable, safe, and accessible housing or 24-hour supervision is often cited as an insurmountable barrier to transitioning from a nursing home or remaining in the community.

The lack of affordable, safe, and accessible housing or 24-hour supervision is often cited as an insurmountable barrier to transitioning from a nursing home or remaining in the community.

Based on LeadingAge New York's analysis of statewide Minimum Data Set 3.0 (MDS 3.0) data, there are approximately 4,600 Medicaid beneficiaries in nursing homes who score on the lower end of the Resource Utilization Groups (RUG) patient classification system.³⁰ Specifically, we identified those residents who were assigned to the Reduced Physical Functioning Categories A, B, and C. Of these, approximately 500 responded affirmatively when asked whether they would like to return to the community. Approximately 1,600 of these lower-acuity beneficiaries have dementia – a condition which complicates independent living in the community.

Regional Distribution of Low-Scoring Residents in New York's Nursing Homes

% of NH long-stay residents who are low-acuity residents (PA, PB or PC in RUG III groups)



²⁹ While community-based care is generally less expensive than nursing home care, it is important to recognize that the total cost of serving medically-complex, frail beneficiaries at home can exceed nursing home costs. In the New York City area, the cost of staff alone for an individual in need of 15 hours of personal care daily (at \$19.00 per hour) can exceed the cost of an average skilled nursing facility day (at \$260) that includes housing, meals, activities, supervision and medical care.

³⁰ RUG is a patient classification system used by the Medicare program and New York's Medicaid program to determine the level of reimbursement provided to nursing homes. This system categorizes each resident into a category based upon his/her care and resource needs as reported in the Minimum Data Set (MDS) resident assessment process. These category assignments in turn are used to assign an acuity score to the resident which is then used to adjust the level of Medicare and Medicaid payments to reflect resident care needs.

At least some nursing home residents would likely qualify for the lower cost services provided by the State's Medicaid Assisted Living Program, other types of Adult Care Facilities (ACFs), or senior housing facilities, and other seniors could avoid nursing home placement through the use of these options. However, the State has provided only minimal capital and operating support for community-based residential settings for the elderly. ACFs (i.e., adult homes and enriched housing programs) are struggling to stay afloat on the SSI Congregate Level 3 rate just over \$40 per day. This rate is intended to pay for all services that an ACF must, by regulation, provide; these include, but are not limited to, personal care, case management, assistance with medication, meals, monitoring, and supervision. The State's portion of the current SSI rate has not been increased in nine years. During that time, ACFs have had to absorb rising costs for supplies, utilities, and workforce. The inadequacy of the current rate has forced many ACFs to reduce or eliminate their census of SSI recipients or to close their doors entirely. New mandates, including the increase in the minimum wage, will only exacerbate the situation, and funds appropriated to mitigate the impact of the minimum wage increase on Medicaid providers will not benefit most ACFs.

In addition to under-funding ACF operating expenses, the State has not provided any capital grants or reimbursement of capital costs associated with the development of ALP or ACF capacity in recent years. A \$3 million MRT appropriation for senior supportive housing was allocated principally to supportive housing providers serving individuals with serious mental illness. While the beneficiaries of these funds are clearly vulnerable and in need of supportive housing, older adults with physical limitations or cognitive impairments are also in need of housing with supports.

... the State has provided only minimal capital and operating support for community-based residential settings for the elderly.

Not only has the State's investment in ACFs been minimal in comparison with other housing and health care investments but New York has also historically imposed stringent limits on the development of ALP beds, based on the possibility of a "woodwork effect" and over-utilization. However, in a value-based payment or managed care environment, these concerns are mitigated. In March 2015, the State solicited applications for 3,600 additional ALP beds. Decisions on those applications, allocating all the available slots, were just announced at the end of May 2016. Meanwhile, demand for ALP beds across the State continues to exceed supply, as the State received applications for three times the number of ALP beds solicited.

Affordable senior housing offers another source of Medicaid savings. In addition to offering safe and accessible housing to seniors, these buildings often house a significant number of low-income residents who either qualify for Medicaid or who are one health or financial event away from qualifying. The non-medical supportive services and socialization offered in affordable senior housing can help these seniors to remain in good health and prevent the need for costlier services. As a result, some of these individuals can delay or avoid the associated "spend-down" to Medicaid eligibility.³¹ With current waiting lists for affordable senior housing of 7 to 11 years in many communities, a substantial expansion of capacity is needed to address growing demand. However, the State has declined to fund the Resident Service Coordinator Program authorized under the Elder Law and to dedicate affordable housing funds to senior housing.

³¹ *Support and Services at Home: First Annual Report*, Prepared for Office of Disability, Aging and Long-Term Care Policy, Office of the Assistant Sec'y for Planning and Evaluation, U.S. Dept. of Health and Human Services, RTI International, Sept. 2014, available at <https://aspe.hhs.gov/pdf-report/support-and-services-home-sash-evaluation-first-annual-report>.

4. Bifurcation of Medicaid and Medicare funding and regulations impedes reform.

Although MLTC plans and their network providers have limited ability to generate savings in LTC services, there are opportunities for those plans and providers to generate reductions in Medicare spending on acute and post-acute care. LTPAC and senior services providers have considerable clinical resources and expertise to serve the medical, custodial, and social needs of complex patients and residents with multiple comorbidities and functional limitations in a variety of institutional and community-based settings. And, LTPAC and senior services providers generally have far more intimate and ongoing knowledge of their patients and residents, their living environments, their caregivers, and their support needs than a typical physician practice or hospital. Moreover, as a general matter, delivering care in an LTPAC or senior services setting is less expensive than delivering care in a hospital.

However, the bifurcation of LTPAC funding streams and associated policies between Medicare and Medicaid presents a significant impediment to real reform. Because partially-capitated MLTC plans are not paid by Medicare, there is no common pool of expenses from which Medicare and MLTC plans can share savings. In fact, as mentioned above, to the extent that the LTC providers and MLTC plans reduce inpatient and post-acute utilization by dual eligibles, they will only drive up Medicaid LTC utilization and associated spending. Every day that a dually-eligible beneficiary is in the hospital or receiving post-acute care services represents a day covered by Medicare, rather than Medicaid. If those Medicare-funded acute and post-acute days are reduced, Medicaid will have to fill in the gap. Thus, the Medicare-Medicaid divide at best creates perverse incentives, and at worst it can lead to cost shifting and lack of accountability for delivering care in the most appropriate setting.

This split in the funding streams for LTPAC services is accompanied by concurrent federal and State regulatory oversight of nursing homes and CHHAs. Federal requirements, overlaid on State programs, at times interfere with efficiencies the State is striving to generate. Examples of these include the use of federally-mandated patient assessment instruments (e.g., the MDS and OASIS tools) in addition to the State's UAS tool and the requirement that managed care plans contract with CHHAs (rather than LHCSAs) for skilled services.

... the bifurcation of LTPAC funding streams and associated policies between Medicare and Medicaid presents a significant impediment to real reform.

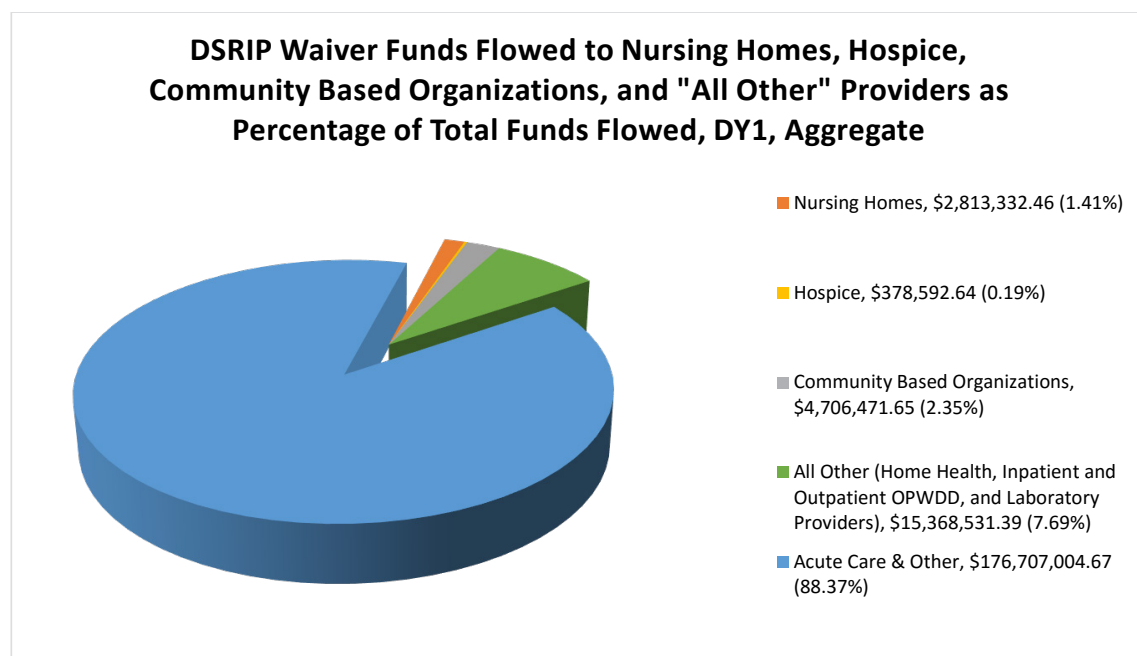
The State and federal governments have attempted to address the perverse financial incentives through integrated Medicaid-Medicare managed care programs, such as PACE, MAP, and the FIDA program. Based on the evidence derived from the PACE program, which has been in operation since 1986, integrated models show promise in reducing nursing home and hospital use and improving longevity.³² To date, enrollment in these programs has been low, due to a number of factors, including the federal prohibition on mandatory enrollment of Medicare beneficiaries in managed care plans and concerns related to payment adequacy.

³² See, e.g., Micah Segelman, MA, Jill Szydlowski, Bruce Kinoshian, MD, Matthew McNabney, MD, Donna B. Raziano, MD, MBA, Catherine Eng, MD, Christine van Reenen, PhD, and Helena Temkin-Greener, PhD, "Hospitalizations in the Program of All-Inclusive Care for the Elderly," *Journal of the American Geriatrics Society*, (Feb. 2014) 62(2):320–324. Darryl Wieland, Rebecca Boland, Judith Baskins and Bruce Kinoshian, "Five-Year Survival in a Program of All-Inclusive Care For Elderly Compared With Alternative Institutional and Home- and Community-Based Care," *J Gerontol A Biol Sci Med Sci* (Mar. 2010) 65A (7): 721-726. Susan M. Friedman, MD, MPH, Donald M. Steinwachs, PhD, Helena Temkin-Greener, PhD, and Dana B. Mukamel, PhD, "Informal Caregivers and the Risk of Nursing Home Admission Among Individuals Enrolled in the Program of All-Inclusive Care for the Elderly," *The Gerontologist* (2006) 46 (4): 456-463. eed the cost of an average skilled nursing facility day (at \$260) that includes housing, meals, activities, supervision and medical care.

In addition to the integrated managed care programs authorized by the State and federal governments, New York is seeking federal approval of a VBP Medicare alignment proposal to enable the State to “virtually pool” Medicare and Medicaid payments so that providers and plans can share in the risk of overall health and LTC spending, regardless of the payer source. This concept will be key to the successful engagement of MLTC plans and providers in VBP initiatives. However, we understand based on the work of the State’s MLTC Clinical Advisory Group, that CMS has not yet expressed interest in moving forward with this virtual pooling.

5. DSRIP and VBP are not expected to provide financial relief for LTPAC providers.

The State has cited its DSRIP program and value-based payment as the path to financial sustainability for its Medicaid providers. However, only a minuscule portion of DSRIP performing provider system (PPS) funds is projected to be disbursed to LTPAC providers. Based on our analysis of the PPS first quarterly reports, only 4.2 percent of DSRIP incentive payments are projected to flow to nursing homes over the next five years, only 3.6 percent to community-based organizations, and only 1.1 percent to hospice programs.³³



Moreover, despite a growing need for new investment in long-term care and the weakened financial position of many providers and plans, the State has indicated that any investments in LTC will be budget neutral – i.e., existing funds will be reallocated, not supplemented. For example, the State will continue to fund its MLTC quality pool and its nursing home quality initiative through withholds of payments, and these withholds will grow exponentially in conjunction with VBP initiatives.

³³ LeadingAge New York analysis of DSRIP PPS First Quarterly Reports, Module 1.2, available at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/first_quarterly_report.htm. Amounts dedicated to home care agencies and assisted living programs are not specifically identified in the quarterly reports. reports. We assume that they are included in the community-based organization category.

Instead of allocating new funds to the LTPAC sector, the State has indicated that it intends to rely on savings generated through VBP arrangements as the source of any new investments in health care delivery, community-based organizations, and affordable housing. However, the overwhelming majority of savings derived from the LTPAC sector will accrue to Medicare (rather than Medicaid). Moreover, to the extent that the State is successful in reducing avoidable hospital use among Medicaid beneficiaries receiving LTC services, it will experience an increase in nursing home days and home care visits reimbursed by Medicaid. As a result, there will be little, if any, savings to be invested in LTPAC. If the State pursues this strategy, the LTPAC sector will experience only reductions in revenue and no new investment, notwithstanding rising costs and a rising population of older New Yorkers.

C. Operational Challenges: Proliferation of New Requirements and Programs, Workforce Shortages and Weak IT Infrastructure

LTPAC providers and MLTC plans are not only confronting significant financial challenges; they are also struggling to adapt to an entirely new operating environment without many of the necessary tools to do so.

1. Rapid pace and scope of change and a proliferation of new regulatory requirements are draining resources and diverting MLTC plans and providers from their core mission.

Over the past three years, LTPAC providers have been adapting to a deluge of new requirements, new programs, and new payment models emanating from both Medicaid and Medicare, with little time to adjust and no new investment to support implementation. In three years, LTPAC providers have gone from a largely fee-for-service financing system to a largely managed care system. Instead of billing two payers – Medicaid and Medicare – they now potentially have to bill two dozen payers, each with its own unique billing requirements. They also have to accommodate a multitude of prior authorization requirements, credentialing requirements, and beneficiaries' changes in plan enrollment. At the same time, LTPAC providers are being asked to participate in DSRIP PPS projects and to implement new value-based payment arrangements under Medicare and Medicaid.

Similarly, MLTC plans have had to adapt to changes in populations and benefits covered, changes in policies governing those populations and benefits, and delays in associated contracts and rate adjustments. Many of these initiatives require complex systems changes, network development,

In three years, LTPAC providers have gone from a largely fee-for-service financing system to a largely managed care system.

and education of providers, consumers and plan staff. The latest initiatives to demand attention are the expansion of the MLTC benefit package to include behavioral health and Medicare cost sharing; the incorporation of Community First Choice Option benefits into MLTC; the transition of the ALP, Nursing Home Transition and Diversion Waiver and Traumatic Brain Injury Waiver populations into mandatory MLTC; and the allocation of supplemental payments to support the minimum wage increase.

Finally, the implementation of the federal home and community-based settings regulations is threatening the viability of provider-sponsored MLTC plans and the provision of LTC services in campus-like settings. These federal rules are intended to ensure that Medicaid beneficiaries with disabilities have access to services in integrated settings. They also include “conflict-free assessment and case management” requirements that are intended to ensure that needs are assessed and care plans are developed by entities that do not have a financial interest in the services to be delivered.

However, these regulations create a presumption against services delivered in campus-like settings, even though many seniors prefer such settings for the convenience and continuity

The (new federal) regulations will stifle the development of new services in affordable locations where providers already have vacant property, precisely when such services are needed.

of services they offer. The regulations will stifle the development of new services in affordable locations where providers already have vacant property, precisely when such services are needed.

The conflict-free regulations further threaten to prohibit MLTC plans from conducting assessments and developing care plans, if they have a financial interest in a provider of services. An over-broad interpretation of this rule may eliminate the ability of

provider-sponsored plans to operate. Such an interpretation may also affect provider-sponsored mainstream plans that arrange for home and community-based services for individuals with physical disabilities who are not eligible for Medicare.

2. Workforce challenges hinder efforts to build capacity and offer services in the most integrated setting.

In many areas of the State, LTPAC providers are experiencing difficulty recruiting direct care workers at all levels, from geriatricians to nurses, to certified nursing aides and home care aides. Workforce shortages are exacerbated, in some settings, by State laws and regulations that prevent providers from efficiently and effectively deploying available professional and paraprofessional employees.

Although the State is experiencing higher growth in health care employment than in other fields, the supply of workers is not keeping up with demand in the LTPAC sector. According to the Center for Health Workforce Studies, nursing homes and home care agencies (including hospice programs) report difficulty recruiting and retaining nurses, certified nursing aides, home care aides, and certain therapists. The shortage of workers is the most commonly cited reason for the difficulty.³⁴ LeadingAge

New York members report particular challenges in recruiting and retaining sufficient numbers of home care aides in rural areas, where

Although the State is experiencing higher growth in health care employment than in other fields, the supply of workers is not keeping up with demand in the LTPAC sector.

patients are dispersed over long distances, and aides must have reliable vehicles and spend hours each day driving among patients’ homes.

³⁴ Bruce C, Roberts EE, Martiniano R, Daman S, Chung R, Baker B, Moore J. *The Health Care Workforce in New York, 2014: Trends in the Supply and Demand for Health Workers*. Center for Health Workforce Studies, School of Public Health, SUNY Albany; September 2015. Available at <http://chws.albany.edu/archive/uploads/2014/08/nytracking2014.pdf>

Another significant factor impeding worker recruitment and retention is the inability to offer competitive wages and benefits.³⁵ Relying almost exclusively on public money, and against the backdrop of significant financial challenges, LTPAC providers have not had sufficient resources to offer competitive wages with the hospital sector. With the recent increase to the minimum wage, LTPAC providers will struggle to cover the additional wages needed to remain competitive and attract and retain quality caregivers. These jobs are extremely demanding both physically and emotionally and require extensive training, intensive documentation, and stringent accountability. Many potential employees will opt for a fast-food job, if offered the same wage by an LTC provider.

While the State's recent increase in the minimum wage is intended to provide a well-deserved raise for the lowest-paid LTPAC workers, it was only partially funded by the State. The funds appropriated will not cover services reimbursed by Medicare, nor will they address the compression effect on workers earning slightly above the minimum wage or the cost of non-statutory benefits that are tied to wages. Nor will the funds cover services paid for by NYSOFA programs, SSI, or consumers. Unfortunately, this well-intentioned initiative will further strain the finances of LTPAC providers and impede recruitment and retention of workers in the compression class.

The effects of workforce shortages and the inability to offer competitive compensation are compounded by State laws and regulations that prevent health care providers from optimizing the skills and training of available professionals and paraprofessionals. Specifically, nurses working in assisted living facilities (with the exception of Enhanced Assisted Living

Residences) are prohibited from practicing nursing, due to the State's prohibition on the corporate practice of a profession. The limitations on nurses in these settings prohibit not only nursing tasks, but also tasks that home health aides are routinely authorized to perform in the community. State regulations also prevent nurse practitioners and physician assistants who work in nursing homes

from performing certain clinical activities within the scope of their licenses. As a result, these tasks must be performed by physicians at a higher cost. In addition, the absence of an "advanced home health aide" title in State law has truncated the career ladder of home health aides and has prevented them from performing certain semi-skilled tasks. As a result, these tasks have been performed by a nurse at a higher cost to the system.

The combined forces of the Olmstead decision, managed long term care, and VBP arrangements are already encouraging the diversion and transition of beneficiaries with increasingly complex conditions to lower levels of care – i.e., from hospitals to nursing homes, and from nursing homes to adult care facilities, assisted living programs, and home care in private homes. As the State continues its efforts to expand access to home care and to reduce hospital utilization by serving higher acuity seniors at home and in nursing homes and assisted living facilities, unnecessary regulatory barriers to the effective and efficient use of professionals and paraprofessionals should be eliminated.

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³⁵ *Ibid.*

3. Health Information Technology (IT) infrastructure is lacking.

Success in today's LTPAC operating environment depends heavily on a robust health IT infrastructure. The ability to collect, share, and analyze clinical and financial information electronically is integral to all of the new models of care and payment embraced by the State and federal governments under health care reform. Providers need the capacity to collect and share information electronically with care partners securely and efficiently, in order to coordinate care, avoid unnecessary utilization, and optimize outcomes. Data and analytics capacity is also critical to quality measurement and improvement efforts and to population health management initiatives. As the State and federal governments move from fee-for-service payments to VBP arrangements, effective health IT solutions that link clinical, cost, and expenditure data across settings are necessary to assess and manage the risks associated with these new payment arrangements.

Despite the clear need for sophisticated health IT in today's health care environment, public investment in the health IT infrastructure needed by

While general hospitals and physician practices have benefited from a concerted effort at the federal and State level to fund investment in EHRs and health information exchange, the LTPAC sector has been largely overlooked.

LTPAC providers to succeed under MLTC and VBP has been negligible. Given their heavy reliance on Medicaid and Medicare revenues and their shrinking margins, many LTPAC providers have not been able to self-fund the substantial investments in robust electronic health record (EHR) systems, health information exchange (HIE), and data and analytics tools necessary for these new initiatives.

While general hospitals and physician practices have benefited from a concerted effort at the federal and State level to fund investment in EHRs and health information exchange, the LTPAC sector has been largely overlooked. LTPAC providers are not eligible for federal EHR meaningful use incentives, and only a minuscule portion of State HEAL funds dedicated to health IT has been invested in the LTPAC sector. Of approximately \$324 million invested in health IT through HEAL New York Phases 1, 5, 10 and 17, only approximately \$6 million (less than 2 percent) was awarded to projects targeting LTPAC providers.³⁶ While some large HEAL awardees included a handful of LTPAC providers among their partners, the overwhelming majority of the funds flowed to RHIOs, hospitals, and physician practices or clinics.³⁷

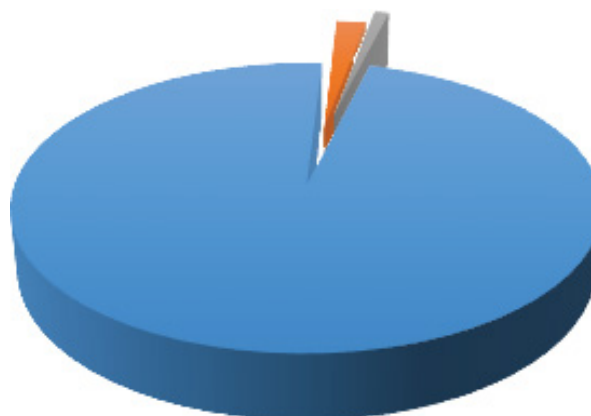
DSRIP payments through PPSs do not appear to be poised to fill this major gap in health IT investment. As highlighted below, only a tiny fraction of DSRIP incentive payments are projected to flow to LTC providers over the next five years.³⁸ An even smaller portion of Capital Restructuring Financing Program (CRFP) and Essential Healthcare Provider

³⁶ LeadingAge New York analysis of HEAL Phases 1, 5, 10 and 17 awards.

³⁷ HEAL New York Phase 22 was dedicated to behavioral health providers participating in health homes. Although the list of HEAL 22 awardees does not appear to be available on the Department's website, we understand that it did not benefit the LTPAC sector.

Program (EHCP) funds was allocated to LTC providers. State infrastructure grant programs have excluded LTPAC providers (including nursing homes) because they are not considered hospitals (i.e., EHCP) or have excluded nursing homes because they are considered hospitals (i.e., Nonprofit Infrastructure Capital Investment Program).

CRFP and EHCP Funds by Sector



- Acute & Primary Care (97%)
- Behavioral Health (2%)
- Long Term Care (1%)

The heavy reliance on public payers in the LTPAC sector, together with progressively shrinking margins, has prevented necessary development of IT infrastructure. This gap will inhibit the adoption of new models of care and payment by LTPAC providers and the ability of the State and federal governments to advance the Triple Aim.

³⁸ LeadingAge New York analysis of DSRIP PPS First Quarterly Reports, Module 1.2, available at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/first_quarterly_report.htm. Amounts dedicated to home care agencies and assisted living programs are not specifically identified in the quarterly reports. We assume that they are included in the community-based organization category.

IV



STRATEGIES FOR OPTIMIZING QUALITY OF LIFE AND ADVANCING THE TRIPLE AIM THROUGH LTPAC AND SENIOR SERVICES



New models of care and payment show promise in advancing our vision for creating a strong and sustainable system of LTPAC, social supports, and housing that optimizes the health and independence of seniors, while lowering the overall cost of care. However, realizing that promise will require new strategies for payment, infrastructure development, housing, and workforce. Special attention must be given to the unique challenges facing seniors in rural communities, where direct care workers and health care professionals are in short supply, and seniors and individuals with disabilities are geographically dispersed across vast areas.

A. Promote Integration of Medicare and Medicaid Funding Streams

The integration of Medicare and Medicaid funding streams and associated streamlining of federal and State regulatory oversight represent significant steps in advancing our vision for the LTPAC and senior services sector. As discussed above, the integration of Medicaid and Medicare creates appropriate incentives to deploy medical and supportive services efficiently to optimize health and independence. It eliminates incentives to shift costs between the programs and instead encourages providers and plans to manage overall costs wisely.

The State has been a leader nationally in the development of integrated models, with nine PACE programs, seven MAP programs, and most recently the FIDA program. FIDA is an ambitious initiative but has been hindered by burdensome requirements and lack of physician engagement. Recent reforms are now moving the program in the right direction, but it will take time for FIDA to develop a positive reputation among seniors and providers, in order to build enrollment. Both the State and federal governments must address the adequacy and timeliness of plan rates in order for the program to succeed.

PACE is already a successful (albeit small) program with strong evidence of its effectiveness. In some communities, where the workforce is limited and transportation poses a challenge, it may be more

feasible and efficient to serve frail seniors in congregate settings, such as a PACE center or adult day health care program, than to provide frequent home visits. With the recent enactment of the federal PACE Innovation Act, there are new opportunities to expand the PACE model to additional populations. The State should actively promote further growth in PACE, particularly in rural areas, by subsidizing the development of PACE centers, publicizing

The integration of Medicare and Medicaid funding streams and associated streamlining of federal and State regulatory oversight represent significant steps in advancing our vision for the LTPAC and senior services sector.

the PACE program in marketing materials and contacts, and supporting innovative proposals to use PACE as a platform for delivering LTPAC care. In addition, PACE's private pay option for non-Medicaid beneficiaries can provide an opportunity for seniors to contribute to the cost of their LTC services, without impoverishing themselves or divesting themselves of assets.

MAP also has potential to promote greater integration of Medicare and Medicaid and align incentives appropriately. Like PACE and FIDA, enrollment remains low. However, its expansion is not limited by the capital investment required by PACE programs, nor is it geographically limited like the FIDA program.

The State could do more to promote all three programs by expanding outreach efforts to community-based organizations and physicians. It should also ensure that the State's information

and enrollment contractors, such as NY Connects, New York Medicaid Choice, the Conflict Free Evaluation and Enrollment Center, and the Health Insurance Information, Counseling and Assistance Program (HIICAP), provide accurate and complete information about these options. Expanding enrollment in these programs could help to prolong independence and prevent health crises that lead to institutionalization.

B. Expand Access to a Continuum of Community-Based and Residential Options for Seniors

In order to ensure that seniors are able to receive care in the most integrated setting appropriate to their needs and to avoid premature placement in nursing homes, the State should support the development of a continuum of residential settings for low- to moderate-income seniors to address diverse needs and preferences. This continuum should include affordable senior housing with supportive services, Naturally Occurring Retirement Communities (NORCs), Neighborhood NORCs, and adult care facilities, including ALPs and enriched housing. By expanding access to these community-based options for seniors, the State will optimize the health and independence of seniors, delay the process of spending down to Medicaid eligibility, and reduce reliance on nursing homes.

1. Invest in affordable senior housing and services.

The State should provide dedicated capital funding for affordable senior housing of \$50 million annually over five years, for a total of \$250 million, and \$10 million to fund the Senior Housing Resident Service Coordinator Program to be administered through the State Office for the Aging. This strategic investment in affordable senior housing will provide low-income seniors with access to basic supports in the community, allowing them to age in place and delay or prevent reliance on high-cost Medicaid services. Ultimately, this proposal represents a modest investment in affordable senior housing and services that will improve seniors' quality of life, save Medicaid dollars, and help the State implement its ambitious Olmstead Plan to serve people in the least restrictive settings

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appropriate to their needs.

The resident service coordinators would assist residents by: (1) establishing and maintaining networking relationships with community-based services and organizations; (2) providing residents with information and referral lists for community services, and assisting them with follow-up; (3) arranging for educational and socialization programs for residents; (4) helping residents arrange

for housekeeping, shopping, transportation, meals-on-wheels, cooking, and laundry services; (5) establishing resident safety programs; and (6) advocating for residents.

Services like resident service coordination in senior housing have been found to promote emotional well-being and stronger social supports, higher resident awareness of services, and better linkages between residents and needed services.³⁹ Service coordinators who connect seniors to appropriate services can help to reduce unnecessary hospitalizations, trips to emergency rooms, and nursing home placements.

³⁹ Levine, C.A., and A.R. Johns. 2008. "Multifamily Property Managers Satisfaction with Service Coordination." Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research. Sheehan, N W., and M. T. Guzzardo. 2008. "Resident Service Coordinators: Roles and Challenges in Senior Housing." *Journal of Housing for the Elderly* 22:240–62 <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412553-Housing-as-a-Platform-for-Improving-Outcomes-for-Older-Renters.PDF>

2. Expand ALP capacity and increase capital and operating funding for ALPs and ACFs.

The State should expand and strengthen the assisted living program and adult care facilities as alternatives to nursing home placement for older adults with functional limitations. Specifically, the current statewide cap on ALP beds should be liberalized, and capital funding should be allocated to facilitate expanded ALP capacity. Additional ALP capacity would allow Medicaid beneficiaries to live in a more home-like setting, at approximately half the cost of nursing home placement. Although the State recently announced the allocation of 3,600 ALP beds, the increase satisfied only one-third of the applications received for additional units. In addition to ALPs, the State should support the development of ACFs for seniors. Because ACFs serve self-pay individuals, as well as those on SSI, expanding and strengthening the ACF model will encourage seniors to utilize their own resources for long term care, rather than divesting assets to obtain Medicaid.

Additional ALP capacity would allow Medicaid beneficiaries to live in a more home-like setting, at approximately half the cost of nursing home placement.

In order to ensure that ALPs and ACFs remain a financially viable option for low-income seniors, the State should increase the SSI Congregate Level 3 Rate and resident Personal Needs Allowance. The State should provide an increase of \$15 per day per person, along with a subsequent annual cost-of-living increase, in the SSI rate to ensure

that ACFs can continue to afford to serve low-income seniors. The current rate of just over \$40 per day is unsustainable and will lead to further reductions in ACF capacity, especially for residents on SSI. An increase in State support for ALPs and ACFs will ultimately save Medicaid dollars by maintaining them as sustainable alternatives to nursing home placement. It would also make these facilities more affordable to individuals who can pay privately for these services because the amounts needed from private pay individuals to cross-subsidize the SSI units would be reduced.

3. Provide capital funding for LTPAC providers.

Within the LTPAC services sector, significant investments are needed for facility upgrades, service enhancements and restructuring initiatives. LTPAC providers have had only negligible access to State funding for needed capital. Acute and primary care providers have been awarded the vast majority of funding available through the Capital Restructuring Financing Program, mostly through the Delivery System Reform Incentive Payment (DSRIP) program. Nursing homes and other facility-based LTPAC providers will not be able to make critically needed investments to modernize their physical plants to improve efficiencies, to enhance their services to respond to changing needs, and to restructure operations through affiliations, mergers and service reconfigurations without a dedicated capital funding stream.

4. Provide additional funding for NORCs/NNORCs.

The State should continue to expand and increase funding for Naturally Occurring Retirement Communities and Neighborhood NORCs. Generally, NORCs are neighborhoods or buildings in which a large number of the residents are older adults who have either aged in place or have migrated to these communities with the intention of remaining there. The State should further support NORCs as a mechanism to support aging in place, improved health outcomes, and reduced reliance on institutional services. With the benefit of geographic proximity and a sense of community, these clusters of seniors provide a cost-effective platform to deliver services and social supports.

5. Support the development of the Village Model.

Like the NORC, the Village concept arose out of community members' desire to reside in their own homes, while being able to access services that address their changing lifestyles as they age. At their core, Villages are grassroots, self-governing, self-supporting consolidators of services that offer their members access to vetted, discounted providers and volunteers for any service they might want or need; healthy living options; and organized programs, seminars, and trips to support connectedness and friendships. There are nearly 30 Villages currently operating or in development in New York State. As with NORCs, the State should disseminate information about the Village model and support the formation and operation of Villages to encourage aging in place, improved health outcomes, use of personal funds for LTC care expenses, and reduced reliance on Medicaid-funded institutional services.

6. Promote expansion and utilization of medical-model adult day health care.

ADHC programs provide an effective, community-based platform for serving beneficiaries with complex medical conditions and functional limitations on a congregate basis. In particular, in communities with shortages of visiting nurses, rehabilitation therapists, and/or home care workers, the ADHC setting may be a more cost-effective way to serve individuals than home visits. ADHCs also provide registrants with more frequent contact with nurses than typical home care patients. This on-site presence of at least one nurse enables the ADHC to implement interventions to prevent avoidable hospital use. Furthermore, the ADHC offers the benefit of social interaction with peers.

The expansion, if not sustainability, of ADHC programs depends in large part on the implementation of regulations adopted by the Department of Health (DOH) to “unbundle” the all-inclusive ADHC rate. These regulations permit managed care plans to contract for discrete services within the ADHC setting based on the needs of the registrant (patient). However, managed care plans and ADHCs have been hindered in contracting for unbundled ADHC services by the absence of managed care billing codes for these services.

We recommend that the Department accelerate its work with plans and ADHC providers to adopt standardized billing codes for these services. The implementation of the unbundled services option for ADHCs paves the way for innovative payment arrangements involving a variety of service packages.

In addition, DOH should promote partnerships between PACE programs and ADHC providers. More people could be served by PACE programs, especially in rural areas, if PACE utilized existing ADHC programs as alternative care sites. This would reduce the need for extensive capital investment in new PACE sites. PACE programs could purchase the whole array of ADHC services or just a portion to meet the needs of PACE members and could also use ADHC program

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space in the afternoon, evening, or weekend hours, when the ADHC program is closed. In order for PACE plans to utilize ADHC in the most innovative and cost-effective way, new billing codes for ADHC must be developed and subsequently promoted by DOH.

C. Invest in Information Technology and Health Information Exchange to Support Value-Based Payment and the Triple Aim

Like hospitals and physician practices, LTPAC providers require a substantial public investment in IT infrastructure in order to survive in today's evolving health care environment. The adoption of EHRs and broad participation in health information exchange among LTPAC providers will be critical to their success in VBP arrangements and the State's DSRIP efforts. LTPAC providers will also need public funding for technology to support the management of financial risk, quality measurement, and performance improvement efforts under VBP arrangements. We recommend that \$100 million be made available for EHR adoption and HIE in the LTPAC sector. A significant portion of these funds should be dedicated to expenses that cannot be capitalized, such as software leases and licenses, and associated training and maintenance costs.

D. Expand the Continuing Care Workforce and Support Efficient and Effective Utilization of Workers

Direct care workers, who provide hands-on care each day, are the key to ensuring that we can deliver quality long-term services and supports to a growing older population. LTC services are labor-intensive, with an estimated 70 percent or more of the total cost of delivering care attributable to staffing. As discussed above, shrinking reimbursement has led to high turnover and significant workforce shortages in some areas of the State. There is no silver bullet that can solve these challenges and ensure that we can meet

the growing demand. However, there are initiatives that the State can undertake to begin to address the issues.

LTC services are labor-intensive, with an estimated 70 percent or more of the total cost of delivering care attributable to staffing.

1. Implement the Advanced Home Health Aide legislation.

The State should work swiftly to implement the recently passed legislation authorizing an Advanced Home Health Aide to perform certain advanced tasks under the supervision of a registered professional nurse and pursuant to an authorized practitioner's ordered care. This new role will advance the field of direct care workers, provide critical access to certain services for consumers living in the community, and increase efficiencies in the delivery of care.

2. Allow for Advanced Certified Nursing Aides.

The State should pass legislation to allow Certified Nursing Aides (CNAs) with additional training to administer medications in residential health care facilities under the supervision of a registered nurse. In New York, there is an exemption to the Nurse Practice Act for direct care staff employed in residences certified by the Department of Mental Hygiene. This exemption allows registered nurses to delegate nursing functions, including medication administration, to direct care staff provided there is adequate medical and nursing supervision.

The State is facing a significant nursing shortage, and many nurses express dissatisfaction with the repetitive task of routine medication administration consuming most of their time, leaving little time for direct care. Meanwhile, aide-level workers are leaving health care to pursue other jobs due to wage restrictions and job satisfaction. Allowing these additional responsibilities can provide increased job satisfaction, allow for wage increases and promote staff retention.

3. Expand the role of the nurse in the ACF.

Like nurses employed by nursing homes and hospitals, nurses employed by assisted living facilities (including ALPs and other ACFs) should be exempt from the corporate practice of nursing prohibition and permitted to practice their profession in those settings. The State should expand current exceptions to the corporate practice prohibition to enable nurses to practice within the full scope of their licenses in assisted living facilities. By allowing nurses in ACFs to perform tasks within their scope of practice, Medicaid beneficiaries living in ACFs would receive more integrated, proactive, and preventive services that can reduce 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.

We recommend that nurses be permitted to provide certain services on an intermittent or incidental basis, in ACFs.

These intermittent or incidental nursing services should not be required of ACFs and assisted living facilities, but rather permitted as optional services provided by those facilities that have the appropriate staffing to do so.

By allowing nurses in ACFs to perform tasks within their scope of practice, Medicaid beneficiaries living in ACFs would receive more integrated, proactive, and preventive services that can reduce emergency department visits and hospital admissions.

4. Cross-certification of direct care workers.

The State should take steps to facilitate cross-certification of aides to promote a flexible and adaptive workforce. Inflexible training requirements create career mobility issues for workers and staffing/cost issues for providers. Currently, certified nurse aides (CNAs) employed in New York's nursing homes are required to receive 100 hours of training to become certified. Home health aides (HHAs) working in home care settings are required to receive 75 hours of training. There is no training reciprocity for these jobs, meaning that a HHA applying to be a CNA must complete the full 100-hour CNA training program, much of which is redundant and postpones the HHA's ability to work in a nursing home. Cross-certification and/or the development of a "core training curriculum" would obviate the need for CNAs, HHAs, and other paraprofessionals to complete an entire re-training when moving from one classification to another.

5. 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 together with regulators and educational institutions to explore cross-training and inter-disciplinary service opportunities in order to alleviate workforce shortages. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.

6. 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.

7. Expand the use of telehealth and remote patient monitoring.

Telehealth and remote patient monitoring technologies can help older adults with chronic or post-acute conditions to manage more of their own care, while reducing home nursing visits and associated transportation expenses and avoidable hospital use. These modalities are especially useful in rural areas, where telehealth and remote patient monitoring can allow for more efficient use of a limited workforce. In addition, these technologies improve access to specialized services in areas with physician shortages.

The State should make funding available to expand access to telehealth and remote patient monitoring tools. It should also eliminate regulatory barriers to their use. In particular, proposed regulations limiting the originating sites for telehealth visits should be broadened to encompass home visits, especially in rural areas.

8. Support informal caregivers.

The State should offer expanded respite benefits, direct financial assistance, greater tax incentives, training programs, and education and community outreach programs for informal caregivers. This assistance would represent an eminently cost-effective approach for the State through Medicaid expenditure avoidance.

E. Allocate Additional Funds to Quality Incentives for LTPAC Providers

Given rising costs and the unavailability of relief through the DSRIP program, the State should infuse new dollars into the LTPAC sector through a quality-focused VBP program. This program should reward performance on quality measures, rather than focusing on

Telehealth and remote patient monitoring technologies can help older adults with chronic or post-acute conditions to manage more of their own care, while reducing home nursing visits and associated transportation expenses and avoidable hospital use.

Medicaid savings. The program could also reward transitions and diversions from nursing homes to community-based care. With the development of new community-based residential options and a stronger workforce, efforts to transition and divert beneficiaries from nursing homes are more likely to bear fruit.

It is critically important that this program incorporate new Medicaid dollars and not merely reallocate existing dollars. If increasing amounts are withheld from rates – whether MLTC or provider payments – the program may merely destabilize providers, rather than providing an effective incentive. Moreover, in the absence of new dollars, the providers in greatest need of additional support may be doubly penalized.

F. Ensure That MLTC Rates are Adequate to Cover the Costs of Care, Care Management and Administration

The future of New York's long-term care delivery system rests on managed care and its promise of "care management for all." Unfortunately, the MLTC rate-setting process has failed to keep pace with the rapidly changing dynamics of the program and the populations it serves. It does not account appropriately for the addition of new benefits and new mandated populations, for the administrative costs associated with various rate "pass-throughs," or frequent policy changes, including wage

mandates. The State should not be seeking to achieve a significant contraction in spending on long-term care services at a time when the population of those needing such services is burgeoning.

The State should ensure that MLTC premiums are aligned with the costs of care, including care management, administration, and needed infrastructure investments. Discounts currently incorporated into the rate-setting process based on the assumptions that MLTC plans can reduce utilization and negotiate price reductions should be eliminated. Programmatic changes should not be implemented until associated rate adjustments and contract amendments have been implemented. The State should further ensure that the high cost nursing home pool is adequately funded, and that the nursing home rate adjustments match nursing home resident enrollment and the average nursing home rate plans actually pay.

G. Encourage Self-Financing of Long-Term Care and Discourage Medicaid Divestiture

1. Expand access to social supports for seniors.

The State should provide greater financial support for the EISEP and CSE programs, both of which target non-Medicaid eligible seniors who want to remain at home but need help with activities of daily living. These programs not only save money by enabling seniors to access services without qualifying for Medicaid, but they do so at a lower cost to the State through the use of consumer cost-sharing. These programs can also support activities to reduce

avoidable hospital use by connecting with the health care delivery system and providing services such as care navigation, wellness classes, and transportation to medical appointments. Added State funding could allow them to serve more people, possibly increase the covered services, and create programmatic linkages with the health care delivery system.

These programs (EISEP and CSE) not only save money by enabling seniors to access services without qualifying for Medicaid, but they do so at a lower cost to the State through the use of consumer cost-sharing.

2. Modernize the CCRC statute.

Continuing Care Retirement Communities (CCRCs) provide a way for individuals with some assets (e.g., from the sale of a home) to plan for and finance their LTC needs and living arrangements. The requirements of the Public Health Law provisions governing CCRCs (Articles 46 and 46-A) have created an environment in which it is prohibitively expensive and administratively burdensome to start or expand a CCRC, and extremely difficult for current CCRCs to operate efficiently and make their services more affordable.

The State should modify Articles 46 and 46-A to eliminate barriers to the development, expansion, and efficient operation of CCRCs. Changes should include consolidating oversight within DOH and authorizing more efficient use of reserve funds. Encouraging the expansion of the CCRC model will allow more seniors to invest in their care and housing needs through a CCRC, rather than divest their assets to qualify for Medicaid-funded services.

Encouraging the expansion of the CCRC model will allow more seniors to invest in their care and housing needs through a CCRC, rather than divest their assets to qualify for Medicaid-funded services.

3. Transfer estate recovery responsibility to OMIG and reinvest recoveries in LTPAC system.

The State could increase Medicaid recoveries by assigning to the Office of Medicaid Inspector General (OMIG) statewide responsibility for making Medicaid recoveries from the estates of deceased beneficiaries, in personal injury actions, and in legally responsible relative refusal cases.

Assuming that New York State could match the historical 2 percent recovery rate of Massachusetts ... the State could realize savings of \$55 million per year.

New York ranked 32nd nationally in estate collections as a percentage of total nursing home Medicaid spending, according to a 2008 report by the Congressional Research Service (CRS). New York's recovery rate was only 0.5 percent of all nursing home Medicaid spending, or approximately \$30 million in 2004 (latest available). Assuming that New

York State could match the historical 2 percent recovery rate of Massachusetts (neighboring state, ranked 8th among the states in the 2008 CRS report), the State could realize savings of \$55 million per year. Those savings could be reinvested in the LTPAC delivery system.

4. Align NY Connects and HIICAP.

The State should ensure that New Yorkers are aware of the array of LTPAC and senior services available through private payment and NYSOFA, as well as Medicaid and Medicare, by aligning NY Connects and the Health Insurance Information, Counseling and Assistance Program (HIICAP). Currently, HIICAP provides free information, counseling, assistance, and advocacy on Medicare, private health insurance, and related health coverage plans through trained volunteers. NY Connects, by contrast, offers information about long-term services and supports and public assistance programs. These programs should work together to proactively disseminate information about LTPAC services and their financing to consumers before a crisis strikes. Counselors should be available to educate consumers on the full continuum of services; supports; LTPAC options; and Medicaid, Medicare, and other sources of payment for services. Building on this base of knowledge, HIICAP counselors could be trained to provide information and referral for all the long-term services and supports available in the community and integrated Medicare/Medicaid managed care plans, while NY Connects staff should be able to inform consumers about health coverage. Providing ready access to this information will help individuals to remain in the community and off Medicaid for as long as possible.



CONCLUSION

Facing a rising population of seniors with high rates of chronic disease and rising rates of disability, the federal and State governments must develop strategies to optimize their health and independence within the constraints of available workforce, funding, technology, and service capacity. These strategies will have to address a variety of factors, including increasing the private financing of LTC. However, integration of Medicare and Medicaid funding, public investment in workforce development, regulatory reforms that allow efficient and effective use of available workers, the development of a robust IT infrastructure in the LTPAC sector, adequacy of MLTC rates, and investment in a continuum of community-based and residential options for seniors must be key components of the State's health care reform agenda.

If you want to hear more about cost-effective strategies for long-term/post acute care services, contact Ami Schnauber at aschnauber@leadingageny.org | 518.867.8854 or Karen Lipson at klipson@leadingageny.org | 518.867.8838.

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