October 10, 2017

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Dear Dan and Mark:

Thank you for the opportunity to provide comments on the proposals presented to the Post-Acute Care Management Models Work Group. As you know LeadingAge New York represents the full continuum of long-term/post-acute care (LTPAC), from senior housing, adult day health care, home care, hospice, assisted living, nursing homes, continuing care retirement communities, managed long-term care, and nursing homes. Our members are engaged in collaborative care and payment arrangements with hospitals, ACOs, physician practices, and other LTPAC providers[1] through bundled payment arrangements, hospital readmission reduction initiatives, and care transition programs. Accordingly, we are well-positioned to provide insights into the implications of changes in state policy for a broad range of providers and the individuals they serve. This letter begins with some general observations about the issues confronting providers and consumers of post-acute care, followed by our comments on some of the proposals advanced at the Work Group meeting, and concludes with some regulatory reforms that we have advanced previously and would like to see included in the Work Group report.

I. GENERAL OBSERVATIONS

We are acutely aware of the many challenges that consumers and providers face in accessing and delivering post-acute care respectively. We welcome and appreciate the Department's efforts to study and address these challenges. Unfortunately, the most pressing and fundamental of these challenges cannot be remedied with changes in State regulations alone. They are: workforce shortages, insufficient supply of affordable and accessible housing for seniors and people with functional limitations, lack of investment in electronic health record adoption and health information exchange for the LTPAC sector, and rising costs along with shrinking revenues. Absent policies and investments that mitigate these

[1] For purposes of this letter, LTPAC providers include nursing homes, assisted living facilities, home care agencies, hospice programs, adult day health care programs, and senior services providers.

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barriers, changes in licensure requirements and reimbursement mechanisms to permit hospitals to deliver home-based services are not likely to ameliorate gaps in post-acute care. Indeed, when the ripple effects of policies to authorize hospitals to deliver home-based services are considered, it is possible that these policies may do more harm than good.

This is not intended to suggest that the State should maintain the status quo. The health care environment is undergoing enormous change. New models of care and payment are gaining traction. New technologies and medications are enabling medically-complex individuals to be served in lower intensity settings. Workforce shortages are demanding that different types of workers be authorized to perform certain services. And, new methods of measuring and incentivizing quality and restraining unnecessary utilization are emerging. Regulations that are intended to enforce minimum quality standards, to prevent over-utilization, or to limit the providers who may perform certain services may need to be revisited. We look forward to continuing to work with the Department on modernizing regulations affecting the LTPAC sector and the individuals it serves.

A. The Looming Demographic Crisis

Demographic shifts demand new approaches and new investments in LTPAC services. The State is facing a "silver tsunami" in which 20 percent of the its population will be age 65 and over by 2030, while the ratio of working-age to aged adults is declining rapidly. LTPAC providers and consumers are already feeling the effects of these demographic changes in most regions of the State – they are most severe in rural areas, but even in parts of Westchester and Long Island, home care agencies and nursing homes are struggling to recruit and retain direct care workers, and consumers cannot access the home care services they need in order to continue to live in their own homes.

B. The Need for Investment Today

Given these demographic trends, the State and federal governments should be investing in the LTPAC sector, in electronic health record adoption and health information exchange, in capital improvements to make nursing facilities more home-like, in assisted living capacity and affordable senior housing, and in policies and programs that support recruitment, retention and optimal use of workers. Regrettably, LTPAC and senior services providers have been largely overlooked in recent State grant awards and incentive payments. Although the DSRIP program is expected to drive a $6.4 billion investment in our health care delivery system, less than 4 percent of the funds paid since April 2015 has been allocated to LTPAC providers. Similarly, the State has invested over $2 billion in capital projects for health care providers over the past two years through the Capital Restructuring Financing Program and the Health Care Facility Transformation Program, but less than 1 percent of those funds was awarded to LTPAC providers. When the federal government offered a 90 percent match for State investments in health information exchange between LTPAC providers and hospitals and physician practices, the State set such stringent eligibility requirements that only 19 facilities and home care agencies qualified.

Moreover, Medicaid and Medicare reimbursement is declining due to a combination of increased managed care penetration, new payment arrangements, and inadequate inflation adjustments in fee-for-service rates. At the same time, the State and federal governments continue to implement initiatives that

raise the cost of care and impede recruitment and retention efforts. Managed care growth under Medicaid and Medicare, for example, has required providers to invest heavily in administrative capacity to manage service authorizations, contracts, and claims submissions. Value-based payment arrangements will require still more administrative investments. New York's minimum wage increase has created new recruitment challenges for LeadingAge New York members; they have historically paid their workers at rates slightly higher than minimum wage, but now cannot afford to exceed the minimum wage and must compete for workers with fast food and retail outlets that pay the same wages.

C. Strong Collaborations among Hospitals, Physician Practices and LTPAC Providers Would Strengthen Post-Acute Care Without Negative Side Effects

The Work Group's discussions focused on requests by hospitals for changes in regulation (principally home care licensure requirements) to allow them to provide home-based physician, nursing and aide services. However, the Work Group did not discuss in detail any particular home-based model, the data in support of any model, the regulatory impediments to that model, and the regulatory changes sought to advance the model. Instead, the Work Group covered at a high level a variety of home-based models delivered by different types of practitioners at different points in the disease process. As a result, it is difficult to weigh the benefits of the regulatory changes sought against the possible adverse consequences.

However, most of the barriers to post-acute care cited by the hospitals could be mitigated through strong collaborations with LTPAC providers that do not require changes in licensure regulations. The Work Group's discussions did not identify any home-based hospital services that could *not* be delivered by a home care agency in collaboration with a hospital or physician group. The Work Group did highlight some of the challenges those collaborations face, including lack of electronic health information exchange and lack of a payment source for patients who are not classified as homebound. These impediments could be ameliorated by investment in technology and payment arrangements that provide funding for home visits for non-homebound patients. A change in licensure requirements is not necessary to address these barriers. Other barriers are more structural – e.g., lack of appropriate housing and lack of a ready workforce to make home visits immediately after discharge. Neither of these barriers would be remedied by the changes in regulation proposed.

Consideration of any change in licensure or other regulations that would permit hospitals to provide services in patients' homes should take into account the impact of those care models on the State's home care agency infrastructure. If we want consumers to continue to have access to home care agency services for long-term care and for post-acute, rehabilitative, and palliative care services that hospitals don't want to deliver, we should not weaken home care agencies by allowing hospitals to absorb their low-acuity (low-cost) cases. This would make it more difficult for agencies to succeed in risk-based payment arrangements and would create additional competition for a scarce workforce.

Moreover, in addition to weighing the impact of proposed hospital home-based models on the home care agency infrastructure, the State should take into account the cost impact of these programs. Notably, under existing law, hospitals' affiliated physician practices can provide physician, social worker and care manager home visits (and possibly nursing visits), but cannot bill at hospital rates for the physician

services and may not be able to bill for non-physician home visits. Thus, the problem appears to be payment-related rather than entirely regulatory. Since hospitals tend to have higher cost structures than home care agencies, it is possible that hospital home-based services will cost more than the same services would cost if delivered by a home care agency. Collaborations among hospitals, physicians, home care agencies, and nursing homes would likely be a more cost-effective method of implementing innovative post-acute models.

Finally, but most important, the State should consider the impact of these models on patients' access to care and experience of care. Hospital and performing provider system (PPS) representatives on the Work Group suggested that hospitals could arrange for home visits within a few hours, whereas home care agencies require more time to send a nurse to a patient's home. If that is accurate, the hospital model would present a real benefit for consumers. However, we wonder whether there are data to support the assertion that hospitals can provide home visits within hours, and in any event more quickly than home care agencies. If home care agencies are slow to provide home visits, we should examine the reasons for those delays – are home care agency delays due to a lack of staff, miscommunications in the discharge process, a heavy reliance by hospitals on Friday afternoon or weekend discharges, or unnecessarily burdensome regulatory requirements? We should consider whether addressing the root causes of home care agency delays would provide a more effective solution than relaxing home care agency licensure requirements. Some suggestions for addressing communication and workforce issues are set forth in Section IV.

In addition, we caution that expanding hospital home visiting programs may add to patient hand-offs that cause disruptions in care. If a patient receives hospital home-based care for 72 hours post-discharge and then transitions to a certified home health agency (CHHA) for two weeks of post-acute rehabilitation, the hospital-based model adds another care transition that must be managed. These models may also create additional layers of care management that can lead to confusion and conflicting instructions. Today's post-acute patient may have three or more care managers, including a hospital or PPS care manager focused on avoiding a readmission, an accountable care organization care manager, and a managed long term care (MLTC) care manager. Ideally, each care manager should be communicating with the others and with the patient and his/her informal and formal caregivers. However, these arrangements create all too many opportunities for miscommunication, duplication, and inconsistent instructions.

Rather than encouraging the creation of a new hospital-based home care infrastructure, we recommend that the Department focus on promoting collaborations among hospitals, LTPAC providers, and physicians practices to support smooth transitions of care, prevent readmissions, and improve the quality and outcomes. These collaborations would offer the same benefits as the hospital-operated models, without the risks. Investment in electronic health record adoption and health information exchange for LTPAC providers would support these collaborations. In addition, addressing workforce shortages through the initiatives outlined in Section IV of this letter would enable successful partnerships.

II. NURSING HOME AND ADULT DAY HEALTH CARE HOME VISITING PROGRAMS

To the extent that the Department decides to pursue changes in licensure regulations to permit hospitals to provide and be reimbursed for home visits, it should also authorize home visiting programs conducted by nursing homes and medical model adult day health care (ADHC) programs. Like hospitals, nursing homes and ADHCs are working to reduce readmissions and to ensure safe and timely discharges from acute and skilled nursing care. Like hospitals, they must work with caregivers and providers along the continuum of care to coordinate discharges and ensure appropriate follow-up care. Moreover, they have expertise in caring for individuals with chronic conditions, functional limitations, and cognitive impairments. They are also accustomed to identifying and remediating environmental issues that pose risks for the individuals they serve.

The role of nursing homes, and by extension the adult day health care programs they operate, in providing home visits is recognized in Article 28. Under Article 28, the term "hospital" includes nursing homes. And, "hospital services" is defined to include:

> post discharge care provided in or by a hospital, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of prevention, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, *home-care nursing and other paramedical service,* ambulance service, service provided by an intern or resident in training, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

Public Health Law § 2801(4) (emphasis added).

A "nursing home" is defined as:

> a facility providing nursing care to sick, invalid, infirm, disabled or convalescent persons in addition to lodging and board or health-related service, or any combination of the foregoing, and in addition thereto, *providing nursing care and health-related service, or either of them, to persons who are <u>not</u> occupants of the facility.*

Public Health Law §2801(2) (emphasis added). These provisions suggest that the statutory support for home visits by nursing homes and their ADHC programs is as strong as the programmatic support.

III. COMMENTS ON RECOMMENDATIONS PRESENTED FOR WORK GROUP CONSIDERATION

We submit the following comments on selected proposals presented to the Work Group:

A. Hospital Home Visiting Services

- *Proposal: Provide funding to hospitals and partnering providers to develop and sustain care transition interventions.*
    - Comment: We support the allocation of funds to LTPAC providers and the hospitals and physician practices that they partner with to develop and sustain care transition interventions.

- *Proposals:*
    - *Issue guidance on Article 36 and when an organization needs to be licensed to deliver services in the home.*
    - *Issue regulations on PHL Section 2803(11) regarding primary care services provided by outpatient or diagnostic and treatment centers in the home.*
    - *Issue clarifying memo on conditionally approved DSRIP waivers of 10 NYCRR 401.2(b).*
    - *Issue guidance on PHL Section 2805-x.*
    - Comments: We would welcome the publication of guidance regarding the licensure requirements for home-based services and the scope of collaborations under PHL §2805-x. In particular, the guidance should address not only the services that can be delivered by hospitals without an Article 36 license, but also the services that can be delivered by physician practices. For example, may a nurse employed by a physician practice provide home-based nursing services? Further, the guidance should clarify the circumstances under which a CHHA or LHCSA can provide a single visit for purposes of an assessment or intermittent monitoring visits without undertaking all of the steps required by regulation for a home care case.

- *Proposal: Under supervision by a physician, allow RNs to make a visit to patients' homes for short-term follow up care if the patient does not meet the requirements for CHHA services.*
    - Comment: This proposal requires additional detail. What barriers or problems is it seeking to address? We assume that the patient does not qualify for CHHA services because he/she is not homebound under Medicare rules, or his/her managed care plan deemed such services medically unnecessary. If so, there is no conventional payment source for these services. If the provider expects to rely on alternative payment arrangements that do not require fee-for-service billing, could the provider partner with a CHHA or LHCSA to deliver the service? Why is a change in State regulation necessary? If there is no payment source, will the proposed change remedy the problem?

      More information is also needed regarding the nature of the care model. Is the nurse employed by an Article 28 facility, a private physician practice, a managed care plan, or some other type of entity? Is the visit part of a structured model, with clinical protocols? What is the duration of the short-term care? Are data reported, and are there quality measures in place? How are transitions to longer term post-acute care and long-term care handled? What is the source of payment?

This proposal raises the issues discussed in Section I(C) of this letter. While the proposal may improve access to short-term, post-acute home care services, it may also result in mismanaged transitions to the next level of care, weakening of the existing home care infrastructure, and higher costs. These considerations would have to be weighed against the benefits of the model. However, without more information, it is difficult to evaluate this proposal.

- *Proposal: Establish the Medicaid reimbursement mechanism under PHL Section 2803(11) for home visits, allow home visits to be provided by RNs, and not be limited to established clinic patients.*
    - Comment: Section 2803(11) allows hospital outpatient clinics and diagnostic and treatment centers to provide primary care services that are not home care services to established patients in their homes, if the services are delivered by primary care professionals. If these services are delivered by a physician or mid-level practitioner, we believe they can currently be billed to Medicaid. (*See Medicaid Physician Procedure Code Manual, Home Services).* We do not believe that such services in the home may be billed when delivered by a nurse, unless the nurse is a midwife or nurse practitioner.

      However, even if there were a source of payment for primary care home visits by a nurse, we believe this proposal would require amendments to both the Public Health Law and the Education Law. Absent licensure as a nurse practitioner or midwife, a nurse may not deliver primary care.

      More information is needed about the nature of the services to be delivered and the problem that is to be addressed by this proposal.

- *Proposal: Relieve regulatory burdens in the area of home care that make it difficult to operate a home care provider organization in New York State.*
    - Comment: As the health care delivery system evolves, and payment arrangements increasingly hold providers accountable for cost and quality, certain regulations are becoming obsolete across the continuum of care. We support updating of regulations and relief from unnecessary and obsolete regulations. We have included an array of proposals in Section IV of this letter to reform regulations across the LTPAC continuum.

Community Paramedicine Programs

- *Proposal: Develop and fund community paramedicine programs.*
    - Comment: We support the development of these programs in rural and underserved areas.

Consumer-Directed Personal Assistance Programs

- *Proposals:*
    - *Provide resources for peer mentoring or a database of potential personal assistants that is centrally funded to help CDPAS consumers transition back into the community successfully.*

- *Revise CDPAS regulations to allow for one to five hours of payment while the consumer is hospitalized to have the PA present and receive training/information during the discharge process.*
- Comment: We support these proposals.

Nursing Home Services

- *Proposals:*
  - *Adjust the payment system to enable SNFs to have separate compensation for specialized transplant and oncology medications. Currently, CMS has some drugs that are carved out of the SNF daily rate, but more drugs need to be added to the list.*
  - *Adjust the payment system to enable SNFs to bill separately for the personnel related to transportation costs associated with medically necessary follow up visits.*
  - *The state should work as necessary with CMS to provide a safe harbor for hospitals and SNFs which are working together to transfer patients to the correct care setting, to allow hospitals to take on the financial burden (expensive drug costs) for the SNF without concern for anti-kickback liability.*
  - *Adjust the NYS Medicaid payment system to enable SNFs to care for patients who cannot be cared for in the community due to dementia and mental health issues.*
  - Comments: We support these proposals and look forward to working with the Department to advance them.

- *Proposal: Establish specific facilities to serve geographic regions to accommodate hard to place patients. The facility would receive reimbursement commensurate with the population they accept and would be able to provide the mental health and recreational services needed.*
  - Comment: This proposal requires additional clarification regarding the nature of the hard-to-place patients, the selection process, the services to be provided, and the payment rates.

- *Proposal: Permit additional LTACH beds in NYC and the Greater NY area which can provide both ventilator and on-site dialysis services, as the population with both medical requirements is growing.*
  - Comment: LTACHs serve a narrow cohort of patients who require specific services during a limited length of stay. The services provided by LTACHs can be provided by skilled nursing facilities at a lower cost. Indeed, nursing homes are increasingly offering on-site dialysis services in New York. The State should reconsider its ventilator bed need methodology and its reimbursement rates for ventilator beds, rather than encouraging the development of LTACHs.

- *Proposal: NY State should align its Level 2 PASARR process with the procedures used by neighboring states, which are more cost effective and benefit patients by expediting transfers.*
  - Comment: We support this proposal.

End-of-Life Care

- *Proposal: Education on advanced care planning, hospice, and palliative care.*

- Comment: We agree that the State, health care providers, and professional schools must strengthen training in advance care planning, palliative care and hospice care. Physician practice and hospital staff (physicians, nurses and social workers) must be trained in facilitating conversations about end-of-life care with patients and family members so that these discussions take place early in the disease process. We further urge the State to fund programs to education providers and consumers about MOLST and to support the use of eMOLST. According to the Dartmouth Atlas of Health Care, New York continues to have among the lowest rates in the nation of Medicare hospice utilization (beating only North Dakota and Wyoming on hospice days in the last 6 months of life) and highest rates of Medicare deaths in the hospital.

Discharge Planning

- *Proposal: Educate discharge planners on the full range of services (i.e. housing options) available to individuals as they prepare to transition home.*
  - We agree that discharge planners are often unfamiliar with the array of community-based options that may be available to patients with complex medical conditions and functional limitations after discharge. In particular, discharge planners are often unaware of PACE programs, assisted living options, and adult day health care options.

IV. LEADINGAGE NEW YORK RECOMMENDATIONS

LTPAC providers along the continuum are serving increasingly complex residents, as managed care plans and value-based payment mechanisms drive hospitals to reduce lengths of stay and discharge patients at an earlier point in their recovery. In addition, as lower acuity patients are increasingly being discharged directly home after an acute episode, nursing homes are admitting primarily those with the highest acuity conditions. Moreover, LTPAC providers are being incentivized to retain patients/residents with acute conditions, rather than transferring them to the hospital. All of these factors require nursing homes and home care agencies to strengthen their clinical capacities, while financial pressures and workforce shortages require them to optimize their use of staff. At the same time, value-based payment arrangements and DSRIP activities are demanding that they collect and share electronic health information. The following proposals are aimed at supporting the efforts of LTPAC providers to be effective partners in post-acute care and value-based arrangements, to operate efficiently, and to deliver the highest quality care to the people they serve.

1) TECHNOLOGY

a) Electronic Health Record (EHR) Adoption and Health Information Exchange (HIE)

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. As we heard in the Work Group, the inability of hospitals to exchange health information with home care agencies is stifling collaboration efforts. Further, 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 need public funding for technology to support the management of financial risk, quality measurement, and performance improvement efforts under VBP arrangements. We recommend that dedicated funding 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.

b) 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. They can also assist nursing homes in managing complex medical conditions and in avoiding emergency department visits and hospital admissions. 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.

2) NURSING HOMES

a) Primary Care Services

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

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

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

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

b) <u>Patient Assessments</u>

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

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

c) <u>Specialty Services</u>

- **Allow Nursing Homes to Offer Enhanced Services that Reduce Avoidable Hospital Use:** Nursing homes face reimbursement and other barriers to providing chemotherapy services. The unavailability of such services in nursing facilities can lead to more lengthy hospital stays and

readmissions. Similarly, if nursing homes were permitted to offer hyperbaric services for wound care and other specialty services which can feasibly be provided in a nursing home, avoidable hospital use could be further reduced. Finally, the Restorative Care Unit demonstration program created in the SFY 2016-17 budget should be broadened to additional facilities.

d) Survey and Oversight

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

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

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

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

e) Staffing

- **Modify Training Required of Paid Feeding Assistants:** New York regulations require feeding assistants who support nursing home residents at meals to undergo more extensive training than

federal regulations require. As a result, many nursing homes continue to use certified nursing assistants (CNAs) to assist some residents at meals who might otherwise be fed by a paid feeding assistant. If State regulations were aligned with the federal requirements, nursing homes could expand their use of feeding assistants and allow CNAs to focus on higher level tasks. This would alleviate an unnecessary administrative burden and facilitate efforts to reduce the overall cost of care.

- **Authorize Advanced CNAs:** 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 that allows registered nurses to delegate nursing functions, including medication administration, to direct care staff provided there is adequate medical and nursing supervision. The State should extend this exemption to CNAs employed in residential health care facilities by authorizing CNAs with advanced training to serve as medication technicians under the supervision of a registered nurse.

  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 more complex 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) ADULT CARE FACILITY/ASSISTED LIVING (ACF/AL)

a) Allow ACF/AL Nurses to Perform Nursing Tasks: Currently, many ACFs, Assisted Living Programs, Assisted Living Residences, and Special Needs Assisted Living Residences employ licensed practical nurses (LPNs) and/or registered nurses (RNs). Unfortunately, these nurses are not permitted to perform nursing tasks in these ACF settings due to statutory limitations in New York related to the corporate practice of professions. By allowing nurses in ACFs to perform tasks within their scope of practice, ACF residents would receive more proactive, preventive services that can prevent emergency department visits and hospital admissions. Nurses working in ACFs could also help to avert declines in health status that trigger nursing home placement, thereby saving money for the state, the federal government and the consumer. Like nurses employed by nursing facilities and hospitals, nurses employed by ACFs should be exempt from the corporate practice of the professions prohibition and permitted to practice their profession in those settings. A.2736 (Gottfried)/S.4398 (Hannon) offers a legislative solution to this issue.

The case for allowing nurses to practice nursing in adult care facilities is particularly compelling in Assisted Living Programs (ALPs) and would require minimal adjustments to Department of Health policies or regulations. All ALPs are currently required to operate a licensed home care services agency (LHCSA) and may provide nursing services anywhere else in the community. These LHCSAs should be permitted to provide nursing services to the residents of their ALP, just as they provide services to individuals in private homes.

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

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

d) Enact the ALP CON Bill and Allow ALP Expansions to Address Rightsizing and Capacity Issues: The Governor should sign the ALP CON bill (A.7727-A (Lupardo)/S.5840 (Hannon)). In addition, ALP capacity should be expanded in a way that supports other policy priorities, perhaps administratively and without instituting a need-based process, e.g.:

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

4) ADULT DAY HEALTH CARE

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

b) Allow Nursing Home Medical Director to Sign Orders for Continued Stay. ADHC programs must rely on community physicians to sign orders every six months for continued stay. It is incredibly difficult to obtain these orders, particularly for large programs where every registrant may have a different physician. The medical director employed by the sponsoring nursing home

currently supervises medical services, reviews a registrant's medical history and diagnostic services, diagnoses and orders for treatment, as well as several other responsibilities under section 425.9. The medical director should be allowed to determine the suitability and continued need for services in addition to the community physician.

5) HOME AND COMMUNITY-BASED SERVICES

a) Advanced Home Health Aide (AHHA): The State should work to implement in a timely fashion the Advanced Home Health Aide (AHHA) legislation (Chapter 471 of 2916).

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

c) Facilitate Cross-Training and Lateral Transfers Across Health and Long-Term Care Settings: Providers of health, LTPAC, behavioral health, and developmental disability services and unions should join with regulators and educational institutions to explore cross-training and inter-disciplinary service opportunities to alleviate workforce shortages. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.

d) 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.

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

6) AFFORDABLE SENIOR HOUSING

Following up on the dedicated capital funding for affordable senior housing that was included in the SFY 2017-18 State Budget, the State should invest additional operating funds for 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. An appropriate supply of affordable and accessible senior housing with support

services will help to alleviate delays in hospital discharges occasioned by the lack of appropriate housing.

Thank you again for soliciting our input. We look forward to working with you and your team to improve the accessibility and quality of post-acute care.

Sincerely yours,

Karen Lipson

Executive Vice President for Innovation Strategies

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