NYAHSA PRIORITY RECOMMENDATIONS
MEDICAID REDESIGN TEAM

A. Bending the Cost Curve Through Policy and Reimbursement Reform

This area includes preserving Medicaid and generating new sources of program financing; reforming regulations and reimbursement policies and increasing access to affordable capital.

1. Enhance Medicaid estate recoveries by centralizing collections and broadening assets subject to collection (Templates #1A and #2A).
2. Eliminate Medicaid spousal refusal (Template #3A).
3. Maximize Medicare funding (Template #4A).
4. Maximize veteran's benefits funding (Template #5A).
5. Encourage the use of reverse mortgages to fund LTC costs through consumer education (Template #6A).
6. Aggressively pursue federal approval to implement the LTC Financing Demonstration Program authorized under Social Services Law § 366-i. (Template #7A)
7. Centralize collection of Medicaid cost-sharing amounts (Template #8A)
8. Allow for less restrictive continuing care retirement community (CCRC) reserve and investment policies, currently set by the Department of Insurance, to facilitate expansions in the number of CCRCs and the services they can provide (Template #9A).
9. Allow Article 46 CCRCs to enter into fee-for-service contracts (Template #9A).
10. Cap the personal care program at 75% of the nursing home rate. Recipients who exceed the cap will be automatically enrolled in case managed programs – the long term home health care program (LTHHCP), managed long term care (MLTC), programs of all-inclusive care for the elderly (PACE) and Medicaid advantage plans (MAP) (Template #10A).
11. Reorganize the personal care program to ensure that that accountability and risk are shared among patients, providers and payers, and that opportunities in the federal Affordable Care Act (ACA) to increase federal financial participation are leveraged (Template #11A).
12. Speed up the admission process for adult care facilities (ACFs) and assisted living (AL) facilities by allowing some flexibility in the paperwork and allowing nurse practitioners to sign medical evaluations (Template #12A).
13. Eliminate the requirement for an assisted living program (ALP) to contract with a certified home health agency (CHHA) or LTHHCP, and allow the ALP's licensed home care services agency (LHCSA) to provide all services it otherwise can to people living in the community (Template #13A).
14. Combine and restructure the administration of all Home and Community-based 1915(c) waiver programs to eliminate redundancy, increase efficiency and generate state savings (Template #14A).
15. Allow nursing homes and other long term care (LTC) providers to include binding arbitration provisions in their admissions agreements, and undertake other efforts to reduce liability insurance costs (Templates #15A, #16A and #17A).
16. Provide access to affordable capital financing. Reauthorize industrial development agency (IDA) authority to provide capital financing for "civic facilities" and CCRCs and develop a state financing program for small loans to LTC providers (Template #18A).
17. Develop a low cost loan pool for federally mandated sprinkler upgrades in nursing homes (Template # 19A).
18. Negotiate a new shared savings agreement (i.e., similar to F-SHRP) with the federal government, aimed at decreasing the cost of Medicaid and utilizing the associated shared savings to fund grants to LTC providers (Template #20A).

B. Ensuring Access to Senior Living, Services and Supports

This area includes expanding access to a full range of services and affordable housing.

1. Create a task force or executive council/agency dedicated to reviewing the array of programs and making recommendations on integrating senior services and housing with a consumer-centric, quality focus and educating the public on individual responsibility to plan for LTC needs (Template #1B).
2. Lift the moratorium on partial cap program expansion to increase MLTC options until fully integrated programs are more widely available (Template #2B).
3. Simplify and speed up admissions to ALPs by allowing them to conduct initial assessments and Local social services districts (LSSDs) would retrospectively review some/all enrollments to ensure program integrity while avoiding admission delays (Template #3B).
4. Simplify and speed up enrollment by allowing MLTC plans to assess and enroll members without LSSD prospective assessment. LSSDs would retrospectively review some/all enrollments to ensure program integrity while avoiding enrollment delays (Template #4B).
5. Simplify and speed up admissions to LTHHCPs by allowing them to conduct initial assessments and LSSDs would retrospectively review some/all enrollments to ensure program integrity while avoiding admission delays (Template #5B).
6. Ensure NYS Office for the Aging and Older Americans Act programs are adequately funded to delay/prevent reliance on more expensive Medicaid funded services (Template #6B).
7. Restore and expand the Low Income Housing Tax Credit program, the Low Income Housing Trust Fund program and the HOME program to promote senior housing development (Template #7B).
8. Expand supportive community models including naturally occurring retirement communities (NORCs), Villages and Aging Friendly Communities (Template #8B).
9. Accelerate the shift from institutional care to home and community-based services (HCBS), by supporting expanded access to less expensive senior housing and HCBS through: 1) advancing NYAHSA's freedom of choice act and 2) expanding Medicaid coverage for AL services (Template #9B and #10B).
10. Amend the DOH regulation for CCRCs to allow unrestricted direct admissions (non-residents) into the CCRC ACF and nursing home levels of care provided it does not impact resident access (Template #9A).
11. Nursing homes, assisted living and home care agencies would have the option to utilize specially trained medication technicians to dispense medications to residents/patients. (Template #11B)

C. Achieving Quality Outcomes

This area includes promoting and expanding new models of care; improving coordination of health services and supports; and revisiting government oversight and consumer satisfaction.

1. Develop collaborative approaches with LTC providers to take advantage of care coordination opportunities (e.g., health homes, accountable care organizations) as authorized under the ACA (Template #1C).
2. Create a task force comprised of providers and other stakeholders to develop a comprehensive model for post acute care bundling (Template #2C).
3. Implement targeted regulatory reforms aimed at increasing efficiency, expanding provider flexibility and allowing greater consumer choice (Template #3C).
4. Reorganize the ACF/AL survey process, without compromising the integrity of oversight, to free up resources to address "look-alike" entities that should be licensed as ACF/AL (Template #4C).

D. Promoting the Use of Technology

This area includes increasing access to health information technology (HIT) and supporting senior living and services with assistive technologies.

1. Provide seed capital for technologies, including electronic health records, telehealth and monitoring technologies, to improve quality of services, increase efficiency and allow seniors to remain in independent settings longer. These investments will ultimately save money over time (Template #1D).
2. Advance initiatives for the coordination of HIT efforts between state agencies and regional health information organizations, and ensure that aging services and housing providers are integrated in the process. Early integration will help ensure a framework which results in greater efficiencies and cost-savings over time (Template #2D).

Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:1A

Proposal (Short Title): Centralize responsibility for Medicaid estate recoveries

Program Area: Long Term Care

Effective Date: 4/1/11 **Implementation Complexity:** Low to Medium
Implementation Timeline: Short Term

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The Office of the Medicaid Inspector General (OMIG) would assume statewide responsibility for making Medicaid recoveries from the estates of deceased recipients, in personal injury actions and in legally responsible relative refusal cases. All local social services districts would be relieved of this responsibility.

Federal law requires all states to have programs in place to recover funds from the probate estates of deceased Medicaid recipients. New York's local social services districts (i.e., counties and New York City) have little, if any, financial incentive to pursue estate recoveries, and thus have not done so aggressively. As a result, 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. New York's recovery rate was only 0.5% of all nursing home Medicaid spending, or approximately $30 million in 2004 (latest available).

Chapter 58 of the Laws of 2008 modified Social Services Law §369(7) to give the Commissioner of Health the authority to assume responsibility for making Medicaid recoveries from estates, in personal injury actions and in legally responsible relative refusal cases from any social services district. As an instrumentality of the Department of Health, the OMIG is authorized to assume this function from one or more social services districts. SSL §369(7) also permits DOH (or in this case, the OMIG) to contract with one or more entities to undertake this function.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$39 million	$52 million	$52 million	$52 million
Total Savings	$78 million	$104 million	$104 million	$104 million

Note: savings estimates assume that New York matches the 2% recovery rate of Massachusetts (neighboring state, ranked 8th among the states) based on nursing home Medicaid spending of $6.7 billion. The resulting $134 million annual recovery would represent an increase of $104 million over the current baseline, and an additional state savings of $52 million or more per year. SFY 2011-12 savings assume three-quarters of annual value; state savings based on 50% state share.

Benefits of Proposal: The stated mission of the OMIG is to "enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care." OMIG has a sizeable staff of attorneys, auditors and other personnel dedicated to this purpose, and as a statewide entity, has significant official standing and the capability to execute broad-based recovery activities utilizing effective approaches. Contrast this with local social services districts which are poorly staffed, get to keep little if any of the funds they recover, and are less insulated from local dynamics that can make these activities difficult to undertake. This would also send a powerful message to New Yorkers that personal responsibility is needed to ensure that Medicaid can continue to fulfill its mission.

Concerns with Proposal: None.

Impacted Stakeholders: Local social services districts would be positively impacted by being relieved of the authority/responsibility for pursuing recoveries. OMIG would assume a new responsibility, although it is conceivable that some of the administrative cost funding currently paid to local districts could be appropriated to OMIG for this purpose. Family members of deceased recipients may receive smaller inheritances as a result of the change.

Additional Technical Detail: (If needed, to evaluate proposal) New York's baseline and comparative state information taken from the report, "Medicaid Coverage for LTC: Eligibility, Asset Transfers and Estate Recovery" by the Congressional Research Service, 2008.

Systems Implications: Communications and information sharing may be needed between local social services districts and OMIG. OMIG will need access to Medicaid eligibility data systems.

Metrics to Track Savings: OMIG would track and periodically report recovery totals and work in process.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:2A

Proposal (Short Title): Broaden assets subject to Medicaid recoveries

Program Area: Long Term Care

Effective Date: 7/1/11 **Implementation Complexity:** Medium
Implementation Timeline: Short Term

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The state would exercise the option to recover Medicaid payments from non-probate assets.

The federal Omnibus Budget Reconciliation Act of 1993 (OBRA '93) defines the term "estate", and requires each state to seek adjustment or recovery of amounts correctly paid by the state for certain Medicaid beneficiaries. Under OBRA '93, states must try to recover from estate assets that are subject to probate (e.g., real property not held in joint tenancy with rights of survivorship, vehicles and certain other personal property). States also have the option to recover non-probate assets, which can include life insurance benefits, retirement accounts, deferred annuities and trusts, as well as property held in joint tenancy with rights of survivorship.

Existing NYS Social Services Law §369(6)] defines estate as "…all real and personal property and other assets included within the individual's estate and passing under the terms of a valid will or by intestacy." This law would be modified to include, consistent with federal law, "…any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$8.4 million	$16.8 million	$16.8 million	$16.8 million
Total Savings	$16.8 million	$33.5 million	$33.5 million	$33.5 million

Note: Estimates assume that: (1) non-probate assets comprise 25% of the amount of probate assets subject to recovery; (2) overall recovery levels reflect increased recoveries associated with NYAHSA's companion proposal, "Consolidate Responsibility for Medicaid Recoveries from Estates"; (3) SFY 2011-12 savings reflect one-half of annual value (i.e., allowing for federal approvals, etc.); and (4) state savings are based on 50% state share.

Benefits of Proposal: This proposal would broaden the definition of estate to increase the amount of funds that can be recovered to offset Medicaid benefits correctly paid. As a result of elder law activity, the complexity of probate and tax considerations, more and more assets are conveyed outside of probate estates. As a result, in cases when Medicaid paid for care of the decedent, assets that pass to others outside of probate are

not recovered. This adds unnecessarily to Medicaid expenditures, and treats non-probate assets differently from those that pass through a probate estate for no compelling reason. This would also send a powerful message to New Yorkers that personal responsibility is needed to ensure that Medicaid can continue to fulfill its mission.

Concerns with Proposal: None.

Impacted Stakeholders: The level of responsibility for making Medicaid recoveries would increase and be borne by either local social services districts (if they maintain this responsibility) or by the Office of the Medicaid Inspector General (OMIG), if it assumes responsibility for recoveries based on NYAHSA's companion proposal. Family members or other beneficiaries of deceased recipients may receive smaller inheritances as a result of the change.

Additional Technical Detail: (If needed, to evaluate proposal) State Medicaid Manual Section 3, Eligibility, explains this provision in greater detail.

Systems Implications: Applicants/recipients will need to be notified of the new policy, and information on the existence of such assets and their planned disposition will need to be gathered and maintained.

Metrics to Track Savings: The party responsible for Medicaid recoveries (i.e., local social services districts or OMIG, as proposed by NYAHSA) would track and periodically report recovery totals and work in process.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:3A

Proposal (Short Title): Limit the use of spousal refusal

Program Area: Long Term Care

Effective Date: 7/1/11 **Implementation Complexity:** Medium
Implementation Timeline: Short Term

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The use of spousal refusal would be eliminated or severely limited by the state.

"Spousal refusal," practiced only in New York, Florida and Connecticut, is a Medicaid planning technique in which a legally responsible relative that has excess income/resources refuses to make them available to the Medicaid applicant/recipient because the relative is absent or refuses or fails to make the income/resources available. In other words, a healthy spouse refuses to share marital assets, and the sick spouse assigns his or her "right of support" to the state. The sick spouse then receives Medicaid coverage for nursing home or home care, and the local social services district can sue the healthy spouse to recover the cost of that care.

Existing NYS Social Services Law §366(3)(a) would be amended to: (1) eliminate spousal refusal entirely; (2) remove the references to "or", so that all three conditions would have to apply; or (3) retain the refusal right, but reserve the right to impose treble damages against refusing spouses. A tightly defined hardship exception could be included to protect against egregious situations that could lead to inappropriate denials of needed services.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$3.8 million	$7.5 million	$7.5 million	$7.5 million
Total Savings	$7.5 million	$15 million	$15 million	$15 million

Note: Estimates assume that each spousal refusal case avoided would lead to an average of $10,000 of expenditure avoidance by Medicaid and that there are currently 1,500 such cases per year. SFY 2011-12 savings reflect one-half of annual value (i.e., allowing for federal approvals, etc.); and (4) state savings are based on 50% state share.

Benefits of Proposal: "Spousal refusal" is being used indiscriminately to avoid financial responsibility, leading to increased Medicaid expenditures. In 2009, over 1,200 people in New York City alone invoked spousal refusal, triple the number of five years ago, according to the *New York Times*. Although local governments can sue refusing spouses, oftentimes they do not, or the suits are settled for much less than the cost of care provided and payments are delayed until the well spouse dies.

This adds unnecessarily to Medicaid expenditures. Restricting the use of spousal refusal in home care and nursing home settings would send a powerful message to New Yorkers that personal responsibility is needed to ensure that Medicaid can continue to fulfill its mission.

Concerns with Proposal: One of the concerns about not having a spousal refusal option has been the lack of Medicaid spousal impoverishment rules for well spouses of certain home care recipients. Currently, federal law only allows states to grant spousal impoverishment protections in cases involving nursing home and home and community-based waiver programs (§§ 1915(c) and (d)). However, § 2404 of the Patient Protection and Affordable Care Act will require states to apply existing spousal impoverishment rules to Medicaid beneficiaries who receive other types of home care services beginning Jan. 1, 2014.

Impacted Stakeholders: Depending on the specific approach taken, individuals who need care could be denied Medicaid coverage if their well spouses simply refuse to make assets or income available. A hardship exception could be incorporated to address such circumstances.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: Applicants/recipients and their spouses will need to be notified of the new policy.

Metrics to Track Savings: Current refusal cases and any others that emerge prior to the effective date could be quantified to determine the potential cost avoidance.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:4A

Proposal (Short Title): Medicare maximization

Program Area: Long Term Care

Effective Date: 4/1/11 **Implementation Complexity:** Low
Implementation Timeline: Short

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: A new program to promote greater Medicare utilization through education and provider outreach could result in more Medicare-covered patient days in nursing homes. This would translate into a corresponding reduction in Medicaid-covered days. Suspending expansion of transitional care units (TCUs) would also help in this regard.

Depending on the measure used, New York currently ranks slightly below the national average in the utilization of Medicare Part A benefits in nursing homes. A Medicare maximization program implemented in law in the mid-1990s was punitive and has in recent years not been reassessed.

Further efforts could be undertaken collaboratively by providers and the state to increase Medicare utilization in nursing homes. Examples of strategies that could be effective include encouraging more consistent use of "presumptive eligibility" upon admission following an acute care stay and using clinical criteria to keep residents on Medicare after their course of rehabilitation has ended.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$14.6 million	$29.3 million	$29.3 million	$29.3 million
Total Savings	$29.3 million	$58.5 million	$58.5 million	$58.5 million

NOTE: Fiscal savings reflect an anticipated increase of 1% in Medicare utilization, of which 90% is assumed to be from dual eligibles. It is assumed for this purpose that any increases in Medicaid's obligation to pay for Medicare co-insurance for dual eligibles would be offset by NAMI amounts that would have been budgeted had the recipients remained on Medicaid. The 2011-12 fiscal savings assume 6 months of savings.

The state should also suspend further expansion of the TCU program. Public Health Law § 2802-a was amended by Chapter 58 of the Laws of 2010 to authorize the creation of 13 more TCUs in hospitals. TCUs are Medicare certified nursing home units, ostensibly created to treat patients that no longer need acute care but have post-acute care needs that cannot be met by nursing homes. However, recent experience with existing TCUs suggests that they are serving Medicare patients that could in fact be served in nursing homes. At a time when the state is seeking to reduce nursing home capacity, creating more of these TCU beds will siphon more Medicare volume away from nursing homes, making them even more dependent on Medicaid funding.

Benefits of Proposal: Increases in Medicare utilization should translate into corresponding decreases in nursing home days paid by Medicaid.

Concerns with Proposal: None

Impacted Stakeholders: Nursing homes, recipients, hospitals, Medicaid and Medicare programs

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: Minor

Metrics to Track Savings: Using cost reports, develop a correlation between increased Medicare utilization and a decrease in Medicaid resident days.

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Proposals to Redesign Medicaid
Proposal #:5A

Proposal (Short Title): Promote the use of Veteran's benefits

Program Area: Long Term Care

Effective Date: ASAP

Implementation Complexity: Low
Implementation Timeline: Short term

Required Approvals:

X Administrative Action
___ State Plan Amend
___ Statutory Change
___ Federal Waiver

Proposal Background/Description: The state should work with the Veteran's Administration (VA) to conduct education and outreach to inform aging and disabled veterans of the benefits that are available to them to help pay for services they may need, such as Aid and Attendance and Housebound benefits. These benefits could assist more veterans to remain in their own home or in an adult care facility (ACF)/assisted living facility for a longer period of time – forestalling or preventing nursing home placement. This benefit is under utilized in large part because people aren't aware of it. NYAHSA could be a partner in this outreach effort.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$3.7 million	$7.4 million	$7.4 million	$7.4 million
Total Savings	$7.4 million	$14.7 million	$14.7 million	$14.7 million

Note: Estimates assume: (1) that better use of veteran benefits will lead to the avoidance of institutional placement and use of ALP for one tenth of 1% of the 494,000 veterans 65 and older in New York (based on Department of Veterans' Affairs data); (2) nursing home costs of $200 per day: (3) SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

Benefits of Proposal: Many of the people likely to be eligible for these benefits are Medicaid eligible or close to Medicaid-eligibility. This source of support is an existing federal benefit that can help keep people at a lower level of care, and forestall the spend down to Medicaid eligibility.

Concerns with Proposal: To date, little information is publicly available about the benefit and we understand that there are significant delays in the processing of applications and payments. The cooperation of the VA would be needed in order to make this is a success.

Impacted Stakeholders: Veterans will access the benefits they are entitled to and be supported in remaining as independent as possible for as long as possible.

Additional Technical Detail: (If needed, to evaluate proposal) It would be helpful to get information from the VA regarding how many veterans are using the benefit, versus how many might be eligible.

Systems Implications: This can be implemented in very simple, no cost ways.

Metrics to Track Savings: Information from the VA regarding how many new veterans utilize the benefit.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:6A

Proposal (Short Title): Encourage the use of reverse mortgages to pay for LTC costs

Program Area: Long Term Care

Effective Date: 7/1/11 **Implementation Complexity:** Medium
Implementation Timeline: Medium

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The use of reverse mortgages to fund long term care (LTC) costs would be encouraged through consumer education.

A reverse mortgage is a special type of home loan that enables an individual to access a portion of his or her home equity tax-free. The loan amount is based on age, the home value and the current interest rate. Unlike traditional mortgages, no repayment is required until the homeowner(s) no longer occupy the home as their primary residence.

Home equity conversion through "reverse mortgages" could generate significant private financing to offset Medicaid costs for LTC services, especially for home and community-based services (HCBS). An estimated 53% of New Yorkers own their own homes, and the current median value of homes in the state is $254,100. According to 2002 U.S. Census Bureau data, home equity represented 84% of the total net worth of people aged 65+ in 2002.

People over the age of 62 can readily access their home equity through reverse mortgages, but very few people use them to fund HCBS that would enable them to remain in their homes longer. Why is this so? First, there is no asset transfer look-back or penalty period imposed on Medicaid applicants/recipients seeking to access most HCBS. Secondly, New York's home equity exemption is $750,000, nearly triple the value of the median home. Third, estate recovery is relatively easy to avoid in the state.

Under this proposal, the state would initiate a public education campaign to emphasize the need to plan for LTC costs and the opportunities to use reverse mortgages and LTC insurance to address these costs.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$1.9 million	$7.3 million	$14.5 million	$14.5 million
Total Savings	$3.8 million	$14.5 million	$29.0 million	$29.0 million

NOTE: Estimate assumes that the equivalent of 0.25 percent of current LTC recipients begin to utilize home equity conversion (or LTC insurance) to purchase services privately, avoiding the average annual per recipient Medicaid cost of $38,839. SFY 2011-12 savings reflect 20% of the estimated annual savings due to program ramp-up; SFY 2012-13 reflects 50% of estimated full annual savings; and each year's savings reflects offsetting funding of $2 million for a sustained public education campaign. State savings are based on a 50% state share.

Benefits of Proposal: Statewide public education efforts, coupled with more diligent efforts to recover from estates and to restrict practices such as spousal refusal, would lead to more out of pocket spending for LTC services in lieu of Medicaid payment for these services.

Concerns with Proposal: New York has elected to exempt up to $750,000 in home equity for purposes of determining Medicaid eligibility. This high limit, combined with ineffective current efforts to recover from estates, deters individuals from tapping into their home equity to purchase services.

Furthermore, with the exception of 1915(c) waiver services, home care recipients are not subject to the 5-year asset transfer look-back and associated penalties, meaning they can transfer assets immediately before applying for Medicaid coverage without consequence. The state should also consider applying to the Centers for Medicare and Medicaid Services for permission to apply the look-back and penalty provisions to other HCBS in concert with extending spousal impoverishment protections to these same individuals.

Impacted Stakeholders: Recipients, the Medicaid program, providers and reverse mortgage lenders

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings: Increases in the number of reverse mortgage loans and LTC insurance policies initiated and attributable to the public information campaign.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:7A

Proposal (Short Title): Seek federal approval to implement the LTC Financing Demonstration Program

Program Area: Long Term Care

Effective Date: 10/1/11 **Implementation Complexity:** Medium
Implementation Timeline: Medium

Required Approvals: _X_ Administrative Action ___ Statutory Change
_X_ State Plan Amend _X_ Federal Waiver

Proposal Background/Description: The state would aggressively pursue federal approval to implement the Long Term Care (LTC) Financing Demonstration Program authorized under Social Services Law § 366-i.

Under this law, the Department of Health (DOH) is authorized to implement a demonstration program, subject to federal approval, for up to 5,000 individuals using alternative approaches to establish Medicaid eligibility. Modeled after the Partnership for LTC and intended mainly for individuals who are unable to obtain LTC insurance, the program would encourage individuals to spend a certain amount of their resources on LTC services, in exchange for having other resources disregarded as part of the Medicaid eligibility determination process.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$3.7 million	$10.9 million	$14.6 million	$21.9 million
Total Savings	$7.3 million	$21.8 million	$29.2 million	$43.7 million

NOTE: Estimate assumes annual total enrollments of 250, 1,000, 2,000 and 3,500 individuals in the program beginning in SFY 2011-12, and that each individual pledges sufficient assets to cover the average annual per recipient Medicaid cost of $38,839 for one year. An offset is taken in each year to reflect the possibility that one-quarter of the participants would spend no more out-of-pocket that they otherwise would have had the program not been in place. State savings are based on a 50% state share.

Benefits of Proposal: The demonstration will encourage consumers (particularly those for whom private LTC insurance is not viable) to spend more of their own resources on LTC services, and to lessen reliance on Medicaid.

Concerns with Proposal: Unless the program is targeted mainly at individuals who are unable to obtain LTC insurance, there is the possibility it could further discourage advance planning and insurance purchases. It is also possible that some number of individuals who are currently expending substantially all of their assets to pay privately for LTC services could preserve additional assets under this program, thus increasing Medicaid costs.

Asset divestiture – giving away one's assets or converting non-exempt assets to exempt assets to avoid out of pocket spending for LTC – is a prevalent and growing problem,

especially in New York. Unless complementary efforts are made to place more restrictions on this activity (elimination of spousal refusal, pursuing estate recoveries, applying asset transfer penalties to home care, etc.) and to encourage responsible planning (e.g., LTC insurance, reverse mortgages, etc.), efforts such as this demonstration are unlikely to achieve the desired outcomes.

Impacted Stakeholders: Recipients, the Medicaid program, local social services districts and providers

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: DOH or its contractor(s) will need to initiate systems to administer the program.

Metrics to Track Savings: Actual asset pledges and fulfillment of those pledges represent potentially avoided Medicaid costs.

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Proposals to Redesign Medicaid
Proposal #:8A

Proposal (Short Title): State takeover of collection of cost-sharing amounts

Program Area: Long Term Care

Effective Date: 7/1/11 **Implementation Complexity:** Medium
Implementation Timeline: Medium

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The state would take over responsibility, directly or through contractors, for collecting Medicaid cost-sharing amounts from recipients in nursing homes, home care and assisted living programs (ALPs).

Under current state law and regulations, Medicaid providers are responsible for collecting cost-sharing amounts from Medicaid recipients. These amounts reflect the recipient's responsibility for contributing a portion of his/her income, as determined through the Medicaid budgeting process. The cost-sharing amounts are commonly referred to as the "net available monthly income (NAMI)" of nursing home residents and the Medicaid "spend-down" amount for recipients receiving services from home care agencies and ALPs. Typical sources of this income include Social Security, private pensions and retirement account distributions. These amounts are deducted from the amounts that providers then bill to the Medicaid program.

Medicaid providers oftentimes have difficulty collecting these amounts due to delays in obtaining eligibility determinations, inadequate information on changes in income, uncooperative families and the involvement of elder law attorneys. Since the uncollectible amounts are oftentimes not worth the legal expenses associated with pursuing them, providers are forced to write them off. Regulations do allow for discharge for failure to pay, but the reality is that providers are unable to discharge such individuals because they cannot assure that another provider would admit the non-paying recipient and cannot "abandon" a recipient who needs services.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0	$0	$6.9 million	$6.9 million
Total Savings	$0	$0	$13.8 million	$13.8 million

Note: Estimates assume that (1) SNF NAMI collection activities account for 5 percent of annual Medicaid allowable administrative/fiscal costs of $585 million ($29.3 million); (2) CHHA and LTHHCP spend down collection activities account for 5% of CHHA and LTHHCP Fiscal/Admin costs of $180 million reduced by half to adjust for fiscal/admin cap ($4.5 million); (3) it would cost $20 million per year for the state to assume or contract for NAMI collections; and (5) state savings beginning when cost year is used as the reimbursement base year.

Benefits of Proposal: By effectively turning hundreds of providers into the Medicaid system's bill collectors, the state has imposed tremendous added administrative/fiscal/ legal costs on these organizations and diffused the efforts. Moreover, providers often do

not have the capacity or the leverage needed to be effective bill collectors. Centralizing this function across Medicaid would create significant economies of scale, and take advantage of the state's greater official standing and ability to obtain collections. The actual collection function could be placed with the state directly or contracted out to one or more private companies. The state could mandate how the payment is made (e.g., direct pay), similar to collection methods used in the child support system.

As suggested above, both the state and providers would save money. State savings would derive from reductions in reimbursable administrative/fiscal costs, and providers would see reductions in these same costs as well as reduced bad debts expenses. Stronger enforcement of collections would also send a message to the public that the state considers the responsibility for meeting these obligations an important one.

Concerns with Proposal: None

Impacted Stakeholders: Providers, recipients, the state and any contractors utilized

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: The state would need to develop processes and protocols for the collection function.

Metrics to Track Savings: Reductions in providers' reported administrative/fiscal costs and bad debt and increases in overall collections of cost sharing amounts.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:9A

Proposal (Short Title): CCRC reform for Medicaid savings and economic development

Program Area: Long Term Care

Effective Date: 07/01/11 **Implementation Complexity:** Medium
Implementation Timeline: Long

Required Approvals: _X_ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: In a fiscal climate that calls for encouraging economic development and containing public spending, increased CCRC development would meet both of these important goals. Residents of CCRCs invest their assets into the CCRC for residential and health-related services, which in turn obviates the need to rely on Medicaid to cover such costs. In addition, the residents of the CCRC spend their income in the community, contributing to the economic growth of the local economy.

The state should address duplicative and costly CCRC regulations that hinder new development and increased operational costs. After 21 years of CCRC development, New York has only 13 CCRCs with one in pre-approval status. In comparison, Pennsylvania has more than 150 CCRCs. Perhaps hundreds of New York seniors each year are moving out of state due to less expensive, more flexible CCRC options or divesting their assets to obtain Medicaid coverage for their long term care services. New York needs to reduce duplicative and costly CCRC regulations and allow the ability of CCRCs to offer more resident contract options that would result in more New York seniors remaining in their local communities.

The state should make the following changes to increase CCRC development:

1. Allow for less restrictive reserve and investment policies for CCRCS regulated under Regulation 140 by the Department of Insurance (DOI). NYAHSA has been developing a proposal to DOI that will provide needed regulatory changes that would lower CCRC costs, reduce resident annual fees, increase CCRC marketability, and increase CCRC development.
2. Currently Article 46 Life Care CCRCs are not allowed to offer fee-for-service (FFS) contracts. FFS CCRC and contacts are especially attractive to the younger senior and those already paying for long term care insurance. In order to compete with surrounding states in offering a wide variety of retirement community options, and to offer incentives for New York seniors to pay for their long term care services, a FFS option should be available to life care CCRCs. NYAHSA has a legislative proposal to allow life care CCRCs to offer FFS contracts.
3. Article 46 currently does not permit CCRCs to provide “Life Care at Home” contracts to seniors who would like to live and secure services outside the CCRC’s campus community and in their private home. A Life Care at Home

product offers consumers' choices from a menu of services based upon their individual needs that are coordinated by a case manager. Life Care at Home allows CCRCs to reach out to seniors at lower income levels, including more "middle-income" New Yorkers. Life Care at Home is another product that will encourage seniors to pay for their own long term care services and not divest their assets to obtain Medicaid.

4. The Department of Health (DOH) has stipulated regulations that restrict direct admissions (non-residents) into the adult care facility and nursing home levels of care after seven years of operation. These regulations prevent admissions into these levels of care when there are openings and a senior living in the community would like to live there. This policy would have a severe negative financial impact on the CCRC, would increase resident costs, and prevent sponsors from developing CCRCs. DOH should revise the direct admissions policy to allow unrestricted access to direct admissions into the adult care facility and nursing home levels of care provided it does not impact resident access.
5. New York CCRCs are regulated by DOH and the Department of Insurance. New York is the only State to have specialized actuarial requirements and a State actuarial review, resulting in unnecessary and costly oversight. Governor Cuomo has proposed the creation of a Department of Financial Regulation, which would merge the Banking Department, the Department of Insurance and the Consumer Protection Board. This consolidation is an opportunity to provide regulatory oversight efficiency for CCRCs.

   New York CCRCs already have strict financial oversight to ensure financial solvency including:

   - Article 46 requires significant cash reserves for debt service and operating expenses;
   - Article 46 contains strict requirements which must be met prior to proceeding with new construction and expansion, including a presales and feasibility study prepared by an independent firm;
   - Strict lender criteria and requirements, including loan-to-value limits, financial ratio covenants, feasibility study prepared by an independent consultant;
   - The CCRC Council reviews and approves Certificate of Authority and Certificate of Authorization applications, with the Department of Insurance as a standing member of the Council.

   Streamlining CCRC regulatory oversight by having only DOH's Bureau of Continuing Care Initiatives (the same bureau that regulates managed long term care programs) provide CCRC regulatory oversight would reduce costs and increase efficiency for both the state and CCRCs.

Fiscal Impact For Each CCRC Developed:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings		* $415,826	* $415,826	* $415,826
Total Savings		$831,653	$831,653	$831,653

Note: Estimates based on Medicaid savings of opening one CCRC in which conservatively one-quarter of the CCRC residents would have divested their assts to obtain Medicaid services. The average CCRC has

42 nursing home beds, times the annual state-share SNF Medicaid rate in Westchester County of $217.00, times 365 days.* Estimates assume: (1) savings from new development would not start until SFY 2012-13; and (2) state savings are based on 50% state share.

With only 13 CCRCs currently operating in New York, the state is conservatively saving $5.4 million each year in Medicaid savings, with a total annual saving of $10.8 million. When CCRCs were authorized in 1989 it was estimated there would be over 100 CCRC developed in New York State by this time. **If even half of the projected CCRCs were developed (50) the annual state Medicaid savings would be $20.7 million, with an annual total savings of $41.5 million.**

In addition, there are Medicaid savings from encouraging FFS CCRC and Life Care at Home contracts that would allow for seniors to pay private dollars for non-institutional services which would delay or prevent nursing home (and most times) Medicaid services.

Benefits of Proposal: These CCRC legislative and regulatory changes would allow for increased CCRC development an expansion; provide incentives for New York seniors to pay for their long term care needs through a CCRC; prevent divesting assets to qualify for Medicaid; increase CCRC and state operational efficiency; increase retirement community options therefore encouraging seniors to remain in New York; and increase economic development throughout the state.

Concerns with Proposal: Consumer financial protections and safeguards can be provided by NYAHSA in combining all CCRC oversight into the Department of Health.

Impacted Stakeholders: New York State; New York seniors; CCRC providers; local economy.

Additional Technical Detail: (If needed, to evaluate proposal) NYAHSA can provide proposed changes to Regulation 140; the bill language to allow life care CCRCs to offer fee-for-service contracts; a proposal paper on the benefits of Life Care at Home; and a letter describing the reason for changing the direct admissions policy for CCRCs.

Systems Implications: Moving duties for CCRC oversight currently within the Department of Insurance to the Department of Health.

Metrics to Track Savings: Increased CCRC applications to DOH; reduced Medicaid applications in counties with CCRCs; increased economic development through construction jobs and ongoing staffing (the average CCRC employs approximately 300 construction workers and 200 full time employees after operation); and reduced out migration of seniors moving to surrounding states for retirement communities with more flexible options.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:10A

Proposal (Short Title): Cost savings in personal care programs

Program Area: Long Term Care

Effective Date: 10/01/11 **Implementation Complexity:** (Med)
Implementation Timeline: (Short Term)

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Consumers with complex care needs that require more personal care assistance (PCA) hours costing more than 75% of the average nursing home cost for that region would enroll in a care management program of their choosing. Programs that currently have a care management component are the Long Term Home Health Care Program (LTHHCP), Nursing Home Transition and Diversion (NHTD) program, the Program for All-inclusive Care for the Elderly (PACE), Medicaid Managed Long Term Care (MMLTC) and Medicaid Advantage Plus (MAP).

The high utilization of PCA suggests the need for care management, and which these programs have a track record of doing, at lower cost. This proposal would include PCA received through all state plan services including the consumer directed personal assistance program.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$23.8 million	$47.5 million	$47.5 million	$47.5 million
Total Savings	$47.5 million	$95.0 million	$95.0 million	$95.0 million

Note: Estimates assume: (1) SFY 2011-12 savings reflect one-half of annual value; and (2) state savings are based on 50% state share.

Benefits of Proposal: In addition to an estimated overall savings of $95 million it would also ensure utilizing the care management component that would integrate and coordinate service delivery. This in turn could lead to improving quality outcomes, especially for those consumers with complex care needs. This proposal would result in greater oversight and accountability for the personal care system.

Concerns with Proposal: The first concern is obtaining support and approval from the stakeholders to for the automatic enrollment into a care management model for those consumers who require a higher cost of personal care. The consumers who receive over 75% of the average nursing home costs equates to approximately 8-10 hours of personal care. Currently, in the LTHHCP there are very few consumers who receive over six hours of PCA a day, therefore this could be an issue for consumers with complex needs. (A Home and Community-Based Service System Reform Blueprint, Independence Care System, Nov. 2010). The second concern would be obtaining

approval from Centers for Medicare and Medicaid Services (CMS) to expand the number of participants for the LTHHCP and NHTD programs. The third concern may be the number of consumers who might need to be institutionalized if the care management models can not meet their service needs.

In addition, the expansion of the LTHHCP, NHTD waiver, PACE, MLTC and MAP during a time when resources and direct care workers are limited may pose a challenge.

Stakeholders: It is anticipated there would be a tremendous push back from consumer advocates who may perceive that consumer choice and Olmstead ruling might be undermined from this proposal. At the same time, individuals requiring a great deal of assistance are likely to be better served in a program in which their care is managed.

Additional Technical Detail: (If needed, to evaluate proposal)

- As of 2009 FFY there were 78,000 recipients receiving $2.3 billion in personal care services in NYS.
- $1.8 billion of PCA costs are for 54,600 New York City recipients as per the Medicaid claims data reports. Of those 54,600 recipients a conservative estimate of 3% or 1,700 recipients receive 24 hours of PCA a day as per as civil lawsuit brought against NYC for improperly authorizing 24 hours of PCA. (Crain's Business Weekly, 1/12/2011). The lawsuit stated NYC improperly authorized care for a "substantial percentage" of some 17,500 Medicaid recipients who got 24-hour care since 2000. The cost for each patient ranged from $75,000 for a single aide to $150,000 a year for several aides.

Conservative savings scenario:

- 1,700 consumers receiving 24 hours of PCA 7 days a week at a cost of $110,000 year, enrolling the consumer in a LTHHCP that cap the cost at 75% of nursing home that is currently at $65,700 would result in a savings of $44,300 per recipient. Total savings of $75 million, NYS share $37.5 million.

Same scenario but enrolling the consumer in MLTC:

- Cost of MLTC $54,000, savings per consumer of $56,000. Total savings of $95 million, NYS share $47.5 million.

Systems Implications:

Metrics to Track Savings: Medicaid Claims Data Reports

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:11A

Proposal (Short Title): Reorganize personal care program

Program Area: Long Term Care

Effective Date: 90 days from date of passage

Implementation Complexity: Medium
Implementation Timeline: Long Term

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Reorganize the personal care program to ensure that that accountability and risk are shared among patients, providers and payers, and that opportunities in the federal Affordable Care Act (ACA) to increase federal financial participation are leveraged.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Increase in federal funding to the state through the ACA and cost savings through better case management.

Concerns with Proposal: None

Impacted Stakeholders: Personal care programs and recipients

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:12A

Proposal (Short Title): Speed up admission process to adult care facilities (ACFs) and assisted living (AL) by allowing nurse practitioners to sign medical evaluations.

Program Area: Long Term Care

Effective Date: 10/1/11

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: ___ Administrative Action X Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Currently, Article 7 of the Social Security Act, § 461-c.7, requires that a physician examine individuals and complete a Medical Evaluation regarding the individual's appropriateness for ACF/AL services and overall needs. We propose that nurse practitioners be able to serve this same function and be able to sign Medical Evaluations for ACFs, Assisted Living Residences (ALRs) and Assisted Living Programs (ALPs). In nursing homes, nurse practitioners are empowered to do analogous functions.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$112,000	$223,000	$223,000	$223,000
Total Savings	$223,000	$446,000	$446,000	$446,000

Note: Estimates assume: (1) 10 Medicaid-eligible individuals per year would be diverted from nursing home admissions -- five into ALP at 50% cost of nursing home care and five into ALR/ACF saving 100% cost of nursing home care; (2) average nursing home rate of $200 reduced to $163 to reflect the acuity of the lowest RUG categories and an ALP rate of $81.50 (50% of the nursing home rate); (3)SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

Benefits of Proposal: This would speed up the admission process to ACFs, ALRs and ALPs, which conceivably could prevent a small number of unnecessary nursing home placements. More importantly, it makes better use of resources in the system and ensures seniors get the services they need more quickly.

Concerns with Proposal: None. Nurse practitioners are allowed to do similar functions in nursing homes.

Impacted Stakeholders: Frail seniors needing ACF/AL services as quickly as possible will benefit from this change. Physicians will be able to dedicate their time to other needs and delegate these tasks to a nurse practitioner who is more than capable of conducting. ACF and Assisted Living providers would likely have increased compliance with getting the evaluations done in a timely manner per the DOH requirements.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: None.

Metrics to Track Savings: To fully track the impact of the provision would require new reporting or at least a provider survey which may not be warranted given the modest savings.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:13A

Proposal (Short Title): Assisted Living Program contracting

Program Area: Long Term Care

Effective Date: 90 days from effective date

Implementation Complexity: Med
Implementation Timeline: (Short)

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Eliminate the requirement for an assisted living program (ALP) to contract with a certified home health agency (CHHA) or LTHHCP, and allow the ALP's licensed home care services agency (LHCSA) to provide all services it otherwise can to people living in the community.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Simplify and streamline the process of providing services to ALP residents.

Concerns with Proposal: None

Impacted Stakeholders: ALPs, home care agencies

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:14A

Proposal (Short Title): Restructuring the administration of all home and community-based 1915(c) waiver programs

Program Area: Long Term Care

Effective Date: 4/1/11 **Implementation Complexity:** (Med)
Implementation Timeline: (Short Term)

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Redesign the administrative structure within the DOH for all federal Medicaid 1915(c) waivers, including the Long Term Home Health Care Program (LTHHCP), Nursing Home Transition and Diversion (NHTD) program, Individuals with a Traumatic Brain Injury (TBI) program and Care at Home, to create centralized access for all waiver providers. This would eliminate unnecessary and duplicative functions at the state level. There is approximately twenty staff that performing similar functions for the waivers. Local districts, such as Herkimer County have implemented this administrative approach and have found several advantages to manage the waivers in one area.

The oversight at the State level could be accomplished in the same manner.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$125,000	$250,000	$250,000	$250,000
Total Savings	$250,000	$500,000	$500,000	$500,000

Note: Estimates assume: (1) administrative costs avoided are Medicaid administrative costs subject to FFP (2) SFY 2011-12 savings reflect one-half of annual value; and (3) state savings are based on 50% state share.

Benefits of Proposal: In addition to an estimated saving of $500,000, it would also ensure a streamlined access and greater consistency of information. It could reduce duplication and create an overall improvement in the development and implementation of the HCBS waivers.

Concerns with Proposal:

- The elimination of several state jobs.
- Staff resistance to change in operations.
- Staff may require additional training on certain waiver components to ensure accuracy of information.

Stakeholders:
Positive impacts:

- Streamlined access to all waivers,
- Greater efficiencies when eliminating duplicative functions and centralized locations so providers can make one call instead of numerous calls.

Negative impacts:

- Elimination of state jobs.

Additional Technical Detail: (If needed, to evaluate proposal) As of 2011 there are over six waiver programs and each waiver program has a program director, a clinical/quality, enrollment, and management component. Elimination of several administrative positions could save approximately $500,000 in wages and benefits.

Systems Implications: None identified.

Metrics to Track Savings: Payroll and benefits expenses for the Office of Long Term Care.

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Stakeholder Group: NYSHFA and NYAHSA
Proposals to Redesign Medicaid
Proposal #15A

Proposal (Short Title): Medical Malpractice -- Allow Arbitration Agreements

Program Area: Long Term Care

Effective Date: 04/01/11 **Implementation Complexity**: Low

Implementation Timeline: Short-Term

Required Approvals: __ Administrative Action _X_ Statutory Change
__ State Plan Amend __ Federal Waiver

Proposal Background / Description:

In an arbitration clause, the parties agree in advance to waive the right to a trial by jury and to submit any future claim or controversy between them to binding arbitration. Under current Public Health Law § 2801-d(7), however, the waiver of the right to commence an "action" against a nursing home under section 2801-d, "whether oral or in writing, shall be null and void and without legal force or effect." Similarly, under current Public Health Law § 2801-d(8), any waiver of the right to a trial by jury "whether oral or in writing, prior to the commencement of an action, shall be null and void, and without legal force or effect." The effect of these provisions is to invalidate the use of pre-dispute arbitration agreements in nursing homes in New York.

The repeal of these anti-arbitration provisions would eliminate the bar against arbitration agreements in the nursing home context.

Benefits of Proposal

Arbitration is advantageous, because it is fair and efficient, quicker and much less expensive than litigation, and it relieves court congestion.

Additionally, the Federal Arbitration Act, 9 U.S.C. § 2 (the "FAA"), embodies a strong federal policy favoring the arbitration of disputes over litigation. To that end, the FAA requires the enforcement of written arbitration agreements in transactions "involving commerce." *See*, e.g., *Citizens Bank v. Alafabro, Inc.*, 539 U.S. 52, 56-57 (2003) (*per curiam*). As construed by the U.S. Supreme Court, the FAA not only "declared a national policy favoring arbitration," but actually "withdrew the power of the states to require a judicial forum for the resolution of claims which the contracting parties agreed to resolve by arbitration." *Southland v. Keating*, 465 U.S. 1, 10 (1984). Thus, states cannot apply their anti-arbitration rules to invalidate arbitration clauses in agreements evidencing a transaction in commerce. If presented with the issue, New York courts would likely conclude that the FAA preempts the restrictions in Pub. Health Law § 2801-d(7) and (8) against the use of binding arbitration agreements between a nursing home and its residents.

In recent years, nursing homes have increasingly challenged similar state anti-arbitration clauses under the FAA. There is a growing body of case law invalidating, on preemption grounds, state statutes disfavoring or prohibiting binding arbitration

agreements between a nursing home and its residents. *See*, e.g., *Owens v. Coosa Valley Health Care, Inc.* 890 So.2d 983 (Ala. 2004); *Briarcliff Nursing Home, Inc. v. Turcotte*, 894 So.2d 661 (Ala. 2004); *Carter v. SSC Odin Operating Co., LLC*, 340 Ill. Dec. 196, 927 N.E.2d 1207 (Ill. 2010); *In re Nexion Health at Humble, Inc.*, 48 Tex. Sup. J. 805, 2005 Tex. LEXIS 422, No. 04-0360, 2005 WL (Tex. May 27, 2005). The repeal of Pub. Health Law § 2801-d(7) and (8) would bring the law in New York into line with the result in these other states.

Projected Cost Savings

Based upon a June 2009 study comparing the cost of arbitrated and non-arbitrated claims in long-term care, "the average total cost of an arbitrated outcome is about $123,000, while the average cost of a non-arbitrated outcome is about $194,000, making arbitrated outcomes about 37% less costly." Aon Global Risk Consulting, "The American Health Care Association: Special Study on Arbitration in the Long Term Care Industry" at 9 (June 16, 2009) (available at http://www.ahcancal.org/research_data/liability/Documents/2009ArbitrationStudy.pdf

Concerns with Proposal: Plaintiff's attorneys may object, as the use of arbitration agreements can be expected to reduce the cost and complexity of resolving disputes and correspondingly, limit attorneys' fees.

Impacted Stakeholders: Nursing home operators, nursing home insurers, residents of residential health care facilities.

Additional Technical Detail: None

Systems Implications:

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Stakeholder Group: NYAHSA and NYSHFA
Proposals to Redesign Medicaid
Proposal #:16A

Proposal (Short Title): Repeal Section 2801-d of the Public Health Law

Program Area: Long Term Care

Effective Date: 60 days from enactment

Implementation Complexity: (Low)
Implementation Timeline: (Short-term)

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Repeal of Section 2801-d of the Public Health Law, which provides a right of action by nursing home residents for alleged violations of a resident-care statute or regulation, without necessarily proving actual resident harm, as well as class action lawsuits and awards of punitive damages and attorneys' fees.

Section 2801-d is no longer necessary and is anachronistic. This statute was enacted in 1975 in the wake of the nursing home abuse scandals of the early 1970s. In providing a statutory right of action in favor of nursing home residents, the legislative intent was to essentially establish the role of a resident "ombudsman", at a time when the Department of Health (DOH) was ineffectual in the survey process and tort actions against nursing homes were unheard of, with few plaintiffs' attorneys willing to prosecute actions on behalf of aggrieved nursing home residents.

The regulatory and legal landscape has changed dramatically over the past 35 years. The modern DOH has a robust nursing home survey and complaint process, with the authority to impose -- and a proven track record of imposing -- civil monetary penalties and fines along with other financial penalties against nursing homes for established violations of regulations affecting resident care. Moreover, Congress over the years has mandated a number of resident-centered conditions of participation that DOH as well as federal surveyors are charged with enforcing in the survey and complaint process. This regulatory scheme, strengthened over the years, adequately addresses resident-care violations, without the need for an additional statutory private right of action.

Finally, there has been an explosion of tort litigation, particularly targeted at nursing homes; today, there is no shortage of plaintiffs' counsel willing to sue nursing homes. Repeal of § 2801-d would remove a grossly unfair and unnecessary additional lever in extracting damages settlements now exercised by the nursing home plaintiffs' bar.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$1.48 million	$3.94 million	$3.94 million	$3.94 million
Total Savings	$2.96 million	$7.88 million	$7.88 million	$7.88 million

NOTE: Estimated fiscal savings assumes **for illustrative purposes only** that implementation of the proposal would result in a 5% reduction in total liability insurance and legal costs to all nursing homes. The figure for SFY 2011-12 assumes 4.5 months of savings (based on a July 1 effective date and assuming that policy renewals occur throughout the year), and state share savings is estimated at 50% of the total.

Reducing liability premiums would lower costs to nursing homes and ultimately to all payors, including Medicaid.

This past year, in California (which also provides a statutory right of action), a jury handed down a verdict of $613 million in statutory damages and $58 million in restitution damages against the operator of nursing homes for violating California law, without a finding of specific harm to patients (Lavender v. Skilled Healthcare Group, Inc.) The parties settled the case for $50 million. Repeal of Section 2801-d should prevent similar jury awards that are disproportionate to the level needed to actually compensate harmed residents, and in the process should lower nursing homes' insurance premiums.

Benefits of Proposal: These include the following:

(1) Reduces nursing home liability and associated insurance premiums, legal fees and the costs of settlements that could otherwise be expended on resident care;

(2) Enhances nursing homes' ability to manage risk;

(3) Eliminates excessive liability awards and costs unrelated to any actual resident harm;

(4) Eliminates a statutory right of action that is redundant and unnecessary in view of existing available common law causes of action for negligence or malpractice; and

(5) Eliminates an inequity in the New York state tort system of making nursing homes the only providers subject to this statutory right of action with enhanced remedies.

Concerns with Proposal: Plaintiff's attorneys will object, as this would give them one less avenue for pursuing claims and obtaining attorney's fees.

Impacted Stakeholders: Nursing homes as well as the payors of nursing home services, including Medicaid, that ultimately bear the additional liability and legal costs associated with § 2801-d actions.

Additional Technical Detail: The onerous provisions in § 2801-d establish a regime of virtually absolute liability on the part of nursing homes, including: (1) liability for alleged deprivation of any "right or benefit" under state or federal statute, code, rule or regulation established for residents; (2) authorization of class actions, naming all of a nursing home's residents as class members; (3) injunctive or declaratory relief; (4) award of compensatory damages in an "amount . . . no less than 25% of the daily per-patient rate of payment" – regardless of any actual (or lack of) physical harm to residents; (5) punitive damages; (6) award of reasonable attorneys' fees; (7) waiver of rights to sue, including arbitration agreements, deemed void; (8) damages awarded under Section 2801-d exempt from determining a resident's Medicaid eligibility; and (9) insurance premiums attributable to liability coverage under Section 2801-d not allowable costs for reimbursement purposes.

Systems Implications: None

Metrics to Track Savings: Reduction in the absolute amount or rate of increase of liability insurance and legal costs, as reported on the nursing home cost report.

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Stakeholder Group: NYAHSA and NYSHFA
Proposals to Redesign Medicaid
Proposal #:17A

Proposal (Short Title): Prohibit use of CMS 2567s from state annual surveys as evidence in malpractice/negligence cases

Program Area: Long Term Care

Effective Date: 60 days from enactment

Implementation Complexity: (Low)
Implementation Timeline: (Short-term)

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Nursing home statements of deficiency (SODs) appear on the CMS Form 2567. Once the nursing home's plan of correction (POC) is completed in response to the SOD, the combined SOD/POC is posted on both the Department of Health's (DOH's) Web site and the federal Nursing Home Compare Web site. The SODs result from the survey process and are intended to be a quality improvement tool, not to form the basis for a private party lawsuit.

Existing Public Health Law § 10(2) provides that written survey reports on questions of fact related to the enforcement of the Public Health Law, the sanitary code or any local health regulation shall be "*presumptive evidence of the facts so stated therein, and shall be received as such in all courts and places.*" When a facility "accepts" an SOD, this provision effectively makes the findings in the survey presumptively admissible in a court of law that can then be used by a private-party plaintiff in a lawsuit against the nursing home.

Subdivision (2) of Section 10 of the Public Health Law should be modified so as to limit this evidentiary presumption to application in DOH enforcement hearings and other regulatory administrative proceedings related directly to the survey process, and specifically to preclude use of DOH survey findings collaterally in any form of private action or proceeding against the nursing home or its staff.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.74 million	$1.97 million	$1.97 million	$1.97 million
Total Savings	$1.48 million	$3.94 million	$3.94 million	$3.94 million

NOTE: Estimated fiscal savings assumes **for illustrative purposes only** that implementation of the proposal would result in a 2.5% reduction in total liability insurance and legal costs to all nursing homes. The figure for SFY 2011-12 assumes 4.5 months of savings (based on a July 1 effective date and assuming that policy renewals occur throughout the year), and state share savings is estimated at 50% of the total.

Benefits of Proposal: There are several benefits to this proposal, including the following:

1. This proposal maintains the original intent of the public posting of the SOD/POC as a consumer guide, and minimizes its abuse in "fishing expeditions" by plaintiff attorneys seeking to generate litigation through private lawsuits.
2. This proposal maintains the original intent of the survey process as a quality assurance mechanism and removes the collateral legal consequences that inevitably result from the broad presumptive evidence standard. It may also result in fewer Informal Dispute Resolution (IDR) procedures (costly to both the state and providers), as many facilities now feel compelled to contest findings and resort to the IDR process out of purely defensive legal motives.
3. The relevance of a particular survey finding, issued at a given point in time based on findings relative to a specific resident population, may in fact be totally unrelated to circumstances alleged in a particular lawsuit and may not even affect the particular resident or residents who are suing. However, the presumptive evidence standard can be used to confuse facts and put the nursing home at a serious disadvantage in a court proceeding by, in essence, creating a "guilty until proven innocent" bias against the nursing home.
4. It is recognized and acknowledged by DOH that the survey process is subject to variability based on regional office practices and the subjectivity of individual surveyors. The presumptive evidence standard makes no allowance for this variability and subjectivity.
5. Ultimately, elimination of the presumptive evidence standard relative to private actions would contribute to fewer frivolous lawsuits, fewer costs associated with defending against such legal actions and fewer legal/court costs overall.
6. The proposal would maintain the presumptive evidence standard in relation to administrative hearings and other proceedings/processes of DOH that are directly related to the survey process.

Concerns with Proposal: None

Impacted Stakeholders: Nursing homes, consumers, legal community, DOH

Additional Technical Detail: (If needed, to evaluate proposal): None

Systems Implications: None

Metrics to Track Savings: Reduction in the absolute amount or rate of increase of liability insurance and legal costs, as reported on the nursing home cost report.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:18A

Proposal (Short Title): Provide access to affordable capital financing to develop senior living facilities

Program Area: Long Term Care

Effective Date: 07/01/11 **Implementation Complexity:** Medium
Implementation Timeline: Short

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Many senior living facilities were built in the 1970s or earlier and are now in need of significant renovation and modernization. In addition, there is a critical need for new capital to finance the construction or rehabilitation of CCRCs, assisted living, nursing homes and senior housing, and to deploy technologies in residential and home and community-based settings.

Traditionally, not-for-profit senior living and services organizations have very limited equity capital, which they have derived from either private (e.g., grants, bequests or donations) or public (e.g., government grants, demonstrations and capital cost reimbursement) sources. Access to low-cost capital is critical to their ability to transition or expand services, but these organizations are rarely considered investment-grade borrowers and therefore have very limited financing options.

in 1997, the Legislature expanded the definition of “civic facilities” to enable the use of Industrial Development Agency (IDA) financing for senior living facilities, including nursing homes, assisted living, retirement communities and CCRCs. A civic facility project may include “facilities” as defined in Article 28 of the Public Health Law (e.g., nursing homes) and senior residential communities, provided in each case the cost of such projects does not exceed $20 million. However, CCRCs were exempted from the $20 million cap. Granting access to IDA financing eliminated the need for credit enhancement required by the Public Authorities Control Board (PACB), allowing not-for-profit (NFP) sponsors that do not qualify for credit enhancement (letters of credit, FHA mortgage insurance or private bond insurance) to access the cost-effective tax-exempt bond market. However, this legislative authority was never made permanent, and civic facility and CCRC IDA authorization expired in January 2008 leaving NFP senior services providers, once again, without an affordable financing vehicle.

NYAHSA is concerned with provisions in the IDA bills currently under consideration by the Legislature that requires the payment of prevailing wages for all construction jobs. These provisions would add substantial costs to the development and operations of all senior housing communities – including affordable senior housing (Low Income Housing Tax Credit and “mixed” financed projects) market-rate retirement communities, assisted living facilities and nursing homes. In the case of affordable senior housing, a December 2008 report by the Citizens Housing and Planning Council (CHPC) concluded that imposing prevailing wages for affordable housing construction in New York City could

increase development costs by 25 percent, increasing resident rents by $400 per month.

The benefits to IDA development are many including lowering construction costs due to using tax-exempt bond financing, the use of a payment-in-lieu-of-taxes (PILOT) agreement and the ability to finance a debt to a lower interest rate (and therefore Medicaid savings) in a nursing home;

The state should make the following changes to increase senior housing development:

- Make industrial development agencies (IDAs) an ongoing financing source for senior living facility construction/renovation without imposing prevailing wage restrictions.
- Evaluate effective ways to expand lending programs through state public authorities or otherwise to provide for smaller loans for technology and building projects to below investment-grade organizations.
- Create a forum for collaboration and open discussions that bring together investment experts, private lenders, providers, government leaders and other representatives. The focus of discussions could include expanding access to private capital while preserving not-for-profit mission and identity.

One of last CCRCs able to finance through the IDA was Fox Run at Orchard Park which provides an excellent example of the impact of IDA financing and the surrounding community. Fox Run financed through the IDA on April 27, 2007 for $77.8 million. The project is a life care CCRC that consists of 180 independent living units, 51 enriched housing units and 50 skilled nursing beds.

Construction of Fox Run at Orchard Park generated a substantial economic boost for Orchard Park with over 350 construction jobs in an open-shop environment and 118 CCRC employees upon operation. Fox Run generates over $17 million of revenue to the local taxing jurisdictions over a 30-year payment in lieu of taxes (PILOT) agreement, with over $12 million going to the Orchard Park Central School District.

Fiscal Impact: Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings				
Total Savings				

It is difficult to provide the cost analysis of Medicaid savings to providing affordable capital financing to develop senior housing, yet considerable savings will be realized by refinancing existing debt at a lower rate including nursing homes and providing financing for non-institutional senior facilities such as retirement communities and CCRCs. For facilities with Medicaid capital reimbursement, Medicaid would save money directly through lower interest payments.

Using CCRCs as an example, with only 13 CCRCs currently operating in New York, the state is conservatively saving $5.4 million each year in Medicaid savings, with a total annual saving of $10.8 million. When CCRC were authorized in 1989 it was estimated there would be over 100 CCRC developed in New York State by this time. If even half of

the projected CCRCs were developed (50) the annual state Medicaid savings would be $20.7 million, with an annual total savings of $41.5 million.

Benefits of Proposal: Senior services organizations face tremendous challenges in raising the funds needed to undertake these projects, which are integral to rebalancing the LTC system and bringing more out-of-pocket and private insurance dollars to the table. These proposals will ensure that senior housing and long term care providers will be able to have access to the capital needed to provide modern and innovate housing to New York seniors. In addition, the state and local economic development benefits will be considerable with construction and ongoing operations jobs.

Concerns with Proposal:

Impacted Stakeholders: New York seniors; senior housing and long term care providers; state and local economy.

Additional Technical Detail: (If needed, to evaluate proposal) NYAHSA's testimony at the Assembly Hearing on Industrial Development Agencies on March 4, 2009.

Systems Implications: Developing an expanded lending program through a state public authority.

Metrics to Track Savings:

- Increased CCRC, retirement housing and nursing home financing and development;
- Increased economic development through construction jobs and ongoing staffing. The average CCRC employs approximately 300 construction workers and 200 full time employees after operation.
- Reduced out migration of seniors moving to surrounding states for retirement communities with more flexible options.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:19A

Proposal (Short Title): Nursing home sprinkler loan pool

Program Area: Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (Med)
Implementation Timeline: (Short)

Required Approvals: _X_ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The federal Centers for Medicare and Medicaid Services (CMS) is currently mandating that all nursing homes be fully sprinklered (click here.) CMS requires that all long term care facilities be equipped with sprinkler systems by August 13, 2013. The decision to implement this requirement is based upon the standards set forth in the 2006 edition of the National Fire Protection Association Life Safety Code (LSC). Prior to this, the 2000 edition of the LSC only required that new construction and remodeled portions of existing structures needed to be fully sprinklered. NYAHSA proposes that the state develop a loan pool that can be used to finance such projects.

For many facilities in New York, this represents a major capital expenditure, ranging from a few hundred thousand dollars to millions of dollars per facility, depending upon the scope of the upgrade need and other factors (e.g., potential asbestos abatement, etc.). Given the difficult financial circumstances of many nursing homes in the state, the ability to access the needed capital is proving extremely difficult, if not impossible in some cases. Where financing is accessible, the rates of interest being charged are excessive due to the fact that in many cases the nursing home is considered a high risk borrower and the loan amount is small.

Fiscal Impact (Dollars in Thousands):

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$10.5 million	$10.5 million		
Total Savings	$21.0 million	$21.0 million		

NOTE: This is a net present value amount which assumes a 1.5% interest reduction amortized over 15 years and 75 % Medicaid reimbursement based on percentage of Medicaid days divided evenly over two years.

Benefits of Proposal: The benefits of the proposal are two-fold. For the nursing home, it represents a means to access needed capital that might otherwise only be available at prohibitively high rates of interest.

Since the state reimburses facilities for interest expense through the capital component of the rate, if facilities are able to obtain the funding at a reduced rate, the state would

derive the savings and allow facilities to continue to operate. The state may also be able to operate the loan pool on a better than break even basis (e.g., the Dormitory Authority.)

The proposal also guarantees that facilities, which otherwise have usable and acceptable physical plants, can continue to operate without the need to completely replace those beds at a much higher cost.

Concerns with Proposal: None

Impacted Stakeholders: Nursing homes, Medicaid, financiers

Additional Technical Detail: (If needed, to evaluate proposal) The Dormitory Authority is a good model to use and could play a role in developing the financing pool without the need to develop any additional administrative overhead.

Systems Implications:

Metrics to Track Savings: Comparison of interest rate of financing pool to non-pool financing.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:20A

Proposal (Short Title): Shared Savings Program

Program Area: Long Term Care, other areas

Effective Date: Upon federal approval

Implementation Complexity: High
Implementation Timeline: Long Term

Required Approvals: ___ Administrative Action __X_ Statutory Change
_X_ State Plan Amend __X_ Federal Waiver

Proposal Background/Description: Negotiate a new shared savings agreement (i.e., similar to F-SHRP) with the federal government, aimed at decreasing the cost of Medicaid and utilizing the associated shared savings to fund grants to LTC providers to support many of the initiatives listed herein.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Shared savings and decreased Medicaid costs to the state.

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:1B

Proposal (Short Title): Create an interagency council to review the array of state programs and make recommendations on integrating senior housing with supportive services

Program Area: Long Term Care, Housing, Health Care and Managed Care

Effective Date: 03/01/11 **Implementation Complexity:** Low
Implementation Timeline: Long Term

Required Approvals: _X_ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The intent of the Interagency Council would be to problem solve the regulation barriers and investigate funding opportunities to assist seniors and people with disabilities to live more independently with home and community based services. The members of the Task Force would include staff from the Department of Health, New York State Office of Aging (NYSOFA), New York State Homes and Community Renewal, Department of State, Department of Insurance (DOI) and various stakeholders including associations and consumers.

Senior housing is the least restrictive, most affordable and most flexible congregate living arrangement in the senior living and services array. It offers an ideal platform for efficiently and effectively delivering home care, other health services and social and environmental supports. These services enable seniors to remain independent for as long as possible.

Discussions and action is needed now on how senior housing facilities can continue to make supportive services available, while promoting resident independence and not being arbitrarily subjected to licensure as adult care facilities and/or assisted living residences. At the same time, the state needs to provide infrastructure funding for new construction and coordinated services in senior housing, and otherwise help senior housing operators to make these supports available.

Issues to be discussed at the Interagency Council could include ensuring funding for supportive services funding through the Older Americans Act and NYSOFA; provide capital for affordable senior housing including restoring and expanding the Low Income Housing Tax Credit Program, CDBG and HOME programs; explore innovative housing with services models such as naturally occurring retirement communities (NORC) and “Village” models (Beacon Hill Village); and the practical application of technologies in senior housing to assist seniors remaining independent.

Fiscal Impact: Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	n/a	n/a	n/a	n/a
Total Savings	n/a	n/a	n/a	n/a

The fiscal impact of developing an Interagency Council would be minimal, while the potential financial benefits of finding innovate ways of allowing seniors to remain in independent senior housing and out of institutional care are great.

Benefits of Proposal: The benefits of developing an ongoing Interagency Council on senior hosing with supportive services include:

- Bringing agency staff, stakeholders and consumers together to examine issues in a holistic manner rather than a fragmented approach;
- Examine issues that are duplicative or onerous while examining approaches to providing system efficiencies; and
- Exploring cross-continuum initiatives that could produce Medicaid savings;

The benefits to developing home and community based programs would assist individuals to remain at home instead of being institutionalized in accordance with the *Olmstead* decision.

Concerns with Proposal: Historically it has been difficult to bring state agencies together to work on cross-continuum initiatives. Support and involvement from the Executive Office would be necessary to bring various state agencies together.

Impacted Stakeholders: The state would realize significant Medicaid savings and seniors would have the ability to live in more independent settings.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: Developing a mechanism to develop meaningful change through cross-agency participation.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:2B

Proposal (Short Title): Remove MLTC expansion moratorium

Program Area: Long Term Care

Effective Date: 7/1/11

Implementation Complexity: Low
Implementation Timeline: Short Term

Required Approvals: X Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Based on a desire of the state to increase the use of managed care that integrates Medicaid and Medicare, state policy prohibits the establishment or expansion of Medicaid-only ("Partial-Cap") MLTC plans. Enrollments into some integrated Medicaid Advantage Plus plans have been slow. Meanwhile, the largest and most experienced MLTC providers are prohibited from expanding into new areas due to the moratorium.

The state should lift the moratorium and allow existing plans to expand their service areas to maximize the number of individuals who have the option to enroll into an MLTC plan with which they are comfortable while the state continues to perfect integration.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$3.2 million	$6.3 million		
Total Savings	$6.3 million	$12.5 million		

Note: Estimates assume: (1) that the provision would facilitate enrollment of 500 individuals who otherwise require nursing home care; (2) a monthly Medicaid MLTC premium of $4,000 and a nursing home rate of $200; (3) SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

MLTC is a cost-effective model of LTC that costs Medicaid an average of $25,000 less per year than institutional placement.

Benefits of Proposal: More prospective enrollees would have the option to enroll into Partially Capitated MLTC plans with well-developed service networks, with the increased availability reducing the frequency of institutional placement. The removal of the moratorium could be used as an incentive to move providers towards integrated care.

Concerns with Proposal: MLTC plans that integrate Medicare and Medicaid services, such as PACE and MAP, offer care coordination advantages for dual eligibles and allow the state to align financial incentives. The impact on integrated plans of a short term increase in single-capitated plan enrollment needs to be weighed against the benefit of increased overall enrollments

Impacted Stakeholders: Individuals in need of MLTC care would be able to access this care more quickly. Single-Cap plans would be able to grow as they work towards integrating Medicare and Medicaid.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: This interim strategy could be used to move the system towards integration while at the same time maximizing the opportunities for those seeking this type of care.

Metrics to Track Savings: Measuring new enrollments in expansion areas would easily show whether an area has unfulfilled demand for MLTC. Although not included in the savings estimate, if used as an incentive to expand integration, the provision would also have other care quality improvement and cost savings in the long term.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:3B

Proposal (Short Title): Streamline ALP admission process

Program Area: Long Term Care

Effective Date: 10/1/11

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: X Administrative Action ___ State Plan Amend X Statutory Change ___ Federal Waiver

Proposal Background/Description: A combination of administrative requirements and legislative (Article 7 of the Social Services Law, Section 461-L), establishes a cumbersome and slow admission process for ALPs. Currently, the assessment process for an individual to enter the assisted living program (ALP) involves not only the ALP, but also the CHHA or LTHHCP that the ALP must contract with, and the LDSS. Involving all three parties makes it impossible for the process to move quickly. At the same time, individuals who are hospitalized and need the services that an ALP provides generally go to nursing homes because the assessment process essentially prevents ALPs from accepting individuals directly from the hospital.

If the assessment process were changed to enable the LDSS to conduct audits post-admission, and enable the ALP to conduct the assessment directly (we in fact recommend the elimination of the requirement for a contract with a CHHA or LTHHCP in another proposal), the state could prevent unnecessary nursing home placement.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$0.7 million	$1.3 million	$1.3 million	$1.3 million
Total Savings	$1.3 million	$2.5 million	$2.5 million	$2.5 million

Note: Estimates assume: (1) five percent of the 1,630 physical function RUG nursing home admissions where Medicaid was primary payor (resulting in 30,000 care days) would be shifted from NH to ALP; (2) average nursing home rate of $200 reduced to $163 to reflect the acuity of the lowest RUG categories and an ALP rate of $81.50 (50% of the nursing home rate); (3)SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

This change would enable the prevention of unnecessary nursing home placement for people needing to be discharged from a hospital, or those in crisis at home who cannot wait for the completion of the ALP assessment process to receive services.

Benefits of Proposal: In addition to Medicaid savings, this would make better use of scarce resources such as nurses and county staff. It also supports hospitals in the management of individuals post-discharge, and is to the state's benefit to have providers other than CHHAs and nursing homes ready to accept people from hospitals.

Concerns with Proposal: When the ALP was originally developed in the early 1990's, it seems there was a perception that the ACFs, historically a social model, needed the oversight of the CHHA and LTHHCP. Some may argue that this "oversight" is still needed, however we see it as duplicative and unnecessary. ACFs and ALPs have developed significantly and are adept in serving the needs of the frail elderly. The ALP's LHCSA must meet the requirements that a community LHCSA would, and is therefore prepared to meet the home care needs of the ALP residents.

The involvement of the LDSS in prospective screening prevents inappropriate admissions; however we believe the same objective can be met with post-admission audits.

Impacted Stakeholders: Individuals needing low-level nursing home services, hospitals and assisted living programs will benefit from these changes. CHHAs and LTHHCPs may object given the loss of contracts with ALPs, however we see continued opportunity for these entities to serve ALP residents and perhaps even develop partnerships and arrangements with ALPs. The LDSS may be benefit in being able to use their resources more efficiently.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: DOH and the LDSS would have to work to revise the admission process. This would not require the development of any new data/computer system, but rather a change in process.

Metrics to Track Savings: While an isolated causal relationship will be hard to determine, this proposal should result in an increase in ALP admissions.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:4B

Proposal (Short Title): Streamline enrollment into MLTC plans

Program Area: Long Term Care

Effective Date: 7/1/11

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: X Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: At this time, DSS or HRA reviews enrollment packets and performs assessments of individuals enrolling into managed long term care (MLTC) to ensure that the individual qualifies for the program. This is in addition to a similar assessment done by the plan. Delays in the DSS or HRA review or assessment may result in delays in plan enrollment in some areas of the state, especially in NY City where the bulk of MLTC is currently concentrated.

If the process were altered to allow plans to enroll applicants based on their assessment with DSS or HRA conducting a retrospective review and assessment, these delays could be avoided and individuals would be able to more easily enroll into these plans.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$300,000	$600,000	$600,000	$600,000
Total Savings	$600,000	$1.2 million	$1.2 million	$1.2 million

Note: Estimates assume: (1) that the provision would facilitate enrollment of 100 individuals who otherwise would have spent six months in an institutional setting; (2) a monthly Medicaid MLTC premium of $4,000 and a nursing home rate of $200; (3) SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

Delay in enrollment may result in hospitalization or institutional placement. If this change facilitated the enrollment of 100 prospective enrollees, the savings of avoided nursing care days would be considerable.

Benefits of Proposal: Individuals seeking long term care services are often in crisis or in need of immediate services due to hospital discharge or health event. Delays in enrollment can drive these individuals to more costly care. Streamlined enrollment would help ensure that individuals can access the care that is most appropriate to their needs at the time that they need it. Because higher cost settings are used if the appropriate setting is unavailable, by ensuring a smooth process the state is likely to realize a cost savings.

Concerns with Proposal: Retrospective review would place plans at risk of payment recoupment if they enroll someone who is not clinically eligible. Disenrollment would

likely disrupt the frail individuals care. Because plans report few disagreements with DSS/ HRA regarding enrollee appropriateness and because having payments for care provides is a significant incentive for plans to ensure accuracy in their enrollment process, this is unlikely to be a significant concern.

Impacted Stakeholders: Individuals in need of MLTC care would be able to access it more quickly.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: Streamlined enrollment would ensure this model of care is optimized for those who need it, thereby allowing other provider types to better utilize their capacity for individuals whose needs optimally meet the service they provide.

Metrics to Track Savings: While a measure of how many enrollments are facilitated by this provision would be difficult to isolate, it would be easy to track how many enrollments DSS/HRA reverses.

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Proposals to Redesign Medicaid
Proposal #:5B

Proposal (Short Title): Streamline LTHHCP admission process

Program Area: Long Term Care

Effective Date:

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals:

___ Administrative Action
___ State Plan Amend
X Statutory Change
? Federal Waiver

Proposal Background/Description: Currently, the assessment process for an individual to enter the long term home health care program (LTHHCP) involves the prospective review and authorization of the LDSS. This slows the admission process, which risks unnecessary nursing home placement of Medicaid-eligible individuals. In addition, the lack of ability to accept someone into the LTHHCP directly from the hospital (due to lengthy admission process) results in unnecessary nursing home placement for Medicaid-eligible individuals. Given the pressure that hospitals are under, there is little choice but to go with nursing home placement-the quickest transfer option-for someone with nursing home-level needs. Changing the admission process to enable the LDSS to conduct an audit post-admission would prevent unnecessary nursing home placement.

Fiscal Impact: Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings				
Total Savings				

This change would enable the prevention of unnecessary nursing home placement for people needing to be discharged from a hospital, or those in crisis at home who cannot wait for the completion of the LTHHCP assessment process to receive services.

Benefits of Proposal: In addition to Medicaid savings, this would make better use of scarce resources such as nurses and county staff. It also supports hospitals in the management of individuals post-discharge, and is to the state's benefit to have providers other than CHHAs and nursing homes ready to accept people from hospitals.

Concerns with Proposal: Eliminating the prospective authorization of the LDSS creates a risk that someone will be admitted to the program that is not thought to be appropriate. We believe that this is unlikely, however, and the post-admission review by the LDSS would help to ensure this did not occur. The provider could incur responsibility for an inappropriate admission, though there should be a third party review in the event of such a disagreement.

Impacted Stakeholders: Individuals needing low-level nursing home services will benefit from being able to remain in the community and not have to go to a nursing home, even for a short term stay. Hospitals will benefit from having additional discharge options for patients with significant needs other than nursing homes. LTHHCPs will benefit from having a greater caseload. The LDSS may be benefit in being able to use their resources more efficiently.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: DOH and the LDSS would have to work to revise the admission process. This would not require the development of any new data/computer system, but rather a change in process.

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:6B

Proposal (Short Title): NYSOFA and OAA Funding

Program Area: Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: Low
Implementation Timeline: Short

Required Approvals: ___ Administrative Action __X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Ensure NYS Office for the Aging and Older Americans Act programs are adequately funded to delay/prevent reliance on more expensive Medicaid funded services.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Adequately funding lower cost programs ensures savings for higher cost Medicaid programs.

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:7B

Proposal (Short Title): Ensuring low income housing options

Program Area: Housing, Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (High/Med/Low)
Implementation Timeline: (Short/Long Term)

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Restore and expand the Low Income Housing Tax Credit program, the Low Income Housing Trust Fund program and the HOME program to promote senior housing development.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Ensuring the availability of low income housing options provides a foundation for providing community based services and avoiding higher cost institutional care.

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:8B

Proposal (Short Title): Community models option

Program Area: Housing, Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (Low)
Implementation Timeline: (Short Term)

Required Approvals: ___ Administrative Action __X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Expand supportive community models including naturally occurring retirement communities (NORCs), Villages and Aging Friendly Communities.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Ensuring the availability of low income housing options provides a foundation for providing community based services and avoiding higher cost institutional care.

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:9B

Proposal (Short Title): Independent Senior Housing Resident Freedom of Choice Act

Program Area: Senior Housing

Effective Date: 06/01/11 **Implementation Complexity:** Low
Implementation Timeline: Short

Required Approvals: ___ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Complex state statutes and regulations governing the operation of and services provided in congregate settings have caused a lack of clarity with regard to the rights and opportunities of senior citizens and persons with disabilities residing in independent housing to choose and access services from the community. These services are available to such individuals if they reside in their own private homes.

Such community-based services help seniors, in private homes and independent housing alike, to "age in place" and remain living in the less restrictive, more integrated setting. Residents have rights under, and housing providers must comply with, the Fair Housing Act (FHA), Americans with Disabilities Act (ADA), and the U.S. Supreme Court's *Olmstead* decision. The ability of seniors and disabled individuals to choose to remain in independent housing and select their own health care and supportive services are critical components of these laws and policies.

This proposal amends the public health law in relation to establishing the Independent Senior Housing Resident Freedom of Choice Act.

Fiscal Impact: Enacting this law could save the State millions in unnecessary placements of seniors into hospitals, nursing homes and other institutional-type settings.

Benefits of Proposal: Ensuring access to such services also furthers New York State's policy of promoting access to community living and community-based services to maintain the health and quality of life of senior citizens and the disabled, as well as to prevent avoidable and costly admissions to medical and other institutional-type facilities. The Independent Senior Housing Resident Freedom of Choice Act would clarify and declare the rights of seniors and persons with disabilities to choose, live and access services in independent housing including personal care, home care, case management, technologies and other community services that support them to live independently in the community.

Concerns with Proposal: None

Impacted Stakeholders: New York seniors, New York State, service providers

Additional Technical Detail: Section 2 of the bill would amend paragraph (j) of subdivision 1 of section 4651 of the public health law to:

1) change the term “facility” to “operator” to be consistent throughout the definition;

2) clarify that any number of residents living in senior housing can obtain personal care or home care services from any licensed or certified home care agency depending on the individual needs of the residents at any given time, as they would otherwise obtain if they were living in their own private home;

3) clarify that residents of independent senior housing can obtain personal care or home care services from any licensed or certified home care agency, personal care program, long term home health care program, or managed long term care program of their choosing that provides services in that location;

4) clarify that a licensed or certified home care agency, personal care program, long term home health care program, or managed long term care program under the authority of its own licensure or certificate is able to perform outreach, arrange, or provide home care services to the residents, so that a resident will have a choice from all available home or personal care service providers and access to any services they would otherwise have access to if living in their own private home;

5) clarify that a resident of independent senior housing has the ability to obtain technologies that assist in maintaining independence, as they would if they were living in their own private home; and

6) clarify activities allowed by the housing operator.

Systems Implications: None

Metrics to Track Savings: The reduction of short-term and long-term placements from independent housing facilities into institutional settings.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:10B

Proposal (Short Title): Expand assisted living options for Medicaid-eligible individuals

Program Area: Long Term Care

Effective Date: Variable, depending on strategy. Could be implemented relatively quickly, but for the most part would take at least a year to become operational.

Implementation Complexity: Low to High, depending on strategy
Implementation Timeline: Short to Long, depending on strategy

Required Approvals: ___ Administrative Action X Statutory Change
possibly State Plan Amend *possibly* Federal Waiver

Proposal Background/Description: New York should expand options for Medicaid-eligible individuals to receive assisted living services, preventing nursing home placement at a greater cost to Medicaid. There are a few ways to achieve this option:

1. ***Expansion of the Assisted Living Program (ALP).*** The ALP is New York's current and only Medicaid-funded assisted living option. Historically capped at 4,200 beds, initiatives in recent years will more than double the program in the years to come. The current process by which the beds are being doled out, however, has been slow. While we agree that DOH should continue to prioritize Nursing Homes that want to decertify beds to create ALP programs, existing ACFs and ALPs could quickly start a program and help to realize Medicaid savings more quickly. Perhaps the state should target a number of beds for the primary aim of getting the slots operational within a period of months (as opposed to years).
2. ***Finding a way for the Assisted Living Residence (ALR) to have access to the ALP Medicaid reimbursement.*** The ALR is a private pay-only model. There may be a way for the ALR to access the ALP Medicaid reimbursement, to extend those options to ALR residents. This process would beg several logistical questions, however, which are noted below.
3. ***Creating a new Medicaid funding stream for the ALR.*** This would have to be achieved either through an ALP-like program making use of the Medicaid personal care benefit, or through the development of a new assisted living federal waiver. The benefit of this strategy is the ability to extend all assisted living options to Medicaid-eligible individuals, rather than just one model. It also allows access to the special needs ALR, for people with dementia/cognitive impairment, which has significant possibilities for further Medicaid savings given the possibilities for preventing nursing home placement. This strategy is rather complex to implement, however, and is likely to take a year or more to implement. It also raises other challenges, mentioned below.
4. ***Examining ways to make better use of our existing home and community based waivers.*** Yet another option is to explore how existing home and community based waivers could work better with the new ALR, EALR and SNALR models. Historically, this combination of services-while attractive on paper-has not worked well in ACFs. The key to any possible success (which is

questionable) would hinge on DOH's ability to work with providers to eliminate the barriers to coordination of care and services, to clarify what is required of each entity, and to eliminate duplication of services and effort wherever possible.

At the very least, New York should continue to provide financial support (such as SSI, the Enriched Housing Subsidy and EQUAL funding) to adult care facilities and assisted living facilities that serve low-income individuals as this supports the prevention of nursing home placement at cost to Medicaid.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$2.95 million	$5.9 million	$5.9 million	$5.9 million
Total Savings	$5.9 million	$11.8 million	$11.8 million	$11.8 million

Note: Estimates assume: (1) that based on statewide average Medicaid rates of ALP and nursing homes (adjusted to reflect lower acuity residents), Medicaid saves $163 per nursing home care day avoided and $81.50 per care day that is transferred from a nursing home to ALP; (2) a shift of 2 percent of the current 19,800 nursing home Medicaid admissions to ALP; (3) SFY 2011-12 savings reflect one-half of annual value; and (4) state savings are based on 50% state share.

Benefits of Proposal: The expansion of assisted living options for Medicaid-eligible individuals is beneficial in multiple ways. Not only does it save Medicaid dollars, but it could also assist New York in becoming eligible for two different Federal Health Care Reform initiatives which would actually bring in more federal dollars. The Community First Choice option of the Patient Protection and Affordable Care Act (PPACA) allows states to receive a 6% increase in their Federal Medical Assistance Percentage (FMAP) if they increase the access to personal attendant care for individuals on Medicaid that have a skilled need. Because the ALP—New York's only Medicaid- funded assisted living option—hinges on the personal care benefit, it is possible that expansion of the ALP could contribute to New York's eligibility for this increase in FMAP.

The HCBS Rebalancing Incentive Program of the PPACA provides enhanced federal matching payments to states to increase the proportion of Medicaid long-term services and supports dollars that go toward HCBS. In New York, less than 50 percent of our total Medicaid long-term services and supports spending is for home and community based services (HCBS). This makes the state eligible for a 2% increase in FMAP for HCBS programs if certain re-balancing goals are met and the state implements the following reforms, much of which is already under way in the state: no wrong door / single Point of Entry, conflict-free case management program, and core standardized assessment. The expansion of Medicaid-funded assisted living options could contribute to the state's rebalancing targets, whether funding the ALP (through the personal care benefit) or a new funding mechanism such as a federal waiver.

Concerns with Proposal: First and foremost, the existing structure of ACF and AL and the subsequent categories of licensure and certification is exceptionally confusing to the consumer, to the provider and even to state oversight. With the creation of the ALR, we have created a model for the "haves", as opposed to the ALP, for the "have-nots". This is unfortunate, and we hesitate to further exacerbate that divide, even though expansion of the ALP is the simplest mechanism to expand options for low-income seniors under our current infrastructure.

At the same time, creating a Medicaid-funding stream for the ALR, Enhanced ALR and Special Needs ALR is a huge undertaking. It would require the development of either an amendment to the state plan to incorporate these facilities into the mechanism by which ALPs access Medicaid (the personal care benefit)-which begs a variety of questions such as whether the ALR must meet ALP requirements, and how to adjust the reimbursement level to accommodate for the additional resources an EALR or SNALR resident would need. The other option to create a federal waiver would be administratively complex, take a great deal of time and further complicate the existing array of waiver programs New York currently operates.

Regardless of the avenue the state took, the amount of time that the state is taking to review CONs for new AL providers is considerable, meaning that it would take at least a year for any providers of AL to be operational, thereby delaying much of the potential savings.

Impacted Stakeholders: Medicaid-eligible individuals requiring some assistance who don't need nursing home placement, if other options were available, would benefit greatly. Many of these individuals go to nursing homes because there is no other suitable option.

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings: Incorporating Medicaid funding into ALR would increase viable alternatives to nursing home placement for low-income individuals with less intensive medical needs. The increased costs would need to be compared to the Medicaid SNF rate. The fiscal impact estimates exclude any of these potential savings.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:11B

Proposal (Short Title): Authorize medication technicians in LTC settings

Program Area: Long Term Care

Effective Date: 10/1/11 **Implementation Complexity:** Med
Implementation Timeline: Long Term

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Nursing homes, assisted living and home care agencies would have the option to utilize specially trained medication technicians to dispense medications to residents/patients.

Nursing homes, assisted living facilities, home care agencies, and other health care providers are faced with a shortage of nurses. Many nurses express dissatisfaction with the repetitive task of routine medication administration consuming most of their time, leaving little time for bedside care to the patient. Meanwhile, certified nurse aides, personal care aides and home health aides are leaving health care to pursue other jobs due to wage restrictions and job satisfaction. Additional responsibilities can provide increased job satisfaction, allow for wage increases, and promote retention of staff.

Elderly people are often placed in more restrictive and more costly environments, due to the limitations of the medication administration in assisted living and community adult care programs.

At least 28 other states have authorized the use of medication aides in nursing homes and assisted living facilities. The state's developmentally disabled system has used medication techs for many years with positive outcomes. Studies have shown an actual decrease in medication errors with administration performed by medication technicians.

The proposal envisions a specialized training program primarily aimed at certified nurse aides, personal care aides and home health aides. The medication technician position should be created as a universal position in the health care delivery system in New York, but also the full scope of practice should then be permitted across all health care venues.

Fiscal Impact:

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	$1.8 million	$3.7 million	$3.7 million	$5.6 million
Total Savings	$3.7 million	$7.3 million	$7.3 million	$11.2 million

Note: Estimates assume: (1) $1.50 per hour savings for substituting aide for LPN wages in a SNF setting for 2,500 FTEs (average of 4 per nursing home); (2) a 5% reduction in ACF/ALR discharges to nursing homes (4256 x 5%= 212) and a 5% reduction in ALP discharges to nursing homes (804 x 5% = 40); (3) average nursing home rate of $200 reduced to $163 to reflect the acuity of the lowest RUG categories and an ALP rate of $81.50 (50% of the nursing home rate); (4) that 2% of the estimated 2600 discharges from LTHHCP to nursing homes could be avoided saving 25% of the average low-acuity Medicaid NH rate of $163 (163 x 25% = $40.75); (5) a 50% reduction in the potential cost savings due to voluntary nature of the provision ; (6) a nursing home base year of

2014-15 making the nursing home wage reduction savings effective for the state in 2014-15 (6) SFY 2011-12 savings reflect one-half of annual value; and (7) state savings are based on 50% state share.

Benefits of Proposal:

- Career ladder for nursing assistants which will provide greater job satisfaction and promote longevity, as well as retention in the health care system where they are desperately needed.
- Providers could utilize medication technicians to fill gaps left by nursing shortages.
- Prevention of unnecessary nursing home placements by allowing assistance with insulin injections in assisted living facilities.

Concerns with Proposal: There is a potential for increase in fatal medication errors. It may add an additional layer in the nursing home, since a nurse is still necessary to perform medical treatments, physical assessments, and oversight.

Impacted Stakeholders: Providers, nurses, certified aides

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: There would have to be an extensive training program and evaluation process to ensure competency. There would have to be a defined scope of practice addressing "advanced" medication pass procedures, such as meds that require a nursing assessment prior to administration, narcotics, administration of medications via gastrostomy tube, and so on.

Metrics to Track Savings: Some supplemental reporting may be needed.

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Proposals to Redesign Medicaid
Proposal #:1C

Proposal: Care Coordination Opportunities Under ACA

Program Area: Cross Continuum

Effective Date: 06/01/11 **Implementation Complexity:** High
Implementation Timeline: Long Term

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend _X_ Federal Demo

Proposal Background/Description: To take advantage of opportunities under the Patient Protection and Affordable Care Act (ACA) to enhance the coordination and quality of care for dual eligibles under demonstration programs such as Medical Homes and Health Homes.

Fiscal Impact: Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	n/a	n/a	n/a	n/a
Total Savings	n/a	n/a	n/a	n/a

Benefits of Proposal: From a financial perspective, these federal demonstrations are meant to develop models that save money through improved care coordination, including maximizing Medicare benefits and ensuring that Medicaid is the payor of last resort. In addition, for two years effective January 1, 2011, states that qualify for these programs will receive a 90 percent federal match (Federal Medical Assistance Percentage – FMAP).

Concerns with Proposal: The opportunities to qualify for these demonstration programs under ACA may be limited and the competition among states and providers is expected to be intense. New York will have to be prepared quickly to coordinate with the provider community in securing these opportunities.

Qualified programs will need to comply with NCQA certification of medical homes for demonstration programs and other initiatives. The NCQA has developed a set of comprehensive standards and assessment tools for medical homes through its PCMH Program. The NCQA defines the PCMH as a model of care for physician practices that strengthens the physician-patient relationship by replacing episodic care based on illnesses with evidence based practices, care coordination, health information technology, and long-term relationships.

Impacted Stakeholders: Eligible individuals are those Medicaid-eligible beneficiaries who have at least: two chronic conditions; one chronic condition and are at risk for having a second chronic condition; or one serious and persistent mental health

condition. The term “chronic condition” includes: a mental health condition, a substance abuse disorder, asthma, diabetes, a health disease, and a body mass index over 25.

Providers that may qualify as a designated health home provider include physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider (including pediatricians, gynecologists, and obstetricians) that is determined appropriate by the State and approved by the Secretary.

Additional Technical Detail: (If needed, to evaluate proposal) A medical home, also known as a health home, is a team-based model of care led by a personal physician who provides continuous and coordinated care to maximize health outcomes. The medical home is responsible for providing for all of a patient’s health care needs or appropriately arranging care with other qualified professionals. This includes the provision of preventive services, treatment of acute and chronic illness, and assistance with end-of-life issues. It is a model of practice in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access and communication, care coordination and integration, and care quality and safety. Specific guidance on this issue is found in CMS SMDL# 10-024.

Systems Implications: If successful, such a program would ultimately constitute a savings to the state Medicaid program by ensuring better coordination of care, resulting in lower institutionalizations, reduced hospital admissions/re-admissions, and ensuring that the most appropriate level of care (e.g. ensuring that Medicaid recipients do not rely on the emergency room for their routine care needs.)

Metrics to Track Savings: A system should be put in place to monitor the costs per Medicaid recipient enrolled in the demonstration program relative to the average cost per recipient outside of the demonstration.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:2C

Proposal (Short Title): Create a task force to develop a comprehensive model for post acute care bundling

Program Area: Long Term Care, Health Care and Managed Care

Effective Date: 4/1/11 **Implementation Complexity:** (Low)
Implementation Timeline: (Medium)

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: The Affordable Care Act created a Medicaid Post-Acute Care Payment Bundling Demonstration Program. This demonstration encourages post-acute care providers, as well as hospitals and physicians, to improve quality and lower costs for the Medicaid program through bundled payments for episodes of care.

The intent of the Task Force would be to study the potential for developing a framework for a bulk payment that would be shared by a hospital, a physicians group, a skilled nursing facility, an adult day health program and a home health agency. The purpose of this approach is to have a shared responsibility in the patient outcome by limiting the number of hospital re-admissions and emergency room use, promoting greater efficiencies in patient care and utilizing a person-centered care model. The members of the Task Force would include staff from the NYS Department of Health (DOH) and provider associations.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	n/a	n/a	n/a	n/a
Total Savings	n/a	n/a	n/a	n/a

This proposal could reduce the number of hospital and emergency room re-admissions, potentially saving Medicaid dollars. It could promote effective management of chronic conditions in a less restrictive and costly setting.

Benefits of Proposal:

- Bring task force members together to examine issues in a holistic manner rather than a fragmented approach;
- Examine the potential use of the Uniform Assessment Tool;
- Address pricing and usage considerations;
- Monitor efforts to bundle Medicare payments;
- Lay the ground work for crosscutting initiatives; and
- Promote compliance with the *Olmstead* decision.

Concerns with Proposal: Difficulty of developing a bundled price; political considerations around the entity that administers the bundle; how quality and outcomes will be measured; and developing a shared savings approach with the federal government.

Impacted Stakeholders:

- Macro level – Medicaid program, DOH, affected provider types
- Micro level - consumers

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications: Significant data would be needed to study possible formulation of bundled payments.

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:3C

Proposal (Short Title): Targeted regulatory reform

Program Area: Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (High)
Implementation Timeline: (Long Term)

Required Approvals: _X_ Administrative Action _X_ Statutory Change
_X_ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Implement targeted regulatory reforms aimed at increasing efficiency, expanding provider flexibility and allowing greater consumer choice.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: New York providers are arguably burdened with the most onerous system of regulation in the nation, and this translates into higher operating cost. Targeted regulatory reform could be used to eliminate unnecessary mandates and ease the related cost burden on both providers (compliance) and the state (enforcement).

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:4C

Proposal (Short Title): Reorganize ACF/AL survey process to focus on poor performing facilities and "look-alikes."

Program Area: Long Term Care

Effective Date: 7/1/11

Implementation Complexity: Medium
Implementation Timeline: Short Term

Required Approvals: X Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Reorganize ACF/AL survey process to free up resources to address "look-alike" entities that should be licensed as ACF/AL. This could help prevent NH placement by developing more licensed assisted living, and ALR licensure fees can bring in modest revenue. The survey process should focus most on issues that relate directly to resident outcomes, and on those facilities that require more attention, without increasing the burden on the already stretched regional office resources. Here are ways that the process could be realigned utilizing existing resources:

1. ***Reinterpret the frequency of an on-site survey***: As it stands in practice, ACFs in substantial compliance are on an 18 month survey schedule. This is more frequent than other DOH-regulated entities such as home care. The 18 month clock starts "ticking" from the first visit of the surveyors, though for various reasons, surveyors may be in the facility additional times making it only a few months in fact until the next survey occurs "18 months later". DOH could achieve some efficiencies by changing the timing to start the 18 month (or 12 month as applicable) "clock" using the date of the final inspection report.

   In addition, if a survey yields a violation, but this violation did not result in any resident harm, DOH should be able to approve the plan of corrections (POCs) without necessarily conducting an on-site visit. For example, some POCs involve staff training, which can be evidenced without an on-site visit.

2. ***Resident-Centered Focus.*** Surveys should take a more resident-centered approach. For example, residents often age in place and ultimately need to move on to a new level of care. This is a challenging transition that takes time to implement. Providers seem to be cited by DOH when this occurs, even if they have followed the proper protocol and are making diligent efforts to find a more appropriate placement. There should be an understanding that this is a normal occurrence, and that the primary concern should be that the resident's needs are being adequately met in some way until a more appropriate placement is secured. This is a far more person-centered approach.

3. ***Methodology of Survey.*** The survey should involve a random sampling of charts/residents. Initiating a regular survey that starts with incident reports does not yield a true picture of the every day, but rather a skewed picture of the out of the ordinary. One incident does not mean there is a systemic issue.

4. ***Utilize Resources More Efficiently When Possible.*** Greater efficiencies can be achieved on campuses with different levels of care or Continuing Care Retirement Communities in which shared services exist. The survey process can be streamlined or at least shortened by either combining survey processes for those areas (for example, inspection of the kitchen) or relying on the other team's report for that aspect of the survey. Current practice can be duplicative.

5. ***Recognize a threshold for errors that does not compromise safety.*** In the survey process for skilled nursing facilities, there is a threshold for some degree of error (no more than 5 percent) as it relates to medication errors for non-critical medications. In ACFs and ALs, there is no tolerance for any error. Of course, resident safety is paramount-but not all medication issues are a safety matter.

6. ***Pursue Look-Alikes.*** Given some of the resources that would be freed up by this change, DOH could dedicate more regional staff time to pursue unlicensed look-alikes that should be licensed as an ACF or AL but have failed to apply. This is an important policy issue to ensure the safety of a vulnerable population and to ensure the integrity and meaning of licensure. To date, DOH has not had sufficient resources to truly address this issue.

7. ***Ensure Consistency.*** Lastly, once a realignment of the survey process occurred, DOH must work to ensure consistency in the survey process, not only among regions but also among surveyors within the same region. Current inconsistencies leave providers struggling to determine what the "right interpretation" of a regulation or policy is. This wastes resources and results in unnecessary confusion.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings				
Total Savings				

Modest savings may be achieved by decreasing the frequency of on-site presence. At this same time, these savings may be offset by on-site evaluation of unlicensed look-alikes. Some modest revenue is likely to be generated by the licensure fees associated with Assisted Living Residence (ALR) licensure.

Benefits of Proposal: Ultimately, this proposal will realign existing DOH resources to achieve greater efficiencies, move towards a more person-centered approach, and ensure the safety of a vulnerable population.

Concerns with Proposal: Some may worry that a decreased on-site presence would jeopardize quality. We fear, however, that the resources of the regional office staff are being worn thin without consideration to where the greatest need is or how to address the unlicensed look-alikes.

Impacted Stakeholders: This has the potential to enable DOH to operate more efficiently and better address its growing responsibilities. Residents of ACFs and Assisted Living may experience calmer transitions and the benefits of a more person centered approach. They may also enjoy more staff time and attention if less time is spent on attempting to interpret requirements. Residents of unlicensed look-alikes

would be protected due to more aggressive enforcement by DOH and the integrity of licensure for ACF/AL providers would be protected.

Additional Technical Detail: (If needed, to evaluate proposal):

Systems Implications: DOH would need to determine how best to realign their resources. This does not appear to require any additional system design or change.

Metrics to Track Savings: DOH would need to determine.

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:1D

Proposal (Short Title): Promoting new technology

Program Area: Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (Med)
Implementation Timeline: (Long Term)

Required Approvals: _X_ Administrative Action _X_ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Provide seed capital for technologies, including electronic health records, telehealth and monitoring technologies, to improve quality of services, increase efficiency and allow seniors to remain in independent settings longer. These investments will ultimately save money over time.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: While this proposal represents an upfront investment on the part of the state, the long term cost savings associated with technology investments is without question. Other states have already been making the necessary investments, and the pay back is obvious. Increasing provider efficiency increases the efficiency of the overall system and translates into savings for the state. It also helps to assist those operators who simply cannot afford the capital investment and are at risk of failure, with resulting disruption to the system and even more cost to the system as recipients turn to higher cost care options (i.e., the hospital emergency room).

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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Stakeholder Group: New York Association of Homes and Services for the Aging
Proposals to Redesign Medicaid
Proposal #:2D

Proposal (Short Title): HIT coordination

Program Area: Long Term Care

Effective Date: 90 days from passage

Implementation Complexity: (Med)
Implementation Timeline: (Long Term)

Required Approvals: _X_ Administrative Action ___ Statutory Change
___ State Plan Amend ___ Federal Waiver

Proposal Background/Description: Advance initiatives for the coordination of HIT efforts between state agencies and regional health information organizations, and ensure that aging services and housing providers are integrated in the process. Early integration will help ensure a framework which results in greater efficiencies and cost-savings over time.

Fiscal Impact (Dollars in Thousands): Undetermined

State Fiscal Year	2011-12	2012-13	2013-14	2014-15
State Savings	TBD			
Total Savings				

Benefits of Proposal: Increasing efficiency in the system reduces costs. Models of HIT integration around the world have proven the benefits of doing so, and New York's own investment in the Department's office of technology further reinforces this concept. Smaller providers need additional support in achieving these statewide goals.

Concerns with Proposal:

Impacted Stakeholders:

Additional Technical Detail: (If needed, to evaluate proposal)

Systems Implications:

Metrics to Track Savings:

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