The Center
for Senior Living & Community Services
A division of the New York Association
of Homes & Services for the Aging

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Linda Gowdy, Director
Bureau of Continuing Care Initiatives
New York State Department of Health
Office of Managed Care
Empire State Plaza
Corning Tower, Room 2084
Albany, New York 12237

Dear Ms. Gowdy:

As you know, on September 13, 2006, the Governor signed Chapter 700 of the Laws of 2006 amending sections of Article 46 of the Public Health Law that governs continuing care retirement communities (CCRCs).

Among the obligations set forth in the legislation is a requirement that the Department of Health (DOH) conduct a review of duplicative requirements in CCRCs including: documentation, inspection, reports, certifications or reviews required to obtain approval or licensure for the Article 46 community and any individual components of the community; duplicative surveys, inspections, financial reports or audits pertaining to shared operations, functions, documentation, volunteers and staff of the community; and staff training, oversight and documentation requirements.

Since enactment of legislation in 1989 authorizing CCRCs in New York state, operators and developers have struggled with separate regulations governing the individual aspects of the CCRC continuum. As stated in Section 4600 in Article 46, it was the Legislature's intent that CCRCs develop "new and creative approaches to help ensure the care of older people in residential settings of their own choice. If carefully planned and monitored, life care communities have the potential to provide a continuum of care for older people that will provide an attractive residential option for such persons, while meeting their long term care needs for life." In practice, the ability of CCRC operators to provide a continuum of care is difficult.

Currently, CCRCs are regulated as several separate licensed entities rather than one integrated package of services that the consumer expects to receive. CCRCs must adhere to duplicative and sometimes conflicting sets of regulations that hinder a continuum of care. For example, a CCRC might have to follow individual licensure requirements and multiple sets of DOH regulations and requirements:

1. an operating certificate under Article 46 of the Public Health Law;
2. Adult Care Facility (ACF) license;
3. Residential Health Care Facility (RHCF) license;

4. Certified Outpatient Rehabilitation Facility license;
5. Home Care Agency license; and / or
6. Diagnostic and Treatment Center.

In addition, CCRC residents expect seamless services as they progress through various levels of care and they understand that this is the case in states other than New York. They are often stymied by regulations that they perceive as roadblocks to their health care.

In a letter dated September 25, 2006, the department asked NYAHSA and its members to provide information regarding duplicative requirements and suggestions for eliminating or alleviating such duplication. Below are suggestions from NYAHSA's CCRC membership and the consultants taken before and after the November 16 conference call that will assist in developing and managing New York's CCRCs:

1. **Allowing clinical staff to practice within their scope of practice at all levels of care within a CCRC**.

Current regulations prohibit clinical staff including registered nurses (RNs), licensed practical nurses (LPNs), occupational therapists, physical therapists and certified nurse aides (CNAs) and other licensed professionals employed by a CCRC, from providing services to residents outside their assigned level of care. Residents of a CCRC expect that continuous and integrated health care will be provided by the clinical staff who know their medical history and will be able to provide individualized health care and related supports.

Especially on "off-hours" such as evenings, nights, and weekends, staffing of CCRCs does not include a full complement of clinical staff at each level of care. Under current regulation clinical staff who are on-duty cannot render care other than at their assigned level. As a consequence it is frequently the case that residents who need attention, but who happen to reside in independent living or at an intermediate (e.g. ACF or EH) level of care cannot receive the attention of a fully qualified clinical professional who is on-duty in another level of care. Instead these residents are told that they must hire (at their own expense) private duty professionals to serve them, or they must be sent from the CCRC campus to a nearby emergency room or urgi-care center for treatment (e.g. wound care) -- while fully qualified and trained staff who know the residents are at work in the CCRC's skilled nursing facility but are unable to assist the resident.

This limitation is inherently incompatible with very concept of a continuing care environment, results in added costs to residents, and may diminish the quality of care received versus receiving services from clinical staff who know their medical history and would be able to provide individualized health care. CCRCs are not able to utilize their clinical staff with assignment at all levels of care to maximize their effectiveness to the CCRC and residents.

NYAHSA recommends that Article 46 be modified to allow licensed clinical staff to provide continuous and integrated care at all levels within a CCRC

2. **Allowing for consolidated medical records for residents within a CCRC.**

The medical community and both federal and state legislators / regulators realize the potential benefits of electronic medical records (EMR) in providing integrated information, streamlined analysis and immediate access to patient medical information. Currently separate medical records are required at each level of care within a CCRC. When a resident is transferred to a higher level of care for a short term or emergency stay within the CCRC, their medical history is not available to the clinical staff. Instead a new medical record must be initiated.

While EMRs are in the early development of being deployed in health settings, CCRCs could be a beta testing site for developing an integrated EMR system in multiple levels of care.

NYAHSA recommends that CCRCs be allowed to develop, through Article 46, the ability to maintain a continuous medical records for residents at all levels of care, including the development of EMRs. Once regulations allow for consolidated medical records, NYAHSA recommends state funding to develop EMRs within CCRCs to test the integration of medical information through technology. EMR testing through a closed system in a CCRC will assist other stand-alone long-term care providers in the future.

Allowing for a consolidation of medical records would help ensure better outcomes for residents while reducing the possibility of medical and medication errors.

3. **Allowing the practice to transfer CCRC contact holders between all levels of care, especially in emergency situations, without assessment tools.**

Current regulations require standardized forms for new admissions to the ACF and RHCF levels of care for all CCRC admissions or a transfer of an existing CCRC resident, even for a short-term stay. The required assessment tools (the DSS-3122 form for ACFs) and Patient Review Instrument (PRI) for RHCFs) must be completed by certified assessors (for the PRI) or by a physician who has seen the patient within 30 days (for the DSS-3122). The premise of requiring these forms is that the receiving facility needs current and complete information in order to evaluate the prospective admission and develop an appropriate plan of care In the case of CCRC residents, the facility has such current and complete information as a consequence of rendering ongoing care and service to its contract holders. Requiring the completion of these forms is therefore unnecessary.

This becomes an even more pressing challenge when a CCRC resident needs additional supervision or care on an urgent or emergency basis. This is commonly the case when a resident with dementia or other chronic condition who is safely supervised by a spouse is left alone due to the sudden hospitalization of the “supervising” spouse. The situation likewise presents itself when a resident who is receiving treatment for cancer or a similar condition unexpectedly needs additional support for a short period as they weather that treatment. The challenge is further magnified if such an urgent situation arises at night,

on a weekend or on a holiday when it is difficult if not impossible to get a qualified assessor or physician to complete the requisite paperwork.

NYAHSA recommends through Article 46 allowing the practice of transferring CCRC contact holders between all levels of care in emergency situations without assessment tools. Mechanisms can easily be developed to ensure that necessary information and action steps (such as tuberculosis testing) be implemented promptly upon transfer and that the contract holder be isolated in the higher level of care until such steps are completed.

4. Allow for continuous treatment and medications for CCRC residents at all levels of care.

It is NYAHSA's understanding that according to ACF and RHCF regulations, if a residents transfers for a short-term stay to a higher or lower level of care, medications can follow the resident under most circumstances. Receiving facilities may refuse the medications and special procedures for controlled substances must be adhered to.

Yet in some cases, CCRCs have reported that medication transfer policy is not being recognized and residents have been unable to transfer their medications. When this happens, medications need to be disposed of and new medications obtained, even if they are exactly the same. This procedure requires new scripts from physicians for all treatments and medications for each transfer, resulting in an unnecessary financial burden on the CCRC resident. Certain medications, including those for cancer treatment, can cost thousands of dollars. Treatments that require expensive medications often require a CCRC resident to transfer for a short time to a higher level of care, often several times during the overall treatment. With each transfer, the resident must twice cover the cost of new medications.

NYAHSA recommends that CCRC residents be allowed to transfer their medications and treatments within a CCRC to all levels of care, and that DOH clarify this policy with surveyors and CCRC operators.

5. Permit surveillance activities for the physical plant and relate matters to be conducted on a consolidated basis rather than for each separate level of care.

Although the intent of a CCRC is to provide continuous care to residents at all levels of the long-term care continuum, CCRCs are often regulated as separate individual entities. This is particularly the case for physical plant oversight within a CCRC. Surveys (often conducted within weeks of each other) for dietary facilities and services, physical plant and life safety (fire alarm, sprinklers and generators) are completed independently for each level of care by the state surveyors, although the facilities and procedures themselves are one and the same. In many cases these duplicative surveys are completed by the same person and review identical documentation.

In addition, DOH requires that each licensed entity within a CCRC obtain a Health Provider Network (HPN) account, and assign an HPN Coordinator. This policy does not

acknowledge those facilities in which one integrated service is made up of several different licensure categories as with CCRCs and Assisted Living Programs (ALPs). In these organizations it is typically the same person that is assigned to be an HPN coordinator for each category of licensure because that person oversees the program as a whole. The HPN coordinators are required to maintain multiple HPN accounts when one account allows them access to all of the needed information. This requirement forces providers to check each account on a regular basis to keep each account active. This duplication of activity takes time away from the HPN Coordinator that could be spent on other duties for the residents.

NYAHSA recommends that CCRCs be allowed to have one consolidated survey for its physical plant that services multiple levels of care; and that CCRCs be allowed to have one HPN Coordinator and HPN account for all levels of care.

6. Clearly establish that the life care contract will serve as the admission agreement for all levels of care within a CCRC for contract holders.

It is our understanding that DOH's Bureau of Continuing Care Initiatives interprets Article 46 as asserting that the life care contract is the only contract that should be signed by a CCRC resident. However, State surveyors are assigning deficiencies for the absence of a separate signed admission agreement for life contract holders who have moved to higher levels of care within CCRCs. The requirement for a separate admission agreement at each level of care for a CCRC resident is duplicative and unnecessary.

NYAHSA recommends that the life care contract serve as the admission agreement for all levels of care within a CCRC and that there be clarification issued to all state surveyors regarding this interpretation.

7. Include the $50.00 per unit licensure and inspection fee required by DOH for CCRCs in calculating any other licensure fee, including the new Assisted Living Residence (ALR) fee.

CCRCs are required to submit an annual $50.00 per unit licensure and inspection fee as part of the regulatory oversight from DOH and the Department of Insurance (DOI).

The new Assisted Living Residence (ALR) law requires a fee to procure an ALR license. The biennial fee for an ALR is $500 per facility, and $50 for each resident, up to a maximum of $5,000. Additional fees for the Enhanced (EALR) and Special Needs (SNALR) certificates are $2,000. CCRCs applying for both certificates are currently required to pay a biennial $3,000 fee.

NYAHSA recommends that since CCRCs are already paying an annual licensure and inspection fee as a CCRC, they should be exempt from paying the biennial ALR, EALR and SNALR application fees.

8. Eliminate inequitable requirements for CCRC cooperatives and condominiums.

Condominiums and cooperatives are equity communities regulated by the Attorney General's Office through Article 23-A of General Business Law and Parts 20 and 21 of the Real Estate Financing regulations, if no long term care is provided. When a condo or co-op is part of a CCRC, DOH) and DOI provide regulatory oversight under Article 46 of the Pubic Health Law and Part 900 of Health regulations, together with DOI Regulation 140.

Inherent in the equity model, including condos and co-ops, are the financial rewards and risks associated with home ownership: the financial gain from appreciation of real estate and the risk of not being able to sell one's home in an unfavorable real estate market. Parts 20 and 21 allow condo and cooperative owners to take that risk. Yet the same equity models, when part of a CCRC regulated under Part 900, require the community to guarantee to repurchase the condo or co-op from the owner if it has not sold to another CCRC resident after a year's time. The repurchase requirement puts an undue financial burden upon the CCRC, and in turn, the existing CCRC residents.

NYAHSA recommends making exceptions for equity model CCRCs to allow refunds upon resale regardless of when the resale is made, as is allowed for in other equity models in New York state.

9. Reduce unnecessary cost report filing.

Because CCRCs involve so many different levels of health care and subsequently are required to apply for and maintain as many as six certificates or licenses, they also are required to file up to six annual reports. For licenses where the CCRC receives no reimbursement from governmental sources, the associated cost reporting seems unnecessary. Examples of this would be the ACF annual report as well as reports for home care and diagnostic & treatment centers. In these two cases, CCRCs would only be serving their continuing care contract residents and would not be billing Medicaid or other government entities where revenue is based on cost. The various reports are highly complex, extremely time-consuming, and take much of the CCRC's resources that would be better spent on providing direct services to residents.

NYAHSA recommends that CCRCs be exempt from filing cost reports in those instances where the CCRC would not be billing government sources for additional revenue, with the exception of the annual CCRC reporting to DOH's Bureau of Continuing Care Initiatives and DOI.

In conclusion, seniors in New York state are unable to take full advantage of one of the best retirement housing options with CCRCs In Pennsylvania there are currently 184 CCRCs; in New York there are eight. Duplicative regulations, unreasonable reserve requirements and other barriers in Article 46 and Regulation 140, inhibit operators from developing CCRCs and add considerable cost to operating the communities that do exist. Eliminating duplicative surveys, inspections, financial reports, oversight and documentation requirements, and other unnecessary regulations, would allow CCRCs to function as true continuums of care, which was intended when they were first authorized.

NYAHSA would like to thank DOH for their interest in receiving comments from the Association and our members. NYAHSA is available to the department for any additional information that is needed to submit your report to the Legislature.

Sincerely,

Ken Harris, Director
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The New York Association of Homes and Services for the Aging