Affordable Housing Medicaid Redesign Workgroup
Supporting Documents

A) Proposal to expand the role of the nurse in ACF and AL settings

Problem: Current interpretation of the statutory definitions of what an adult care facility (ACF) is has resulted in the restriction of nurse's abilities to perform functions within their training and licensure. These interpretations have extended to the assisted living program, assisted living residence, and special needs assisted living residence (collectively referred to as "assisted living" in this document), as assisted living facilities are also licensed as ACFs. The limitations on nurses in these settings go beyond those tasks that could be performed by someone with a nurse's training, to include certain tasks that home health aides are routinely trained to perform in the community.

Proposal: The following services would be allowed in an ACF, assisted living program, assisted living residence or special needs assisted living residence *if the facility has nurses on staff*, to provide intermittent or incidental nursing services. These intermittent or incidental nursing services should not be required of an ACF or an assisted living setting, but rather may be **offered** as optional services for those facilities that have the appropriate staffing to do so. The services should only be provided within the scope of practice of that licensure, whether the employee be a licensed practical nurse (LPN) or a registered nurse (RN). Any of the services should be able to be provided without having to apply t DOH for a waiver, as this hinders the provider's ability to respond to the resident's needs and is an administrative burden to DOH and providers alike.

Nurses should be able to:

- Administer PPD (i.e., tuberculosis) tests, for both residents and employees;
- Apply certain topical health treatments, such as ointment/antibiotic cream and bandages;
- Administer eye, ear or nose drops;
- Administer nebulizer treatments (We recommend that the resident must be capable of identifying when the treatment is needed and communicating if the treatment has been effective);
- Change colostomy bags after colostomy has achieved normal functioning, is mature and stable;
- Change Foley bags;
- Change external catheter bags;
- Apply splints, braces and prostheses; and
- Assist a resident on a regular basis with oxygen (use of equipment).

It is important to note that **nearly all of the above tasks** — with the exception of the administration of the PPD test — **are allowed to be performed by a home health aide in a home care setting.** This is striking, as home health aides have less training and operate in a person's home, functioning fairly independently. Appendix A gives more information about these tasks and parameters for home health aides.

Parameters:

- **Overall, the nursing services to be offered in the facility are not intended to allow a resident who requires nursing home care to remain in the ACF and avoid nursing home placement.**

- **Both the organization and the nurse have the option to determine what, if any, of these services, will be provided in the facility.** The nurse must feel comfortable in performing the tasks and confident that his or her training and experience is such that they are capable of doing so.

- **The condition related to the nursing treatment or function must be stable.** For example, if the resident had a condition that required continuous monitoring by a nurse, then it would be more appropriate to employ a home care agency to monitor.

- **Residents eligible for Medicare have the right to access Medicare-covered home care services when circumstances are such that they qualify for such services.** The facility should assist the resident in maximizing this benefit as appropriate, and the intermittent nursing services provided in an ACF or assisted living setting should not be seen as a replacement for Medicare-covered home care services.

Rationale: Many organizations have chosen to employ nurses (both LPNs and RNs) in their ACF or assisted living setting. Given the increasing frailty of this population, it is helpful to have nurses in leadership roles and providing case management. It would be even more helpful to enable them to provide some treatments and services directly, to prevent the resident from having to access services at cost to them or to move on to a higher level of care to access the service. Many of these tasks can easily be performed by a nurse in this setting, and performing them with a nurse on staff could improve the quality of life and quality of care for the residents. The resident would be able to access services quickly from people they know and trust, at a lower cost.

As noted above, the vast majority of these tasks are allowed to be performed by home health aides in the home care setting with minimal supervision. Obviously, nurses have a higher level of training than home health aides. It seems incongruous and a waste of a resource if a higher-trained professional can't perform the same task simply because he or she happens to be in a *licensed* setting.

There is precedence for this practice in other states, such as Oregon, New Jersey and Washington. As an example, Washington — a forerunner in the field of assisted living — allows facilities to choose to provide intermittent nursing services. Included in such services are tasks such as catheter care, tube feedings, medication administration, non-routine ostomy care, diabetic care management and administration of health treatments such as eye drops and skin cream. Washington also allows nurses to delegate functions to aides within certain parameters. The nurse, aide and resident must agree to the plan, and the delegation is resident-specific. Both the nurse and aide must have specific training around this process and the aide must have training regarding the task, and the nurse is ultimately responsible for the task under their licensure. While we may not be ready to take all of these steps, New York can certainly learn from the experience of other states that have had success in assisted living, being far more flexible in terms of the populations they serve and how those services are provided.

It should be noted that, in New York there remain many ACFs and assisted living facilities that do not have any nurses working in that setting, and we are not suggesting that providing nursing services become a mandate of any sort. Rather, these services would be optional services that nurses could perform, if the organization and the nurse chose to. The decision to do so would have to be on a case-by-case basis, examining the available

resources, options for Medicare-covered home care services, the nurse's expertise with the particular task or services necessary, likely duration of the need, etc.

To sum, nurses are a scarce and valuable resource in this state, and we should be using them most effectively in every setting. Allowing nurses to perform these duties will likely reduce the utilization of higher levels of care or outside providers and result in savings to both the state and the consumer. This would also result in a better experience for the consumer. Other states have found a way to successfully utilize nurses in this level of care, with positive outcomes. We should follow suit.

What Steps are Necessary to Implement the Change?

Interestingly, the part of statute that has historically prohibited this shift is not necessarily a barrier to implementation. New York State Social Services Law, Article 1, § 2, subsection 21 states that an ACF provides residential care and services to adults who, " though not requiring continual medical or nursing care as provided by facilities licensed pursuant to article twenty-eight of the public health law or articles nineteen, twenty-three, thirty-one and thirty-two of the mental hygiene law, are by reason of physical or other limitations associated with age, physical or mental disabilities or other factors, unable or substantially unable to live independently." Our proposal suggests intermittent or incidental services provided by a nurse, most of which are categorized as services that could be provided by a home health aide in the home setting. We are not requesting the ability to provide "continual medical or nursing care." Thus, we believe DOH has the authority to implement this proposal without new statutory authority.

While this warrants careful review, we did not see anything in regulation that prohibits this change, either. DOH would have to consider how best to approach such a policy change, however, as this reflects a departure from current practice.

Note: It is essential to clarify that, even with this proposed change, ACFs and assisted living settings are not medical facilities. These intermittent or incidental nursing services are periodic in nature and not a requirement. This must be clarified for the purposes of ensuring that ACF and assisted living residents continue to be appropriate for Supplemental Security Income (SSI) Congregate Care Level 3 payments.

(See table, next page)

Appendix A:

Which of the Proposed Tasks Can a Home Health Aide Perform?

Task	Permissible HHA task?	Special Parameters for HHA
Administer PPD tests for both residents and employees	No	
Apply certain topical health treatments, such as ointment/antibiotic cream and bandages	Yes	Applying topical medications can only be provided if it is a stable skin surface and is for a patient who is self-directing; i.e. has the capability to make choices about the activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices.
Administer eye, ear or nose drops	Yes	Removing the proper amount of medication from the container and installing or applying the medications only for a patient who is self-directing; i.e. has the capability to make choices about activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices.
Administer nebulizer treatments. (We recommend that the resident must be capable of identifying when the treatment is needed and communicating if the treatment has been effective.)	Yes	The placing of prescribed medication in the nebulizer is allowed for a patient who is self-directing; i.e. has the capability to make choices about activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices.
Change Foley bags	Yes	This activity can only be provided for a patient who is self-directing; i.e. has the capability to make choices about activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices; and when the home care aide provides services exclusively to his/her within a particular day.

Change (external) catheter bags	Yes	
Change colostomy bags after colostomy has achieved normal functioning, is mature and stable	Yes	
Apply splints, braces and prostheses	Yes	(allowed except for prosthetic eyes)
Assist a resident on a regular basis with oxygen (use of equipment)	Yes	Setting the rate or flow of oxygen is permitted for a patient who is self-directing; i.e. has the capability to make choices about activities of daily living, understands the impact of these choices and assumes responsibility for the results of the choices.

Source:

HOME HEALTH AIDE SCOPE OF TASKS

Guide to Home Health Aide Training and Competency Evaluation

and MATRIX Permissible and Non-Permissible Activities

NYS Department of Health

March 2009

B) ALP Efficiency Bill and Memo

AN ACT to amend Social Services Law to establish a more efficient and streamlined manner in which to deliver assisted living program (ALP) services.

Section 1. paragraph e of subdivision 1 of section 461-L of the social services law is amended to read as follows:

(e) "Services" shall mean all services for which full payment to an assisted living program is included in the capitated rate of payment, which shall include personal care services, home care services and such other services as the commissioner in conjunction with the commissioner of health determine by regulation must be included in the capitated rate of payment, and which the assisted living program shall provide, or arrange for the provision of, through contracts with a social services district, **and coordination with** [~~a long term home health care program or a certified home health agency, and~~] other qualified providers.

Section 2. Subdivision 2 of section 461-L of the social services law is amended to read as follows:

2. General requirements. (a) Applicability. Unless expressly provided otherwise in this article or article thirty-six of the public health law, an assisted living program shall be subject to any other law, rule or regulation governing adult care facilities, long term home health care programs, certified home health agencies, licensed home care agencies or personal care services.

~~[(b)If an assisted living program itself is not a certified home health agency or long term home health care program, the assisted living program shall contract with a certified home health agency or long term home health care program for the provision of services pursuant to article thirty-six of the public health law. An assisted living program shall contract with no more than one certified home health agency or long term home health care program, provided, however, that the commissioner and the commissioner of health may approve additional contracts for good cause.]~~

(b) The assisted living program may through its licensed home care services agency, or, certified home health agency or long term home health care program if the organization is licensed as such, contract directly with the local department of social services for the provision of services pursuant to article thirty-six of the public health law. A licensed home care services agency operated by an entity identical to an as-

sisted living program may provide any services to residents of that assisted living program that a licensed home care services agency is authorized to provide under article thirty-six of the public health law. An assisted living program shall coordinate and may contract with certified home health agencies, long term home health care programs, or residential health care facilities as defined in article twenty-eight of the public health law to provide those services outlined in section (e) of 461-l of social services law that the assisted living program or its home care component are unable to or choose not to provide directly.

(c) Participation by eligible persons. Participation in an assisted living program by an eligible person shall be voluntary and eligible persons shall be provided with sufficient information regarding the program to make an informed choice concerning participation.

(d) Patient services and care.

(i) An assisted living program**, in conjunction with its home care component, or a certified home health agency, long term home health care program, or residential health care facility,** [~~, or if the assisted living program itself does not include a long term home health care program or certified home health agency an assisted living program and a long term home health care program or certified home health agency, ~~]shall conduct an initial assessment to determine whether a person would otherwise require placement in a residential health care facility if not for the availability of the assisted living program and is appropriate for admission to an assisted living program. The assisted living program shall forward such assessment of a medical assistance applicant or recipient to the appropriate social services district.

(ii) No person shall be determined eligible for and admitted to an assisted living program unless the assisted living program **and its home care component, or a** [~~and the~~] long term home health care program, [~~or the~~] certified home health care agency**, or residential health care facility** agree, based on the initial assessment, that the person meets the criteria provided in paragraph (d) of subdivision one of this section and unless the appropriate social services district prior authorizes payment for services. **The social services district may conduct post-assessment audits to ensure eligibility for the program.**

(iii) Appropriate services shall be provided to an eligible person only in accordance with a plan of care which is based upon an initial assessment and periodic reassessments conducted by an assisted living program **and its home care component or a**[~~, or if the assisted living program itself does not include a ~~]long term home health care program, ~~or~~ certified home health agency**, or residential health care facility.** [~~An assisted living~~

~~program and a long term home health care program or certified home health agency.~~] A reassessment shall be conducted as frequently as is required to respond to changes in the resident's condition and ensure immediate access to necessary and appropriate services by the resident, but in no event less frequently than once every six months. No person shall be admitted to or retained in an assisted living program unless the assisted living program **and its home care component or a** [~~, and~~]long term home health care program, ~~or~~ certified home health agency**, or residential health care facility** are in agreement that the person can be safely and adequately cared for with the provision of services determined by such assessment or reassessment.

(iv) To the maximum extent possible and consistent with staffing standards, assisted living programs shall achieve economic efficiencies through the provision of shared services including, but not limited to, shared aides.

Section 3. Subdivision 3 of section 461-L of the social services law is amended to read as follows:

3. Assisted living program approval. (a) An eligible applicant proposing to operate an assisted living program shall submit an application to the department. Upon receipt, the department shall transmit a copy of the application and accompanying documents to the department of health. Such application shall be in a format and a quantity determined by the department and shall include, but not be limited to:

(i) a copy of or an application for an adult care facility operating certificate;

(ii) a copy of or an application for a home care services agency license or a copy of a certificate for a certified home health agency or authorization as a long term home health care program; (iii) a copy of a proposed contract with a social services district or in a social services district with a population of one million or more, a copy of a proposed contract with the social services district or the department;

(iv) [~~if the applicant is not a long term home health care program or certified home health agency, a copy of a proposed contract with a long term home health care program or certified home health agency for the provisions of services in accordance with article thirty-six of the public health law; and~~]**a description of what services the ALP home care component will provide directly, and how the ALP will access additional services the resident will need. Copies of proposed contracts and/or agreements with other service providers should be included; and,**

(v) a detailed description of the proposed program including budget, staffing and services.

(b) If the application for the proposed program includes an application for licensure as a home care service agency, the department of health shall forward the application for the proposed program and accompanying documents to the public health and health planning council for its written approval in accordance with the provisions of section thirty-six hundred five of the public health law.

c) An application for an assisted living program shall not be approved unless the commissioner is satisfied as to:

(i) the character, competence and standing in the community of the operator of the adult care facility;

(ii) the financial responsibility of the operator of the adult care facility;

(iii) that the buildings, equipment, staff, standards of care and records of the adult care facility to be employed in the operation comply with applicable law, rule and regulation;

(iv) the commissioner of health is satisfied that the licensed home care agency has received the written approval of the public health council as required by paragraph (b) of this subdivision and the equipment, personnel, rules, standards of care, and home care services provided by a licensed home care agency ~~and certified home health agency or long term home health care program~~ **] and other services providers with which the ALP has agreements or contracts with,** are fit and adequate and will be provided in the manner required by article thirty-six **or article twenty-eight** of the public health law and the rules and regulations thereunder; and

(v) the commissioner and the commissioner of health are satisfied as to the public need for the assisted living program.

(d) The department shall not approve an application for an assisted living program for any eligible applicant who does not meet the requirements of this article, including but not limited to, an eligible applicant who is already or within the past ten years has been an incorporator, director, sponsor, principal stockholder, member or owner of any adult care facility which has been issued an operating certificate by the board or the department, or of a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by an office of the department of mental hygiene, or of any residential health care facility or home care agency as defined in the public health law, unless the department, in conjunction with the department of health, finds by substantial evidence as to each such applicant that a substantially consistent high level of care has been rendered in each such facility or institution under which such

person is or was affiliated. For the purposes of this paragraph, there may be a finding that a substantially consistent high level of care has been rendered despite a record of violations of applicable rules and regulations, if such violations (i) did not threaten to directly affect the health, safety or welfare of any patient or resident, and (ii) were promptly corrected and not recurrent.

(e) The commissioner of health shall provide written notice of approval or disapproval of portions of the proposed application concerning a licensed home care agency, certified home health agency or long term home health care program, and, where applicable, of the approval or disapproval of the public health and health planning council to the commissioner. If an application receives all the necessary approvals, the commissioner shall notify the applicant in writing. The commissioner's written approval shall constitute authorization to operate an assisted living program.

(f) No assisted living program may be operated without the written approval of the department, the department of health and, where applicable, the public health and health planning council.

* (g) Notwithstanding any other provision of law to the contrary, any assisted living program having less than seventy-five authorized bed slots, located in a county with a population of more than one hundred ten thousand and less than one hundred fifty thousand persons and which at any point in time is unable to accommodate individuals awaiting placement into the assisted living program, shall be authorized to increase the number of assisted living beds available for a specified period of time as part of a demonstration program by up to thirty percent of its approved bed level; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section. In addition, any program which receives such authorization and which at any point on or after July first, two thousand five is unable to accommodate individuals awaiting placement into the assisted program, shall be authorized to further increase the number of assisted living beds available as part of this demonstration program by up to twenty-five percent of its bed level as of July first, two thousand five; provided, however, that such program shall otherwise satisfy all other assisted living program requirements as set forth in this section. Further, any such program which receives authorization to increase the number of assisted living beds available pursuant to this paragraph shall submit a report annually to the commissioner of health, the governor, the temporary president of the senate and the speaker of the assembly, which contains the cost of the program, including the savings to state and local governments, the number of persons served by the program by county, a description of the demographic and clinical characteristics of patients served by the program, and an evaluation of the quality of care provided to persons served by the program. After release of the second report by any such program if the findings of the report do not reflect a cost

savings to the state and local governments, the program may be terminated immediately by the commissioner of health. Within thirty days of the termination of a demonstration program, the commissioner of health shall submit a report to the governor, the temporary president of the senate and the speaker of the assembly which outlines the reasons for early termination of such program.

* NB Repealed September 1, 2013

(h) The commissioner is authorized to add one thousand five hundred assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand seven.

(i) The commissioner of health is authorized to add up to six thousand assisted living program beds to the gross number of assisted living program beds having been determined to be available as of April first, two thousand nine, provided that, for each assisted living program bed so added, a nursing home bed has been decertified upon the application of the nursing home operator or that the commissioner of health has found pursuant to subdivision six of section twenty-eight hundred six of the public health law that any assisted living program bed so added would serve as a more appropriate alternative to a certified nursing home bed and has accordingly limited or revoked the operating certificate of the nursing home providing that certified nursing home bed, provided further that nothing herein shall be interpreted as prohibiting any eligible applicant from submitting an application for any assisted living program bed so added. The commissioner of health shall not be required to review on a comparative basis applications submitted for assisted living program beds made available under this paragraph. The commissioner of health shall only authorize the addition of six thousand beds pursuant to a five year plan.

Section 4. This act shall take effect one hundred and eighty days after it shall have become law.

Assisted Living Program Efficiency Sponsor Memo

TITLE OF BILL: AN ACT to amend social services Law Section 461-L to establish a more efficient and streamlined manner in which to deliver services in the assisted living program (ALP).

PURPOSE OR GENERAL IDEA OF THE BILL: The bill eliminates the requirement for ALPs to contract with certain home care agencies for the provision of certain services. If the ALP home care component requirement is satisfied by having a licensed home care services agency (LHCSA), that LHCSA is empowered to provide any services it is authorized to provide under article thirty-six of the public health law, thereby enabling ALPs to provide more services directly if they so choose. The ALP may then select from a variety of service provider options, including residential health care facilities, to maximize the efficient delivery of those services that the ALP and its home care component would not itself provide. The bill also allows the option for the ALP to maintain the traditional contracting relationship with a certified home health agency (CHHA) or long term home health care program (LTHHCP), if that is most efficient option. Lastly, the bill allows for an individual to be admitted to an ALP without an assessment conducted by local department of social services (LDSS) *prior* to admission. Rather, LDSS can conduct post-admission audits to ensure appropriate admissions.

SUMMARY OF SPECIFIC PROVISIONS:

Section 1 of this bill amends paragraph (e) of subdivision 1 of Social Services Law Section 461-L by clarifying that the ALP does not require a contract with a LTHHCP or CHHA for the delivery of certain services the ALP is responsible for. Rather, the ALP would be able to *coordinate* care with these and other qualified providers. The ALP may choose to continue to contract with a CHHA or LTHHCP, but is no longer *required* to.

In Section 2 of this bill, a new paragraph (b) replaces the original paragraph (b) of subdivision 1 of Social Services Law Section 461-L. This change clarifies that a LHCSA operated by an entity identical to the ALP may provide any or all of the services to the residents of that ALP that the licensure as a LHCSA would otherwise enable them to provide. Presently, DOH limits the functions that an ALP's LHCSA can provide, because of the ALP is technically an adult care facility. Given that the LHCSA is separately licensed, however, and meets all of the criteria necessary to provide services in the community, it can be viewed as an entity separate from, but related to, the ACF. This new paragraph eliminates the *requirement* for an ALP to contract with a CHHA or LTHHCP, but retains it as an *option*. Rather, the ALP may coordinate care, and contract if they so choose, with one *or more* CHHAs or LTHHCPs for the provision of required services that the ALP and its home care component are unable or choose not to provide directly. Further, ALPs may also coordinate care or contract with residential health care facilities for the provision of those same services.

Subsection (i) of paragraph (d) is amended to eliminate the *requirement* that that ALP utilize the services of a contracted outside agency to conduct an assessment (if not licensed as a CHHA or LTHHCP). Consistent with paragraph (b), the ALP is empowered to conduct an initial assessment for eligibility for the ALP program directly by utilizing its home care component, whether it is a LHCSA, CHHA or LTHHCP. The language retains the flexibility, however, for the ALP to utilize an outside entity such as a CHHA, LTHHCP or residential health care facility to aid in the assessment, if this is the most efficient method to conduct assessments.

Subsection (ii) of paragraph (d) is amended to reflect the aforementioned changes, clarifying that no one shall be admitted to the ALP unless the parties involved in the assessment, outlined in subsection (i) agree that the

person is appropriate. Further, this subsection is amended to clarify that an individual could be admitted to the ALP without a pre-admission assessment conducted by the local social services district (LDSS). The LDSS may confirm eligibility after admission through an audit process of some sort.

Subsection (iii) of paragraph (d) is amended, consistent with the aforementioned changes, to state that services will be provided to ALP residents in accordance with a plan of care based on an initial assessment and reassessments conducted by the parties outlined in subsection (i) of paragraph (d). Further, no one will be admitted or retained in the ALP unless the ALP and the parties engaged in the assessment process, outlined in subsection (i) of paragraph (d), agree that the person can be safely and adequately cared for in that setting.

Section 3 of this bill amends subsection (iv) of paragraph (a) of section 3 of Social Services Law Section 461-L, to be consistent with the above elimination of the requirement that an ALP contract with a CHHA or LTHHCP for the provision of certain services, if not licensed as such. Rather, the subsection is amended to require that the ALP outline what services the home care component of the ALP will provide directly. In the case that the ALP's home care component is a LHCSA, the LHCSA may choose to provide some, but not all of the services authorized under article thirty-six of the public health law. In addition, the ALP will maximize accessing Medicare-covered services as appropriate. The ALP applicant must outline to the department how those other services, required to be delivered to ALP residents, will be arranged for. The applicant must provide to the department proposed contracts and/or agreements with other service providers, which may include one or more CHHAs, LTHHCPs and residential health care facilities.

Subdivision (iv) of paragraph (c) of section 3 omits language referencing the requirement that an ALP contract with a CHHA or LTHHCP if not licensed as such. For the purposes of gaining approval to operate an ALP, it clarifies that the commissioner of health must be satisfied that the applicant, its LHCSA, and those entities with which the ALP has agreements or contracts with, must meet the appropriate standards outlined in their respective regulations.

JUSTIFICATION:

Overall, these changes will enable the ALP to operate most efficiently. Flexibility is retained in the statute to enable the ALP to determine what method of service delivery is most efficient, as this may vary depending on the location of the program and the available resources in that community.

Allowing an ALP to provide more services directly through its LHCSA will allow ALPs to be more responsive to resident needs and in some cases be able to provide services at a lower cost to the ALP. In some regions of the state, ALPs must wait for their contracted CHHA or LTHHCP to be available to provide services to the resident. The ALP must pay the CHHA or LTHHCP for the provision of services, some of which they are capable of providing to the residents themselves through a LHCSA. Empowering the LHCSA to provide more services directly is ideal, given that the LHCSA staff are most familiar with the resident, and likely to be able to respond more quickly than an outside entity. The coordination of the resident's care will be improved, and duplication of staff and services, such as nursing—a scarce and valuable resource, would be eliminated.

In addition to the aforementioned flexibility, the ability to coordinate with a nursing home to provide assessments and some of the ALP services typically provided by a CHHA or LTHHCP will allow ALPs in organizations with a continuum of care to provide services more efficiently. Many nursing homes have outpatient rehabilitation capabilities, for example, which could effectively and easily provide services to ALP residents.

In most cases, these changes will enable the ALP to operate more efficiently. Some ALPs may find, however, that retaining the traditional contractual relationship is most beneficial. Flexibility is maintained in the statute to enable the ALP to choose the most efficient solution for that organization in that particular region. ALPs

should also ensure that Medicare-covered benefits are maximized, and thus coordination with a CHHA or LTHHCP will still be necessary.

This bill also enables the LDSSs to conduct their assessments after someone is admitted through some sort of post-audit process. The provider would be responsible for ensuring admissions are appropriate, and this, along with the ability for the ALP to conduct their own assessments (as opposed to relying on a third party), would enable admissions to happen more swiftly. The current practice, involving three parties, is unnecessary, cumbersome, and makes it nearly impossible to accept admissions from hospitals. Some number of individuals end up in nursing homes on Medicaid because the ALP admission process takes too long, at a higher cost to the state.

PRIOR LEGISLATIVE HISTORY: None. This is a new bill.

FISCAL IMPLICATIONS: It is estimated that this will result in savings to the state of up to $1.3 million annually in prevented nursing home placements.

EFFECTIVE DATE: This will take effect ninety days after it has become law.

C) Capital Component Bill and Memo

STATE OF NEW YORK

8248

2011-2012 Regular Sessions

IN ASSEMBLY

June 8, 2011

Introduced by M. of A. GOTTFRIED -- read once and referred to the Committee on Health

AN ACT to amend the public health law, in relation to capitated rates of payment for services provided by assisted living programs

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Paragraphs (a) and (b) of subdivision 6 of section 3614 of the public health law, paragraph (a) as amended by section 17 of part D of chapter 58 of the laws of 2009 and paragraph (b) as added by chapter 645 of the laws of 2003, is amended to read as follows:

(a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect (i) the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided, and (ii) real property capital construction costs associated with the construction of (A) a free-standing assisted living program, or (B) other assisted living programs for which the commissioner determines that such real property capital construction cost adjustment would provide net fiscal savings to the state; such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, based upon the mean prices for the first of July, nineteen hundred ninety-two (utilizing nineteen hundred eighty-

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD11023-04-1

three costs) for freestanding, low intensity residential health care facilities with less than three hundred beds, and for years subsequent to nineteen hundred ninety-two, adjusted for inflation in accordance with the provisions of subdivision ten of section twenty-eight hundred seven-c of this chapter, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision.

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved adult care facility beds, as applicable, are provided to residents who are subject to the assisted living program; and (iii) with respect to an assisted living program under clause (A) of subparagraph (ii) of paragraph (a) of this subdivision, the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs.

§ 2. This act shall take effect immediately.

BILL NUMBER: A8248

SPONSOR: Gottfried

TITLE OF BILL: An act to amend the public health law, in relation to capitated rates of payment for services provided by assisted living programs

PURPOSE OR GENERAL IDEA OF BILL: To allow Medicaid reimbursement for real property capital construction costs for certain assisted living program facilities (ALPs)

SUMMARY OF SPECIFIC PROVISIONS: Amends Section 3614 of the Public Health Law to allow Medicaid reimbursement of real property capital construction costs for ALP facilities where the Department of Health determines that the construction will result in net fiscal savings to the state.

JUSTIFICATION: Current state policy is encouraging a transition from nursing home beds to ALP beds in order to "rightsize" the system of care, by placing persons with lesser or unique care needs into more appropriate care-providing residences. The ALP is the only assisted living option for Medicaid-eligible individuals, whether they are seniors or individuals suffering from HIV/AIDS and related complications, who need care but at a level less intensive than skilled nursing care.

Many of the original ALP programs (or adult care facilities seeking ALP licensure) are housed in aging buildings that require significant capital improvements to update physical plants to meet the needs of more frail residents who might otherwise need nursing home care. Funding is needed for resident safety and quality of life, as well as to meet increasing structural requirements imposed by the Department of Health.

This initiative will save Medicaid dollars by enabling low-income seniors and other individuals in need of care to reside in ALPs at half the cost of the nursing home rate. It also enables residents to live in a more home-like, community-oriented setting.

PRIOR LEGISLATIVE HISTORY: New bill.

FISCAL IMPLICATIONS: Potential Medicaid savings.

EFFECTIVE DATE: Immediately

D) Independent Senior Housing Freedom of Choice Bill and Memo

STATE OF NEW YORK

4319

2011-2012 Regular Sessions

IN SENATE

March 29, 2011

Introduced by Sen. YOUNG -- read twice and ordered printed, and when printed to be committed to the Committee on Aging

AN ACT to amend the public health law, in relation to establishing the independent senior housing resident freedom of choice act

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be referred to as the "independent senior housing resident freedom of choice act".

§ 2. Legislative intent. The legislature hereby finds and declares that the complexity of state statutes and regulations governing the operation and services provided in congregate settings has caused or contributed to a lack of clarity in, and thus caused confusion and interference with the rights and opportunities of senior citizens and persons with disabilities residing in independent housing to choose and access services from the community, services that would otherwise be available to such individuals if residing 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 that independent housing also represents, consistent with the Olmstead decision of the United States Supreme Court. Ensuring access to such services is also in furtherance of the state 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 admission to medical and other institutional-type facilities.

Therefore, the legislature enacts this act in order to advance the opportunities for seniors and persons with disabilities to choose, live and access services in independent housing.

§ 3. Paragraph (j) of subdivision 1 of section 4651 of the public health law, as added by chapter 2 of the laws of 2004, is amended to read as follows:

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [-] is old law to be omitted.

LBD10539-01-1

(j) independent senior housing, shelters or residences for adults. For purposes of this article and for purposes of determining certification pursuant to article seven of the social services law, the department shall by regulation, define independent senior housing, provided such definition shall be based on whether the operator does not provide, arrange for, or coordinate personal care services or home care services on behalf of residents; and the [~~facility~~] operator does not provide case management services in a congregate care setting for residents. Nothing in this chapter shall preclude [~~a resident of~~]: (i) any independent senior housing resident or any number of such residents from personally and directly obtaining [~~private~~] personal care or home care services from [~~a~~] any licensed [~~or certified~~] home care services agency, certified home health agency, long term home health care program, programs of all-inclusive care for the elderly or other managed long term care program;

(ii) an agency or program licensed or approved under article thirty-six or section forty-four hundred three-f of this chapter from offering, arranging for or providing services to the residents of such housing as such agency is otherwise authorized to offer, arrange for or provide to any other person or persons residing in their own home or apartment or in the home of any other responsible relative or adult in the community;

(iii) any independent senior housing resident or any number of such residents from personally and directly choosing and obtaining services from an appropriately licensed or approved agency or program offering personal care, home care or case management services, or from obtaining, personally and directly, technologies that assist in maintaining independence; or

(iv) an independent senior housing operator from offering room, board, laundry, housekeeping, information and referral, security, transportation or concierge-like services; assisting tenants with housing issues; providing information to tenants about services and activities available in the community; assisting tenants wishing to do so in connecting with such services and activities; providing access to such services and activities; and contacting appropriate responders in an emergency or other situation involving any tenants that appears to warrant immediate attention, assistance or intervention.

§ 4. This act shall take effect immediately.

BILL NUMBER: S4319

SPONSOR: YOUNG

TITLE OF BILL:
An act to amend the public health law, in relation to establishing the independent senior housing resident freedom of choice act

PURPOSE:
To clarify that individuals living in senior housing have the right to access and obtain the same services that they would if they were an individual residing in the community, from the provider of their choosing. These services include personal care, home care, case management, technologies and other community services that support them to live independently in the community.

SUMMARY OF PROVISIONS:
Section 1 states that the bill shall be referenced as "The Independent Senior Housing resident Freedom of Choice Act".

Section 2 lays out the legislative intent behind the bill.

Section 3 amends 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.

Section 4 states the effective date.

JUSTIFICATION:

The complexity of state statutes and regulations governing the operation 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.

Ensuring access to such services is also in furtherance of New York State 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 admission 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.

LEGISLATIVE HISTORY:
New Bill.

FISCAL IMPLICATIONS:
The bill may result in cost savings due to seniors remaining in the community rather than transitioning into more expensive settings Undetermined at this time.

EFFECTIVE DATE:
This act shall take effect immediately.