MEMORANDUM

A.8193 (Schimminger)/S.1803-A (Rivera)

AN ACT to amend the public health law, in relation to promoting efficient and effective oversight of continuing care retirement communities; and to repeal certain provisions of such law relating thereto

This legislation would modify Articles 46 and 46-A of the Public Health Law in a way that would eliminate various barriers to the development, expansion, and efficient operation of Continuing Care Retirement Communities (CCRCs) in New York State while preserving vitally important resident protections. It would consolidate authority for the approval and operation of CCRCs into the Department of Health (DOH).

Article 46 was first enacted in New York in 1989, and Article 46-A (which allows for fee-for-service CCRCs) was added in 2004. Over the last 30 years, the number of CCRCs and similar communities has grown dramatically across the nation, including in neighboring states such as Pennsylvania. CCRCs have become one of the primary means by which seniors of varying income levels can fund and provide for their ongoing health care, service, and housing needs. However, since Article 46 was first enacted, only 12 CCRCs have become operational in the state.

The requirements of Articles 46 and 46-A have created an environment in which it is prohibitively expensive and administratively burdensome to start or expand a CCRC, and extremely difficult for current CCRCs to operate efficiently and make their services more affordable. CCRCs are regulated by two State agencies (DOH and the Department of Financial Services (DFS)) and in certain cases by a third one (the Office of the Attorney General). This level of oversight is burdensome, time-consuming, creates conflicts and duplication, and adds significantly to the cost of developing and operating CCRCs.

This model made sense 30 years ago when DOH lacked any experience with insurance. However, since that time, DOH has developed a vast depth of expertise with insurance. It is now responsible for the programs covering more than one in three New Yorkers; approximately 7 million people are covered through Medicaid, Child Health Plus, the Essential Plan, and NY State of Health (NYSOH). DOH currently reviews financial oversight and solvency – the only DFS role — resulting in considerable duplication of functions.

In addition, the CCRC Council must provide final approval for establishment and most operational changes. Unfortunately, the Council has experienced significant turnover, resulting in members who are often unfamiliar with the details of the program. By statute, only one member of the Council may be an operator or board member of a CCRC. In addition, the Council frequently has difficulty even achieving a quorum. Cancellation of the infrequently scheduled Council meetings is common. Most recently, the past two Council meetings (November 2018 and May 30, 2019) were cancelled because they could not get a quorum. The first Care-at-Home CCRC is delayed in getting established because the Council must meet to give its approval.

Another example of the real-world implications of these delays is debt refinancing. Due to the inability of the Council to meet to provide the timely required approval of refinancing, CCRCs have in the past missed out on securing lower interest rates. Ultimately, LeadingAge NY needed to secure a statutory change to allow DOH to approve these transactions.

Not only does the cumbersome multiple agency oversight and Council approval cause delays that result in increased costs for existing CCRCs, but it also discourages providers who might otherwise pursue this model of care from proceeding. We believe this is a significant contributing factor to New York's lack of CCRCs compared to neighboring states: Pennsylvania (197), New Jersey (27), and Massachusetts (31).

This legislation would address these problems by modifying provisions of Articles 46 and 46-A that mandate multiple agency involvement to consolidate oversight in DOH and make it clear that other agencies are involved in a limited, consultative role. It would also limit the CCRC Council to an advisory role. It is important to note that almost all other councils in the health space are exclusively advisory in nature.

Both nationally and here in New York, CCRCs have proven themselves to be financially stable and sound investments for residents and their communities. Rather than costing the State money, CCRCs are a proven economic driver for local communities. The CCRC model is not a new Medicaid program that will cost the State money. On the contrary, seniors who invest in their care and housing needs through a CCRC do not divest their assets to qualify for Medicaid-funded services.

For these reasons, LeadingAge NY strongly supports this legislation and recommends that it be adopted.

LeadingAge New York represents over 400 not-for-profit and public long term care providers, including nursing homes, home care agencies, senior housing, retirement communities, assisted living, adult care facilities, adult day health care and managed long term care.