NEW YORK STATE
CONTINUING CARE RETIREMENT COMMUNITIES

REPORT TO THE GOVERNOR AND LEGISLATURE ON DUPLICATIVE REQUIREMENTS

Prepared by the New York State Department of Health
January 15, 2007

New York State Department of Health

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report has been prepared in fulfillment of the statutory requirement under Chapter 700 of the Laws of 2006 which amended Article 46 of the Public Health Law in relation to continuing care retirement communities (CCRCs). Under Chapter 700 the Department of Health is directed to conduct a review of duplicative requirements in continuing care retirement communities and report its findings and recommendations for eliminating such duplication to the Governor and Legislature.

Continuing care retirement communities consist of three integrated components: independent residential housing; an adult care facility; and, a skilled nursing facility. Statutory oversight for the establishment of these communities is contained in Article 46 of the Public Health Law. The health care components of a CCRC are subject to additional oversight under Article 7 of the Social Services Law for adult care facilities, and Article 28 of the Public Health Law for skilled nursing facilities. Specific documentation, review, and survey procedures are mandated for the community's health care components. The purpose of this report is to identify and make recommendations related to eliminating duplicative requirements in certification and monitoring of these facilities.

In preparing this report to the Governor and the Legislature, the Department analyzed reports and materials currently required in the approval, certification, licensure and survey processes. In addition, in September 2006, the Department asked CCRCs, consultants and the industry association to provide their views on requirements that are duplicative and could be eliminated. The New York Association of Homes and Services for the Aging (NYAHSA) gathered information from its member communities and, following a telephone conference, provided the Department with its response in December 2006. That response was heavily relied upon in preparing this report.

Summary of Findings

Continuing care retirement communities offer residents a life style which combines independent living, supportive social and health care services and, if needed, residential care in a licensed adult care facility or skilled nursing home. CCRCs instill a shared sense of neighborhood among residents. Communities are well-organized, stable and committed to providing residents with quality services and amenities, in both independent living and health care. Coordination and integration of these services at all levels is the major operational goal expressed by continuing care providers.

The Department of Health understands and commends the CCRC providers' commitment to an integrated care system. After careful review of the suggestions made by the CCRC industry, the Department has identified a

number of areas where duplication can be eliminated or where clarification of the current requirements would improve the efficiency of administration of CCRCs. In addition, areas where further Department review of current practice is indicated have been identified. These recommendations include:

- Further examination of current requirements surrounding clinical practice across all levels of care within the CCRC.

- Use of a consolidated single resident medical record available to both the CCRC adult care facility and skilled nursing facility.

- Assisting CCRC skilled nursing facilities in developing policies that would allow transfer of resident medication from home or from an adult care facility.

- Consolidation of the Department's surveillance of the CCRC's physical plant.

- Clarification by the Department that the continuing care contract is the single contract to be used for all levels of care by CCRC residents except for residency agreement requirements of Article 46-B, Assisted Living Residences. The Department supports an exemption from the residency agreement requirements of Article 46-B for CCRC resident contract-holders.

- Potential elimination of the requirement for the ACF, home care agency and diagnostic and treatment center to file cost reports with the Department when they will not be billing Medicaid or other government entities. The Department will continue to explore the elimination or reduction of current cost reporting requirements for CCRCs.

A number of other requirements were identified by the industry as duplicative. The industry also pointed out certain areas where revisions to Article 46 could be made in order to exempt CCRCs from the state regulations that pertain to skilled nursing facilities and ACFs. The Department carefully reviewed these suggestions and found that they could not be supported by the Department because of requirements in current state law or regulation or because of concerns that eliminating the requirement would not be in the best interest of the residents of the communities. These include:

- Allowing a CCRC to transfer contract holders between levels of care without completing patient assessments

- A reduction in the required CCRC licensure and inspection fee or exemption from ALR fees since such fees support different activities and purposes

- An exemption from the timing of the refund provisions at §4609 for cooperative model CCRCs

The Department is committed to working in cooperation with continuing care retirement communities and their representatives to implement recommendations within current statute and regulation which will help foster the integration of care within the CCRCs.

1. INTRODUCTION

The New York State Department of Health has prepared this report for Governor Spitzer and the New York State Legislature in fulfillment of the provisions of Chapter 700 of the Laws of 2006. Chapter 700 requires the Department to review and report on duplicative requirements in continuing care retirement communities and make recommendations for eliminating such duplication.

Article 46 of the Public Health Law, the legislation authorizing continuing care retirement communities, was created by Chapter 689 of the Laws of 1989 and signed into law on August 8, 1989. The statute addressed the need for an integrated living and health care arrangement, combining an independent life style with a continuum of on-site health care services, allowing residents to age in place in a community setting. Article 46 defines the requirements and procedures for the establishment, approval and monitoring of continuing care retirement communities.

This Report follows two previous reports to the Governor and Legislature detailing the early development of continuing care retirement communities, "Life Care Communities, A Report to the Governor and Legislature, January 1991", and, the advisability of authorizing the development of alternate models of continuing care retirement communities, "Continuing Care Retirement Communities, A Report to the Governor and Legislature, January 1996".

In the years since publication of the January 1996 report, continuing care retirement communities have experienced steady growth and positive development. Amendments to the original 1989 statute have enabled project financing through use of escrowed entrance fees and local industrial development agencies. Subsequent revisions have led to increased regulatory flexibility by broadening the definition of the required meal service and allowing Commissioner and Superintendent approval of refinancing requests. In 1997, amended legislation allowed operators to offer modified or Type B contracts in Article 46 communities. These contracts include a limited skilled nursing facility benefit of at least sixty (60) days. In 2004, new legislation under Article 46-A of the Public Health Law authorized the development of fee-for-service continuing care retirement communities in New York State. Fee-for-service continuing care retirement community contracts include no guaranteed skilled nursing benefit. Residents admitted to the skilled nursing home or adult care facility pay for services on a per diem basis. Because the contract includes no guaranteed health care benefits, the State Insurance Department does not provide evaluation or monitoring of these communities.

Scope of Report

Chapter 700 of the Laws of 2006 amends Article 46 of the Public Health Law by establishing broader criteria for the release of escrowed entrance fees and increasing the number of residential health care facility beds available to continuing care retirement communities. Chapter 700 was signed into law on September 13, 2006.

The final requirement of the amendment is the submission by the New York State Department of Health of a Report to the Governor and Legislature on duplicative requirements in the continuing care retirement community review and approval process. This Report is submitted in accordance with that requirement and addresses the following issues:

- CCRC background and beginnings in New York State
- Regulatory reform initiatives – 1989 through 2006
- Request for information and recommendations
- Review and analysis of submitted information
- Identification of duplicative requirements
- Recommendations for alleviation or elimination of duplicative requirements
- Future activities

2. CONTINUING CARE RETIREMENT COMMUNITIES IN NEW YORK STATE

Background

Article 46 of the Public Health Law authorizing continuing care retirement communities was signed on August 8, 1989. Under the establishing legislation, CCRCs were proposed as an integrated residential and health care system for seniors that would allow residents to remain in the community while receiving needed long-term care. Although senior residential options were available in New York State, most did not provide access to a continuum of health care services. CCRCs were a response to this need for supportive independent living combined with a continuum of on-site health care.

While supporting the prudent development of continuing care retirement communities, Article 46 also emphasized consumer protections, the security of resident finances, and the long term financial viability of the community. Specific protections included required escrow of resident entrance fees, review of the character and competence of the sponsor and manager, and determination of the financial feasibility of the community through an accounting of required presales prior to construction. Article 46 also defined a rigorous procedure for approval and monitoring of projects, including direct project review by the Department of Health and the State Insurance Department, and consideration by senior citizen advocates, service providers and consumers in the form of an appointed Council.

The Continuing Care Retirement Community Council consists of representatives from four State agencies, Health, Insurance, Aging and the Attorney General's Office, and eight public members appointed by the Governor with the advice and consent of the Senate. All Council members have a demonstrated expertise or interest in CCRCs and at least two members must be continuing care retirement community residents.

The members of the CCRC Council and their affiliations are identified in Appendix 1.

Change and Progress

Article 46 initially authorized only full life care communities which include an unlimited skilled nursing facility contract benefit. Limited financing options were available to developers at this time. Subsequent legislation expanded this scope by permitting use of escrowed entrance fees in construction, financing by Industrial Development Agencies (IDA), and allowing communities to offer residents a modified contract with a limited skilled nursing facility benefit. With IDA financing available, interest in CCRC development increased. Between 1994 and 2000, ten proposed communities initiated the Certificate of Authority

application process, with seven projects receiving full Certificates of Authority and eventually admitting residents.

Currently, there are eight fully operational communities, with an additional six projects in various stages of construction or development. Of the operational communities, two are located in Westchester County and two in Suffolk County. The remaining communities are located in Tompkins, Orange, Monroe and Erie Counties. The number of independent living units available in each community varies from 250 apartments and cottages at Peconic Landing at Southold in Suffolk County, to 91 apartment units at The Summit at Brighton in Monroe County. Proposed communities will be located in Erie, Nassau, Ulster, Suffolk, Queens and Broome Counties. All operational and planned communities are sponsored by not-for-profit organizations.

A listing of operational and in-development communities follows this report as Appendix 2.

3. **REGULATORY REFORM – 1989 THROUGH 2006**

Continuing care retirement communities have, from the outset, been supported by an authorizing statute which exempted the health care components of Article 46 communities from certain Public Health Law (PHL) and Social Services Law (SSL) requirements. Subsequent legislative amendments were designed to encourage continued project development and allow flexibility in service delivery.

The following statutory exemptions and allowances were originally authorized under Article 46:

- An exemption from PHL 2801-a(4)(d and e) allows limited partnerships, a corporation operated by another corporation, or a limited liability company to operate a CCRC, including the residential health care facility (RHCF) component of the CCRC;
- The RHCF component of a CCRC is exempted from any determination of public need and, except in the case of a facility with 90+ beds, the approval of the State Hospital Review & Planning Council is not required.
- PHL 4604(5) specifically established a set aside of 1000 RHCF beds that may be approved as components of CCRCs outside determination of public need;
- Article 46 includes an exemption from the restrictions on issuance of an adult care facility operating certificate found at SSL 461-b(1)(a); from the adult care facility public need requirement found at SSL 461-b(2); and, allows the CCRC adult care facility to provide contracted residents with an informational notice in lieu of a written admission agreement as required by SSL 461-c(4)(1).

In addition to the provisions found in the original statute, Article 46 has been amended several times with the intent of promoting CCRC development. These revisions have established financing alternatives, allowed additional contract types and streamlined some approval processes.

Following are the major revisions to Article 46:

- Chapter 66 of the Laws of 1994 established significant financing options for CCRCs by authorizing use of escrowed entrance fees for construction and allowing local Industrial Development Agencies to issue bonds for CCRC financing.

- Chapter 659 of the Laws of 1997 allowed Article 46 communities to offer Modified or Type B contracts which include a limited skilled nursing facility benefit of at least 60 days. Any CCRC offering modified contracts and requesting an exemption from the public need determination and/or IDA

financing must assure that all residents have the ability to fund the estimated cost of nursing facility services for a period of one year.

- Chapter 401 of the Laws of 2003 authorized the Commissioner of Health, in consultation with the Superintendent of Insurance, to approve or reject refinancing proposals if the CCRC Council had previously approved the community's application. Prior to this revision, refinancing approvals were subject to full Council approval. Chapter 401 also eliminated the requirement that a CCRC provide "board" which had been interpreted as a daily meal.

- Chapter 700 of the Laws of 2006 amended Article 46 by allowing the release of escrowed entrance fees to an operator when contract sales reach 70% of proposed independent living units with 10% deposits, and increased the original residential health care facility set-aside from 1000 to 2000 beds. Chapter 700 also requires a Department-conducted review of duplicative requirements which is the subject of this report.

In addition to these amendments to Article 46, on September 14, 2004 Governor Pataki signed legislation establishing Article 46-A, the Fee-for-Service Continuing Care Retirement Communities Demonstration Program. This legislation allows for the development of up to eight communities providing independent residential living and offering health care services on a fee-for-service basis.

Contract types offered under Article 46 and Article 46-A are more fully defined in Appendix 3.

4. **IDENTIFICATION OF DUPLICATIVE REQUIREMENTS**

Chapter 700 of the Laws of 2006 directs the Department to conduct a review of duplicative requirements in continuing care retirement communities 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.

To determine the requirements contributing to duplication of effort and to determine policies which may impede full integration of the CCRC's continuum of health care services, Department staff requested specific examples and recommendations for improvement from interested parties.

In a September 26, 2006 letter, the Department of Health asked continuing care retirement communities and consultants to provide information regarding duplicative requirements and suggestions for eliminating or alleviating such duplication. As CCRC health care components must comply with all rules and regulations of Public Health Law and Social Services Law, except for those regulatory exemptions detailed in Article 46, the industry was asked to identify the specific revisions that would need to be made to current regulation in order to eliminate the duplicative requirement described. In addition, interested parties were asked to specify what action, including a proposed change in policy, regulation or statute, would be necessary to eliminate or alleviate an identified duplicative requirement.

The September 26, 2006 request for information and recommendations is included in this report as Appendix 4. The list of interested parties to whom the request for information was sent is included as Appendix 6.

In response to the Department's request, the New York Association of Homes and Services for the Aging (NYAHSA) provided suggestions from the organization's CCRC membership and the consultants who assist in the development and management of New York State continuing care retirement communities.

5. REVIEW OF ISSUES PROVIDED BY THE INDUSTRY

The following suggestions and comments were submitted by the New York Association of Homes and Services for the Aging. The full text of the December 1, 2006 letter submitted by NYASHA is included as Appendix 5.

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

Current New York State laws and regulations prohibit clinical staff, including registered nurses, licensed practical nurses, rehabilitation therapists and certified nurse aides, employed by the CCRC skilled nursing facility (SNF) from providing services to adult care facility and independent residents. Operators believe that their residents expect continuous and integrated health care provided by clinical staff that know the resident's medical history and are be able to provide individualized care. Residents are aware that medical professionals are available within the CCRC (as skilled nursing facility staff) and question why this licensed staff cannot provide simple or routine medical services for independent and adult care residents. Such care would save residents time and money and prevent unnecessary medical or emergency room visits.

Industry representatives contend that limiting residents' accessibility to available on-site health care staff is inherently incompatible with the concept of a continuing care environment. Transferring a resident to a hospital with staff unfamiliar with the resident may diminish the quality of care received, instead of receiving services from clinical staff that know the resident's medical history and are able to provide individualized care.

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

DOH Discussion/Concerns:

Health care provided by licensed professionals must comply with the requirements of State Education Law. In addition, the programmatic aspects of such health care are further defined, for skilled nursing facilities and home care services, by Public Health Law. The provision of health care must have a clear line of supervision.

While CCRC residents may receive care from a physician who leases space on the CCRC grounds, the CCRC does not usually maintain medical records for independent residents and SNF staff do not have access to the medial histories of residents outside of the institutional setting.

The industry has proposed an alternative that may provide an opportunity to improve the efficient delivery of health care services to CCRC residents across all levels of care. The Department will examine current regulatory and statutory requirements to determine if certain clinical services can be provided by CCRC staff across the integrated components of the CCRC setting. Important issues such as the supervision of and professional liability for the staff performing clinical services outside of the institutional setting would need to be addressed.

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

As separate medical records are required at the adult care and skilled nursing facility levels, CCRC operators state that, on transfer to a higher care level within the CCRC, the resident's medical history is not available to the clinical staff. Instead a new medical record must be initiated. A consolidated medical record would ensure better outcomes for residents while reducing the possibility of medical and medication errors.

The industry recommends that CCRCs be allowed to develop, through Article 46, the ability to maintain continuous medical records for residents at all levels of care, including the development of Electronic Medical Records (EMR). Once regulations allow for consolidated medical records, they recommend 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.

DOH Discussion/Concerns:

NYS regulations require an individual's medical information be provided to a facility (an adult care facility or SNF) on admission and when the resident moves from a SNF to an adult care facility or to home. If a CCRC resident moves between care levels, from adult care to skilled nursing and back to adult care, relevant portions of the medical record or medical history could be copied and provided to the admitting level of care. As many CCRC health care components are contiguous or located on different floors of the same building, a single, consolidated medical record available to clinical staff at all levels appears more convenient and efficient.

The Department of Health supports the concept of a consolidated medical record available to appropriate clinical staff and maintained in a central area shared by the adult care facility and the SNF although confidentiality of the medical record must be assured. An electronic medical record (EMR) may provide an efficient method of maintaining and securing medical information.

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

Current statute and 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 or emergency. The required assessment tool for the RHCF is the Patient Review Instrument (PRI); the assessment tool for any ACF admission is the DSS-3122. These tools must be completed by a certified assessor (the PRI) or by a physician who has seen the patient within 30 days of admission (DSS-3122). The premise of requiring either form is that the receiving facility needs current and complete information in order to evaluate the admission and develop a plan of care. The industry states that, in the case of CCRC residents, the facility has current and complete medical information as a result of rendering ongoing care and service to its residents. Requiring the completion of this form is unnecessary and duplicative.

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

DOH Discussion/Concerns:

In all transfer situations, including emergencies, the paramount issue is ensuring that the resident receives proper care and necessary medical services. Both New York State Health (Title 10) and Social Services (Title 18) regulations require patient assessment prior to any facility admission. Regulation at 10 NYCRR 415.26(i) requires all nursing home patients be admitted to a facility only with a physician's order and a completed Patient Review Instrument and Screen. Regulation at 18 NYCRR 488.4 and 487.4 requires completion of a patient medical evaluation prior to admission to an enriched housing facility or adult home. Medical assessment prior to admission ensures that a resident's needs can be met.

The industry's discussion assumes that CCRC staff will have full and immediate access to the medical histories of independent living residents, which is not necessarily the case. Medical information on independent residents is not generally maintained by the community and therefore would not be available to adult care facility or skilled nursing staff.

Currently, there is no exemption from the required completion of the DSS-3122. Exemption from adult care facility and skilled nursing facility pre-admission assessments would require a change in statute.

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

Industry representatives understand that per ACF and RHCF regulations, that when residents transfer for short-term stays 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. CCRCs have reported that medication transfer policy is not being recognized and residents have been unable to transfer their medications. When this occurs, medications must be disposed of and new medications obtained, even if exactly the same.

The industry 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.

DOH Discussion/Concerns:

As an adult care facility is a personal residence, medication can be brought in by the resident and belongs to the resident at discharge. Residents may self administer medication.

There are no State or Federal regulations prohibiting residents from bringing their medications into a skilled nursing facility. However, a skilled nursing facility allowing such admission of medications must develop a formal policy and procedure. The Department will clarify requirements related to transferring medications and will work with CCRC operators to develop Best Practices in establishing a workable policy for their community.

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

Although CCRCs were developed to provide integrated care to residents at multiple service levels, CCRC components are often regulated as separate individual entities. This is particularly true for physical plant oversight. While facilities and procedures are the same, surveys for dietary facilities and services, physical plant and life safety (fire alarm, sprinklers and generators) are completed independently for each level of care by state surveyors. These duplicative surveys may be completed by the same person, within weeks of each other, and involve multiple reviews of the same documentation.

The industry 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 one HPN account for all levels of care.

DOH Discussion/Concerns:

The Department agrees that surveys of the adult care facility and skilled nursing facility physical plants can be coordinated. Department staff are in the process of working with the Department's area offices to inform and educate designated on-site surveyors. The coordinated scheduling may result in an increased number of adult care facility inspections as skilled nursing facilities are currently inspected on a more frequent basis than adult care facilities.

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.

Although the Department has determined that, under Article 46, the continuing care contract is the only agreement that may be signed by a resident for provision of services included in the contract, state surveyors have cited deficiencies for the absence of separate signed admission agreements for life care 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.

The industry recommends that the continuing 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.

DOH Discussion/Concerns:

By statute, the CCRC residency agreement is the single contract covering all services provided by the community. Residents may not be asked to sign a SNF admission agreement or an adult care facility admission agreement. Article 46 specifically exempts CCRCs from the adult care facility admission agreement requirement contained in social services law. The Department will provide clarification on this issue to all state surveyors.

While §4604(3) specifically exempts continuing care retirement communities from the adult care facility admission agreement requirement, CCRCs have no clear exemption from the residency agreement requirements under Article 46-B for Assisted Living Residences. The Department would support a statutory change to exempt CCRC resident contract-holders from the residency agreement requirements of Article 46-B.

7. Include the $50 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.

The industry recommends that since continuing care retirement communities are already paying an annual licensure and inspection fee as a CCRC, the

communities should be exempt from paying the biennial ALR, EALR and SNALR application fees.

DOH Discussion/Concerns:

Section 4602(2)(e) allows the CCRC Council to establish and charge to CCRCs, an annual fee to subsidize, in part, expenditures incurred in reviewing applications for certificates of authority and in inspecting, regulating, supervising and auditing these communities. The annual fees, which range from a low of $4,500 to a high of $12,800, are used to reimburse the Insurance Department for extensive on-site auditing activities performed by Department of Insurance field staff and to support the activities of the CCRC Council. The fees paid under §4602(2) for monitoring and auditing CCRCs will not be available for any expenses associated with the licensure and monitoring of Assisted Living Residences. In each case, the fees are established for a different and specific purpose and are utilized by different Department of Health staff.

As the Assisted Living Residence fees are required under Article 46-B, any exemption from ALR application and biennial fees would require a statutory change. Such statutory change would not be supported by the Department as the required fees under each statute are intended for separate purposes.

8. Eliminate inequitable requirements for CCRC cooperatives and condominiums.

Cooperatives and condominiums established under Article 23-A of the General Business Law are regulated by the Office of the Attorney General. When established as a model continuing care retirement community, condominiums and cooperatives are regulated under Article 46 of the Public Health Law and Department of Insurance Regulation 140. Repurchasing requirements under General Business Law and Public Health Law differ as CCRCs, under Public Health Law, must repurchase the condo or co-op from the owner if not sold to another CCRC resident within one year. The industry believes that this puts an undue financial burden on the CCRC.

The industry recommends making exceptions for equity model continuing care retirement communities to allow refunds upon resale regardless of when the resale is made, as is allowed for in other equity models in New York State.

DOH Discussion/Concerns:

Section 4609 of the Public Health Law clearly establishes the refund process and timeframe when a CCRC resident cancels a continuing care contract or dies. Any refunds must be paid no later than thirty days after the formerly occupied unit has been resold, but in no event later that one year after the formerly occupied unit has been vacated. This requirement applies to all CCRC models

and to all contract types. A resident (or the resident's estate) is assured of receiving the contractually-established refund and is aware of the timing of the refund. This guaranteed refund, provided within a specified time period, is an important and necessary consumer protection.

Any exemption from §4609 would require a statutory change. The Department does not support exempting cooperative model CCRCs from this requirement. Statutory requirements controlling contract termination and the refund process should be consistent across all CCRC models.

9. Reduce unnecessary cost report filing.

Because CCRCs include multiple health care services and maintain multiple certificates or licenses, they are required to file multiple annual cost reports. For licenses where the CCRC receives no reimbursement from state-funded sources, the associated cost reporting seems unnecessary, such as the ACF annual report and cost reports for home care agencies and diagnostic & treatment centers. In these two cases, CCRCs would serve continuing care residents and would not be billing Medicaid or other government entities where revenue is based on cost. Required reports are complex, time-consuming, and utilize resources that would be better spent providing services to residents.

Industry representatives recommend 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 the Departments of Health and Insurance.

DOH Discussion/Concerns:

The industry recommends CCRCs be exempt from filing cost reports in those instances where the CCRC would not be billing government sources for additional revenue. Article 46 allows an operator of a CCRC to admit individuals from outside the community to the CCRC's skilled nursing facility and adult care facility (§4605(2)(a) and (b)). The intent is to allow the CCRC operator, with a newly constructed skilled nursing facility and adult care facility, to utilize these health care resources to generate needed revenue for the community. The operator is authorized to admit out of community residents if the operator agrees not to discriminate in the admission of individuals eligible for Medicaid and/or SSI benefits. Most CCRCs have requested authorization to admit out of community individuals to the CCRC's health care facilities. Admissions from outside the CCRC would therefore include both private pay individuals and persons subsidized by government financing.

The recommendation to exempt CCRCs from filing current cost reports in those circumstances where the CCRC would not bill government sources can be further reviewed. However, if the CCRC operator chooses not to admit

government financed individuals, the community would be closed to all outside admissions and would be required to serve only resident contract-holders.

The Department will continue to explore the elimination or reduction of current cost reporting requirements.

6. RECOMMENDATIONS AND FUTURE ACTIVITIES

This report explores a number of areas that have been identified as duplicative requirements that may impede the CCRCs goal of providing residents with a seamlessly integrated health care environment.
As a result of this report and input from stakeholders, the Department has identified a number of areas where duplication can be eliminated or where clarification of the current requirements would improve the efficiency of administration of CCRCs. The Department has also identified areas where further Department review of current practice is indicated. These recommendations include:

- A further examination of the issues surrounding allowing clinical staff to practice within their scope of practice at all levels of care within a CCRC. The Department will examine current requirements to determine if professional staff can provide any form of clinical services to those residents of the CCRC not residing in the health care facility.

- Use of a consolidated single resident medical record available to both the CCRC adult care facility and skilled nursing facility. The single record would include relevant information on medical treatments, history and services provided in the adult care facility and the skilled nursing facility. The record could be maintained in a secure, central area convenient to both the ACF and SNF.

- Permitting CCRC skilled nursing facilities to develop policies that would allow transfer of resident medication from home or from an adult care facility.

- Consolidation of Department surveillance activities of the CCRC's physical plant.

- Clarification by the Department that the continuing care contract is the single contract to be used for all levels of care by CCRC residents and that CCRC residents should not be asked to sign separate admission agreements for the adult care facility or the skilled nursing facility. CCRCs may require a statutory exemption from the residency agreement requirements of Article 46-B, Assisted Living Residences. A statutory change exempting CCRC resident contract-holders from the residency agreement requirements of Article 46-B would be supported by the Department.

- Potential reduction or elimination of the requirement for the ACFs, home care agency and diagnostic and treatment center to file cost reports with the Department when they will not be billing Medicaid or other government

entities provided, however, that these providers would then be closed to all outside admissions and would be able to serve only resident contract holders. The Department will continue to explore the elimination or reduction of current cost reporting requirements.

The Department finds that a number of other suggestions cannot be implemented administratively because they require a change in statute or regulation or because the Department believes that they are not in the best interest of CCRC contractholders. These include:

- Allowing a CCRC to transfer contract holders between levels of care without completing patient assessments.

- A reduction in the required CCRC licensure and inspection fee or exemption from ALR fees since such fees support different activities and purposes.

- An exemption from the timing of the refund provisions at §4609 for cooperative model CCRCs.

MEMBERS OF THE CONTINUING CARE RETIREMENT COMMUNITY COUNCIL

Linda Gowdy, Chairperson
Director
Bureau of Continuing Care Initiatives
NYS Department of Health
Corning Tower 2084
Albany, New York 12237

Vera Prosper
Housing Specialist
NYS Office for the Aging
Agency Bldg #2, 4th Fl
Empire State Plaza
Albany, New York 12223

Kenneth E. Demario
Assistant Attorney General
Real Estate Financing Bureau
NYS Office of the Attorney General
120 Broadway, 23rd Fl
New York, New York 10271

Patricia Patwell
Senior Insurance Attorney
NYS Insurance Department
Twin Towers, 19th Fl
1 Commerce Plaza
Albany, New York 12257

Wayne Kaplan, Esq.
Ruskin Moscou Faltischek PC
East Tower, 15th Fl
190 EAB Plaza
Uniondale, New York 15556

Robert G. Spann
Consumer Representative
Jefferson's Ferry
Jefferson's Ferry Dr
South Setauket, New York 11720

Patricia Williams
Consumer Representative
Kendal at Ithaca
Savage Farm Rd
Ithaca, New York 14850

Robert Chur
President & CEO
Elderwood Senior Care
7 Limestone Dr
Williamsville, New York 14221

Edward C. Weeks
President & CEO
Episcopal Church Home of Western New York & Affiliates
24 Rhode Island St
Buffalo, New York 14221

Appendix 2

OPERATIONAL AND PROPOSED CCRCs IN NEW YORK STATE

CCRC	DATE OPENED	CONTRACT TYPES OFFERED	# ILUs/ACF/SNF
Kendal at Ithaca 2230 N. Triphammer Rd Ithaca, NY 14850 Tompkins County	December 1995	Full Life Care Modified	213 Apartments & Cottages 36 Adult Home Units 35 Skilled Nursing Units
Glen Arden, Inc. 46 Harriman Drive Goshen, NY 10924 Orange County	June 1996	Full Life Care Modified	148 Apartments 28 Enriched Housing Units 40 Skilled Nursing Units
The Summit at Brighton 2000 Summit Circle Dr Rochester, NY 14618 Monroe County	May 1998	Full Life Care Modified	91 Apartments Affiliation with Wolk Manor for Enriched Housing Care Affiliation with Jewish Home of Rochester for Skilled Nursing Care
Canterbury Woods 24 Rhode Island St Buffalo, NY 14213 Erie County	June 1999	Full Life Care	243 Apartments & Cottages 32 Enriched Housing Units 48 Skilled Nursing Units
Jefferson's Ferry 1 Jefferson's Ferry Dr South Setauket, NY 11720 Suffolk County	June 2001	Full Life Care	248 Apartments 60 Enriched Housing Units 60 Skilled Nursing Units
Westchester Meadows 55 Grasslands Rd Valhalla, NY 10595 Westchester County	March 2002	Full Life Care	120 Apartments 10 Enriched Housing Units 20 Skilled Nursing Units
Peconic Landing at Southold 1500 Brecknock Rd Greenport, NY 11944 Suffolk County	August 2002	Full Life Care Equity Model Community	250 Apartments & Cottages 24 Enriched Housing Units 44 Skilled Nursing Units
Kendal on Hudson 1010 Kendal Way Sleepy Hollow, NY 10591 Westchester County	May 2005	Full Life Care Modified	222 Apartments 24 Enriched Housing Units 42 Skilled Nursing Units
Fox Run at Orchard Park Orchard Park, NY Erie County	Under construction. Anticipated opening September 2007	Full Life Care Modified	180 Apartments 51 Enriched Housing Units 50 Skilled Nursing Units
Woodland Pond at New Paltz New Paltz, NY Ulster County	Signing contracts. Anticipated opening December 2007	Full Life Care Modified	179 Apartments 60 Enriched Housing Units 40 Skilled Nursing Units

CCRC	DATE OPENED	CONTRACT TYPES OFFERED	# ILUs/ACF/SNF
The Amsterdam at Harborside West Shore Road Port Washington, NY 10050 Nassau County	Signing contracts. Anticipated opening January 2008	Full Life Care Modified	256 Apartments 34 Enriched Housing Units 40 Skilled Nursing Units
Harbor Village at Mount Sinai Route 25A & Echo Ave Mount Sinai, NY Suffolk County	Signing contracts. Anticipated opening November 2008	Full Life Care Modified	234 Apartments 43 Enriched Housing Units 60 Skilled Nursing Units
Skyline Commons Queens Hospital Center Jamaica, NY Queens County	Certificate of Authority application under review	Full Life Care Modified	143 Apartments 19 Enriched Housing Units 40 Skilled Nursing Units
Good Shepherd Village at Endwell Cummings Rd Endwell, NY 13760 Broome County	Certificate of Authority application pending	Article 46-A Fee for service contracts	150 Apartments 32 Enriched Housing Units 32 Skilled Nursing Units Fee-for-service CCRC

ILU – Independent Living Units

ACF – Adult Care Facility (Adult Homes and Enriched Housing are types of Adult Care Facilities)

AH – Adult Home
EH – Enriched Housing
SNF – Skilled Nursing Facility

CONTINUING CARE RETIREMENT COMMUNITY CONTRACT TYPES

Life Care Contracts (Type A):

The resident pays a substantial entrance fee and a monthly fee and receives in return, independent housing and use of community amenities, residential services such as housekeeping, a meal plan, scheduled transportation services, access to physician services, rehabilitation and prescription drug services, and, the opportunity to take part in a variety of social, cultural and educational opportunities. In addition, the life care contract provides unlimited adult care facility services, if offered by the CCRC, and unlimited skilled nursing facility services. The monthly fee may increase based on annual adjustments but increases are not based on the level of care or services needed by the resident. Under a life care contract, as the resident moves from independent living to the adult care facility to the skilled nursing facility, the monthly fee does not increase but remains at the level paid in independent living.

Modified Contracts (Type B):

Modified or Type B contracts were permitted under Article 46 beginning in 1997. Modified contracts cover all residential services and amenities included in a life care contract, but include a limited skilled nursing facility benefit of at least 60 days. Any adult care facility benefit, if provided by the community, may also be limited. When the benefit period ends, residents requiring skilled services pay a per diem market rate for care. As Type B contracts do not promise lifetime nursing home care, entrance fees can be set lower than full life care.

CCRCs offering modified contracts are allowed to access the residential health care facility bed set-aside established under Article 46 and to use IDA financing if the community guarantees to the State that each resident can pay for at least one-year of nursing home care before becoming Medicaid eligible. If the resident is unable to pay for the full year, the community must pay for the skilled nursing care.

Currently, all Article 46 communities offer life care contracts. About one-half of the operational communities also offer modified contracts, although the majority of residents have opted for full life care.

Fee-for-Service Contracts (Type C)

Chapters 519 and 545 of the Laws of 2004 established Article 46-A, the Fee-for-Service Continuing Care Retirement Communities Demonstration Program. Article 46-A authorizes the development of up to eight (8) fee-for-service projects to encourage affordable care options for middle income seniors. These contracts

include access to on-site geriatric services, including nursing facility, adult care facility, home health services, meals, social services and independent living. The Continuing Care Retirement Community Council has the same authorization and approval functions as for Article 46 communities. The Department of Health continues as the lead monitoring agency, but as there is no promise of skilled nursing care, the State Insurance Department has no role in the Article 46-A review process. Up to 350 nursing home beds from the original set-aside may be used by fee-for-service CCRCs.

As the resident pays per diem for all health care services, fee-for-service contracts offer a lower entrance and monthly fee than life care or modified contracts. Fee-for-service contracts cannot be offered at Article 46 continuing care retirement communities.

September 26, 2006 Department Request for Information and Recommendations regarding Duplicative Requirements

Dear Colleague:

On September 13, 2006, the Governor signed Chapter 700 of the Laws of 2006. Chapter 700 amends two sections of Article 46 of the Public Health Law. Section 4610 is amended by allowing the release of escrowed entrance fees to an operator when executed contracts and deposits equal at least ten percent (10%) of total entrance fees due at occupancy for at least seventy percent (70%) of all proposed living units. Section 4604 is revised by authorizing an increase in the residential health care facility bed set aside from the original 1000 to 2000 beds.

In addition to these amendments, Chapter 700 requires the Department to conduct a review of duplicative requirements in continuing care retirement communities 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. The Department is directed to review continuing care retirement community requirements and report the findings of this review to the Governor and Legislature, along with recommendations for eliminating such duplication. This report must be presented to the Governor and Legislature by January 15, 2007.

To assist the Department in developing a practical and experience-based report, we are asking continuing care retirement communities and consultants to provide us with information regarding duplicative requirements and suggestions for eliminating or alleviating such duplication. Information and suggestions submitted should consider that, except as specifically provided in Article 46, the activities of continuing care retirement communities (and the health care components of continuing care retirement communities) are subject to any other law governing such activities, including but not limited to Article 28 of the Public Health Law, Article 46-B of the Public Health Law, Article 7 of the Social Services Law and any regulations promulgated under these statutes.

We would appreciate receiving the following type of recommendations:

- Your information describing a duplicative requirement, action or process. Specification regarding dates, types of documentation or required material submissions would be helpful.
- In addition, please identify what action would be necessary to eliminate or alleviate the duplicative requirement; i.e., a Departmental policy change, a regulatory change, or a change in current New York State law.

Please provide information and suggestions to the Department by October 20, 2006. Your recommendations can be submitted to Loretta Grose or myself at the NYS Department of Health, Bureau of Continuing Care Initiatives, Corning Tower Room 2084, Empire State Plaza, Albany, N.Y. 12237. Facsimile transmittals can be made to 518-474-6961. Electronic submissions should be directed to Lrg02@health.state.ny.us.

Continuing care retirement communities provide residents with an extraordinary social and health care support system. We are committed to working with continuing care retirement community operators and advocates in maintaining this standard of excellence. Thank you for your assistance.

Sincerely,

Linda Gowdy

Linda Gowdy, Director
Bureau of Continuing Care Initiatives

Appendix 5

The Center
for Senior Living & Community Services
A division of the New York Association of Homes & Services for the Aging
150 State Street, Suite 301 Albany, NY 12207-1698
Tel 518.449.2707 Fax 518.455.8908 www.nyahsa.org

December 1, 2006

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
The Center for Senior Living and Community Services
The New York Association of Homes and Services for the Aging

INTERESTED PARTIES
Received the September 26, 2006 Information Request Regarding Duplicative Requirements

Maureen Coughlin
Executive Director
Glen Arden, Inc.
46 Harriman Dr
Goshen, NY 10924

Peter Sanna
Executive Director
Westchester Meadows
55 Grasslands Rd
Valhalla, NY 10595

Karen Brannen
Executive Director
Jefferson's Ferry
1 Jefferson's Ferry Dr
South Setauket, NY 11720

Daniel Governanti
Executive Director
Kendal at Ithaca
2230 N. Triphammer Rd
Ithaca, NY 14850

Carol Silver-Elliott
Executive Director
The Summit at Brighton
2000 Summit Circle Dr
Rochester, NY 14618

Robert Syron
Executive Director
Peconic Landing
1500 Brecknock Rd
Greenport, NY 11944

Edward C. Weeks
Executive Director
Canterbury Woods
705 Renaissance Dr
Williamsville, NY 14221

Ken Harris
NYAHSA
150 State St
Albany, NY 12207

New Life Management & Development
20000 Horizon Way Suite 700
Mt Laurel, NJ 08054

Patricia A. Doyle
Executive Director
Kendal on Hudson
1010 Kendal Way
Sleepy Hollow, NY 10591

Daniel Sisto
President
Healthcare Association of NYS
1 Empire Dr
Rensselaer, NY 12144

NYSHFA
33 Elk St
Suite 300
Albany, NY 12207

John Kowalik
Retirement Living Services
100 Allyn St
Hartford, CT 06103

Michael Keenan
Good Shepherd-Fairview Home
80 Fairview Ave
Binghamton, NY 13904

Mark Pancirer
Amsterdam Nursing Home Corporation
787 7th Ave
New York, NY 10019

Vera Prosper (CCRC Council Member)
Housing Specialist
NYS Office for the Aging
Agency Bldg #2 4th Fl
Empire State Plaza
Albany, NY 12223

Kenneth Demario (CCRC Council Member)
Assistant Attorney General
Real Estate Financing Bureau
NYS Attorney General's Office
120 Broadway 23rd Fl
New York, NY 10271

Patricia Patwell (CCRC Council Member)
Senior Insurance Attorney
NYS Insurance Department
Twin Towers 19th Fl
1 Commerce Plaza
Albany, NY 12257

Wayne Kaplan (CCRC Council Member)
Ruskin Moscou Faltischek PC
East Tower 15th Fl
190 EAB Plaza
Uniondale, NY 15556

Robert G. Spann (CCRC Council Member)
Jefferson's Ferry
3 Jefferson's Ferry Dr
South Setauket, NY 11720

Patricia Williams (CCRC Council Member)
Kendal at Ithaca
426 Savage Farm Rd
Ithaca, NY 14850

Robert Chur (CCRC Council Member)
President & CEO
Elderwood Senior Care
7 Limestone Dr
Williamsville, NY 14221