FW: ESAAL comments to Affordable Housing Workgroup
Lisa Newcomb
to:
affordable@health.state.ny.us
11/04/2011 12:05 PM
Cc:
"mlk15@health.state.ny.us", "sdoolan@hinmanstraub.com", "lsievers@hinmanstraub.com"
Show Details

With this email I am forwarding ESAAL's recommendations for legislative, regulatory and policy adjustments pertaining to the Assisted Living Program. Thank you.
Lisa Newcomb

From: Carla Erhartic
Sent: Friday, November 04, 2011 12:00 PM
To: Lisa Newcomb
Subject:

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Empire State Association of Assisted Living

November 4, 2011

To Members of the MRT-Affordable Housing Workgroup:

We appreciate the opportunity to share our comments about assisted living with you, and thank you for your consideration. As you know a subcommittee of this Workgroup has been developed to focus specifically on redesign of the Medicaid-funded Assisted Living Program (ALP). Our first conference call will take place on Monday, November 7th. At that time ESAAL will discuss our detailed recommendations as to what changes might be made to the ALP that will further align it with the State's goal to transition its long term care programs into a Managed Care or Care Coordination Model framework. For your consideration in advance of our call, we briefly describe below our primary recommendations.

Permit Adult Care Facilities (ACF) to competitively bid for new ALP capacity for the indigent. Consumer demand and need for Medicaid-funded assisted living, or the ALP, far exceeds existing capacity. State policy currently favors growth of ALP capacity only where nursing home beds are closed as a result. This substantially limits ALP availability to nursing home operators willing to close nursing home beds. Moreover, it limits ALP capacity to those areas that have excess nursing home capacity, thereby neglecting to consider ALP bed need in other regions.

This current approach usually requires new construction or significant renovations to the nursing home which results in the expenditure of substantial state and federal funds to develop the ALP beds, through the use of HEAL and other public funding. The sizable upfront cost to the State and taxpayers means that it will take years to realize any net savings, if ever. This policy underutilizes existing licensed adult home and enriched housing program infrastructure, much of which was developed with private dollars and is already well suited to serve this population. A much more cost effective approach is available and at the State's disposal: Many adult homes and enriched housing programs are willing to provide ALP services to low and middle income seniors, and their relatively new buildings have already been reviewed for compliance with applicable building codes. They are "ready-made" and they require little, if any, capital assistance from government. Moreover, many of these facilities currently serve seniors that pay with their own private resources. At a time when government is desperately trying to reign in expenditures, using private resources to subsidize Medicaid helps to contain Medicaid costs.

Modify the ALP's admission/retention standards so that ALP providers may choose to provide more "aging-in-place" services, further delaying or preventing nursing home admissions. ALP providers should be given the flexibility to expand their admission/retention criteria, much like their EALR counterparts. For example, current regulation requires a person needing assistance from two persons to transfer or walk to be discharged from the ALP. Many ALPs are able and willing to serve that individual but cannot do so because of the criteria currently in regulation. Allowing ALPs the flexibility to expand services, and adjusting their reimbursement accordingly, makes fiscal sense because typically the only other option for residents discharged from an ALP is the more costly, institutionally-based nursing home.

Allow the Registered Nurse employed by the ALP's Licensed Home Care Services Agency (LHCSA) to conduct assessments. Current law requires that the Certified Home Health Agency (CHHA) or Long Term Home Health Care Program (LTHHCP) with which the ALP contracts must conduct all resident assessments. The ALP provider must pay the CHHA for all post-admission assessments, and the CHHA bills Medicaid separately for the pre-admission assessment. The ALP's RN is qualified to conduct all such assessments, which would save money for both the ALP provider and the State. Thus, we propose that the ALP's RN have the option to perform those assessments. With regard to the pre-admission assessment, we propose that the ALP receive additional Medicaid reimbursement but at a lesser rate than what the CHHA is currently paid, thereby saving the State additional funds.

Allow ALPs the option to utilize their LHCSA home health aides to perform all functions within their scope of practice/tasks. Access problems are growing because the CHHAs/LTHCCPs with which the ALPs contract are unable or unwilling to provide some home health aide level services commonly needed by the elderly in the ALP (i.e. eye, nose and ear drops, nebulizers, etc.). ALPs should have the option to use the certified home health aides that they employ in their LHCSA to perform functions within their scope of tasks. Just as they provide supervision of aides for personal care tasks provided to residents (i.e. Activities of Daily Living-ADLs), the ALP's' Registered Nurse could provide the required aide supervision for the home health tasks.

Remove the limitation on ALP residents' ability to access therapy services from providers other than the ALP's contracted CHHA/LTHHCP. Regulations state that the ALP must contract with a CHHA or LTHHCP for "nursing and therapy services". The Department interprets this to mean that the contracted CHHA or LTHHCP is the only organization that may provide such services. However, there are circumstances where an ALP resident can appropriately receive services from another entity. For instance, maintenance Physical Therapy is available from private PT companies under a **different Medicare benefit.** ALP residents' right to choose providers should be promoted so that they have access to all of their Medicare benefits.

Clarify standards for prior authorization of durable medical equipment (DME) covered in the ALP's capitated rate. There has been much confusion as to what DME equipment is covered in the ALP rate. The standard for what DME requires "prior authorization" is often changing and difficult to monitor. The Department should ensure clear guidance. Also, because changes in prior authorization significantly impact/increase costs to ALP providers, they should be given the opportunity to provide input before such decisions and changes in policy are made.

Foster transition of supported housing residents in need of 24-hour supervision into ALPs, if the resident so desires. At the first meeting of the MRT's Affordable Housing Workgroup, we learned from supported housing provider members that they struggle to find placement for their aging clients who develop the need to live in a setting with 24-hour supervision and staff assistance. Fostering appropriate ALP placements will both assist the supported housing provider in fulfilling its responsibility to find appropriate alternative placement for their client and will make more of the limited supportive housing capacity available for others awaiting placement. Expansion of the ALP as described in our first proposal would create the capacity necessary to achieve this. Then, there should be a method to foster relationships between supported housing and ALP providers within their respective communities.

Ensure that decisions made by hospital discharge planners result in appropriate placement of the individual. Within the next year, ALPs and other Medicaid-funded home care programs will begin mandated use of the State's 10-page Uniform Assessment Tool (UAS-NY). In contrast, nursing home admissions requires the much less onerous PRI. Many decisions about placement are made during a person's hospitalization, and hospitals may be reluctant to wait while the lengthy UAS-NY is completed. This may exacerbate the existing problem that hospital discharge planners can be incentivized to refer patients to a nursing home, even when the person is appropriate for an ALP or home care, simply because the initial paperwork is much less onerous. The assessment form should be standardized to ensure there are no administrative barriers which result in a referral bias.

Foster the ALP's ability to transition into the MRT's newly designed Care Coordination Model. The ALP is unique in that it provides both licensed housing and services in a home and community based setting. By nature of the ALP's capitated method of payment, the comprehensive package of services covered within that rate (assumption of financial risk), and the in-depth case management/care coordination services provided to ALP residents, this program already achieves many of the Care Coordination Model principles/guidelines recently approved by the MRT. Modifications, such as expanding the services included in the capitated rate (with commensurate adjustment to the rate), can and should be made to further align the ALP with the new Care Coordination Model.

Clarify the lines between independent senior housing and licensed assisted living, and adopt standards proposed in ESAAL-sponsored legislation S.7844/A.11231-A. Independent senior housing is critically needed for the growing number of seniors that do not require ongoing supervision and case management services, but desire the meals, housekeeping and other amenities available in senior housing. Moreover, individuals living in independent senior housing should continue to be able to access home care services from community providers just as any other person living in their home may do. However, some organizations representing themselves as senior housing are, in fact, providing and/or arranging for supervision, case management and personal care services for which current state law requires an adult home or enriched housing program license. Some senior housing providers are skirting that law to avoid Department of Health regulation and oversight, leaving the seniors living there without the important protections that Department of Health oversight affords. This is in contrast to the licensed and heavily regulated adult homes and enriched housing programs that these senior housing organizations "look like". It is an unlevel playing field and in some cases seniors are lacking important consumer protections. Again, respecting the legitimacy and need for independent senior housing, we should clarify by statute the standards for which a license is required, using the same or similar approach as that in S.7844/A.11231-A.

We appreciate your consideration of our recommendations. Today, many seniors choose to live in assisted living settings using their own private resources. Many others would like to choose assisted living, but are unable to because they rely on government assistance and access is limited. There is no question that a person living in an ALP costs the government less than if that same person were living in a nursing home. We are committed to working with other stakeholders to expand and modify the ALP so that the State can capitalize on this opportunity, and seniors can access this option when they so choose.

Respectfully submitted,

Lisa Newcomb

Executive Director