LeadingAge New York
formerly NYAHSA

LeadingAge NY recommendations for Assisted Living Program Redesign

The assisted living program (ALP) has been an effective cost-saving Medicaid program since the early 1990s. By effectively coordinated the care of nursing home-eligible individuals, the ALP is a wonderful home-like alternative for certain nursing home-eligible individuals. Given that the ALP has both home care and congregate housing components and serves low-income individuals, it is a vital resource where affordable housing is scarce.

Our reforms seek to build on the strengths and experience of the ALP while allowing it to evolve to work well in a managed care environment. Our goal is to provide more flexibility to the ALP to operate in whatever way is *most efficient for that particular ALP.* We recognize that different providers have different realities with regard to work force, regional resources, etc., and thus it is important to provide options to empower the ALP to determine the best way to provide quality services to their residents. Adopting these reforms will benefit the ALP, the managed care entity, the state and the consumer.

These are our specific recommendations:

1. **Eliminate the requirement for ALPs to contract with a certified home health agency (CHHA) or long term home health care program (LTHHCP) for the provision of certain services.** Presently, the ALP must contract with a single LTHHCP or CHHA. This reform allows more flexibility to maximize efficiency by enabling the ALP to access services as quickly as possible at the lowest cost. This also enables the ALP to honor resident choice. The ALP *may* choose to continue to contract with a CHHA or LTHHCP but is no longer *required* to. *This is a reform measure for this legislative session, and it requires statutory change.*

2. **Empower the licensed home care services agencies (LHCSAs) associated with ALPs to provide any services they are authorized to provide under Article 36 of the public health law, thereby enabling ALPs to provide more services directly *if they so choose*.** Presently, ALPs must have a home care component, which is typically a LHCSA. Despite the fact that the LHCSA follows the same regulations as a LHCSA serving the community, it is limited in the functions it can perform. This limitation stems from the thinking that the ALP technically is an adult care facility, which is traditionally considered a social model program. Our proposed reform allows ALPs to maximize efficiency by providing services directly if that is deemed most effective. Residents benefit by receiving services from staff they are familiar with, and their needs may be met more quickly. *This is a reform measure for this legislative session, and it requires statutory change.*

3. **Allow nursing homes to be able to provide those services traditionally provided by a CHHA or LTHHCP.** Certain ALP services such as therapies are accessed from CHHAs or LTHHCPs. This reform allows more flexibility, allowing the ALP to access such services in the most efficient manner. Providing more options would allow the ALP to access services more quickly and potentially at the lowest cost. For example, a NH on the same campus as an ALP may be well-

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equipped to provide therapies efficiently. *This is a reform measure for this legislative session, and it requires statutory change.*

4. **Lift moratorium on CHHAs to enable ALPs to serve their residents.** ALPs could more effectively deliver services and manage the care of their residents if enabled to do so directly through CHHA services. *This is a reform measure for this legislative session, and DOH could do this administratively.*

5. **Allow for an individual to be admitted to an ALP without an assessment conducted by local department of social services (LDSS) or HRA *prior* to admission. Rather, the LDSS can conduct post-admission audits to ensure appropriate admissions.** Currently, an ALP resident must go through a "triple screen" before being admitted to the ALP: being evaluated by the ALP, CHHA or LTHHCP and local district. This means that admissions rarely happen quickly. The goal of this provision is to speed up this process and prevent unnecessary nursing home placement. This change is consistent with recent changes in managed care; PACE and MLTC are subject to a retroactive review. *(The specifics of this may be changed to recognize the current law for the state to take over local district functions within five years. This may change, however, given the movement toward managed care. Ultimately, a managed care/MLTC will likely take over that function.) This is a reform measure for this legislative session, and it requires statutory change.*

6. **Expand the ALP retention standards to mirror the Enhanced Assisted Living Residence retention standards.** To enable more aging in place, ALPs would have the option to admit or retain persons who: (a) are chronically chairfast and unable to transfer, or chronically require the physical assistance of another person to transfer; (b) chronically require the physical assistance of another person in order to walk; (c) chronically require the physical assistance of another person to climb or descend stairs; (d) are dependent on medical equipment and require more than intermittent or occasional assistance from medical personnel; or (e) has chronic unmanaged urinary or bowel incontinence. An individual who requires services up to 24-hour skilled nursing care can be retained if the necessary parties agree that the resident's needs can be met. For the safety of residents, however, wording in the statute should state clearly that if a physician or the operator does not feel the resident's needs can be safely and adequately met in the facility, that the resident must move to a more appropriate setting.

   It is important to note that this provision will only work if the ALP is paid for the additional services it provides. We recommend that this be implemented once managed long term care has taken root statewide, so that the ALP can negotiate a fair rate with the managed care entity. If implemented in present time, the state must adjust existing ALP Medicaid rates. *Without an interim rate adjustment, this is a long-term reform measure that requires statutory change.*

7. **Let home health aides (HHAs) in the ALP do what they are trained to do and would do in someone's home with less supervision than the ALP affords.** Presently, HHAs are restricted

from performing certain functions in ALPs, much as nurses have been restricted from performing within their training and licensure, because ALPs are ACFs/social model programs. We propose that HHAs working in an ALP setting should be able to perform the functions that their training allows them to perform. It has been confusing for providers to understand the limitations of the HHA in the ALP, and it has been challenging to regulate. As long as an HHA has the proper training and the LHCSA is following the same regulations as in the community, a HHA should be permitted to provide identical care functions.

These changes will save money throughout the system by preventing unnecessary utilization of additional health care resources if the need could be otherwise met in the facility. It also saves time and money in the training and retraining of workers and encourages more flexibility in the work force, which is beneficial to aides and employers. *This is a reform measure for this legislative session, and we believe it requires DOH administrative action only.*

8. **Change notice requirements to enable an ALP bed to be given up if someone is not expected to return in a timely manner.** Current requirements, including the 30-day notice for termination of a residency agreement and the ability of a resident to appeal, can result in lengthy periods during which the operator is essentially required to hold that slot for the resident without receiving Medicaid payment. While services are not being provided to the resident, the facility continues to provide case management and is not able to reduce staffing. Thus the ALP costs remain the same. ALPs end up losing a significant amount of money annually as a result, and in some areas it presents a real access issue. Changes in the notice requirements that preserve consumer rights and allow the resident the next available ALP bed but also provide necessary flexibility would result in state savings by preventing unnecessary nursing home placement and would help ALPs to be more financially viable. *This is a reform measure for this legislative session, and it requires statutory change.*

9. **Adjust the Medicaid rate or provide an "add-on" to enable caring for special populations.** In the time it takes for managed care/managed long term care to develop statewide, the state can take an interim step to achieve savings. Special populations such as people with dementia or psychiatric disabilities could be cared for in the ALP if the payment were sufficient to address the resources necessary to provide such individuals quality care. The ALP can provide these services at a lower cost than the nursing home, in a more home-like setting. Providing a modest add-on can save the state significant dollars until the time that ALPs are contracting with managed care. *This is a reform measure for this legislative session, and it requires statutory change and a budget initiative.*

10. **Expand the ALP.** The ALP should be expanded to meet the needs of low-income seniors who do not need nursing home placement but cannot remain at home. This initiative would save the state dollars by preventing unnecessary nursing home placement for Medicaid-eligible individuals. The state's recent initiatives have given preference in awarding new ALP beds to nursing homes that are downsizing. We recommend that beds also be awarded to existing

ACFs or other entities that are positioned to develop ALPs quickly. *This is a reform measure for this legislative session, and it requires statutory change.*

11. **Eliminate the ADHC as an ALP service. Adult day health care (ADHC) is one of the package of services that the ALP must provide or arrange for within its capitated rate.** ADHC is a medical model program and a Medicaid state plan service. Given the cost of ADHC programs, it has not been financially feasible for the ALP to pay for these services within its own Medicaid rate, and the ADHC would provide services that were duplicative of the ALP services. *This is a reform measure for this legislative session, and it requires statutory change.*

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Diane Darbyshire
to:
Mark L. Kissinger, Sheri B. Senecal
11/07/2011 04:13 PM
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Mark,
Here are our recommendations to share with the group.
-Diane

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