

**Report of the  
Adult Care Facilities Workgroup**

**Submitted to:**

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**Commissioner**

**Department of Health**

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## Table of Contents

	<u>Page</u>
<b>Executive Summary</b>	<b>i - xiii</b>
<b>Introduction</b>	
<b>A. Purpose of Report</b>	1
<b>B. Background</b>	2
• What Are Adult Care Facilities and Who Lives in Them?	2
• Payment for Adult Care Facility Services	5
• Quality Problems in Adult Care Facilities	6
<b>C. Improving the Quality of Life and Services for Current Adult Home Residents</b>	7
• Assessments	7
• Medication Management	9
• Independent Service Coordinator Program	18
• Peer Bridger Initiative	24
• Advocacy	26
• Personal Needs Allowance and Clothing	26
<b>D. Restructuring the Housing and Services for Adult Home Residents</b>	26
• Housing Options	28
• Housing Vacancy List	32
• Unlicensed Facilities	33
<b>E. Potential Fiscal Impact</b>	33
• Assessments	34
• Medication Management	35
• Independent Service Coordinator Program	37
• Peer Bridger Program	37
• New Housing Models	38
• Refurbishing Existing Adult Homes	39
<b>F. Potential Fiscal Savings</b>	47
<b>G. Program Administration</b>	55
• Adult Home Surveillance/Enforcement	55
• Role of Public Health Council	56
• Office/Commission of Adult Home	56
• Advisory Committee	56

## **Appendices**

Appendix A: Adult Care Facility Workgroup

Appendix B: Housing Options

Appendix C: Presentations to New Models Workgroups

Appendix D: Supportive Congregate Housing as an Alternative to Adult Homes

Appendix E: Office of Mental Health Residential Programs Typology

Appendix F: Capital Financing, Housing Subsidy, and Service Programs  
Available for Affordable Senior Housing

Appendix G: SSI Benefit Levels Chart

Appendix H: New York State Commission on Adult Homes

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Adult care facilities (ACFs) are a model of care designed over thirty years ago to provide housing, supportive services and some personal care to elderly New Yorkers who are no longer able or choose not to live on their own, and who do not need access to continuous nursing care and can manage their own lives with some assistance. However, for the past thirty years the population living in ACFs has been changing. Today 25% – 30% of the resident population has a diagnosis of psychiatric disability, and a substantial portion of this group has additional non-mental health medical comorbidities.

Although this model may be effective and appropriate for some elderly New Yorkers who are physically frail, it does not provide adequate care and quality services to residents with psychiatric disabilities. Documented problems with quality of care and quality of life for a small segment of the industry date back to the 1970s. We have learned a great deal over the past three decades about the most effective approaches to delivering housing, supportive services and medical and long-term care to vulnerable populations. We now understand that effective service planning and delivery depend on active and informed consumer involvement, direction and choice. Furthermore, there has been an explosion in New York over the past ten years in the types, scope and intensity of community-based services financed by publicly supported programs.

A growing consensus developed that current residents of adult care facilities who have psychiatric disabilities, as well as the frail elderly, deserve a range of options in the community and, if they so choose, in a reconfigured congregate setting. This report, however, primarily focuses on better meeting the needs of residents with psychiatric disabilities. The operational construct for this group of people was predicated on the belief that all needed congregate level care and are too fragile to live more independently. As work progressed, that assumption was challenged again and again. A great many people with many of the same issues and needs live every day in integrated, community settings across New York State (NYS).

Oversight authority for ACFs was transitioned to the Department of Health (DOH) in 1998. Since that time, the DOH has made significant progress imposing enforcement actions upon providers that are not operating homes in a safe and effective manner. The primary tool for ensuring this goal is through the implementation of a consistent survey and enforcement process under the auspices of the State's regulatory authority.

Despite DOHs increased oversight, much remains to be accomplished. While current health and mental health care systems theoretically provide a wide range of services that are needed by ACF residents, there are numerous examples of ACF residents who experience duplicated or fragmented services due to poor case management. In some cases, perverse financial incentives result in over-utilization, poor service delivery or unnecessarily expensive levels of care.

## PURPOSE OF REPORT

In the Spring of 2002, at Governor Pataki's direction, the Commissioners of Health and Mental Health, and the Chairman of the Commission on Quality of Care for the Mentally Disabled, embarked upon a comprehensive review of ACF policy, program and financing. The overall goal of the review is to modernize the program of housing, supportive services and care so that it reflects current long term care policy objectives:

- Maximize New Yorkers' autonomy, privacy, dignity, choice and community integration;
- Obtain the best possible outcomes for consumers in terms of quality of life and quality of care; and
- Hold providers accountable for producing these outcomes.

An Adult Care Facility Workgroup was appointed to evaluate the strengths and weaknesses of the current Adult Care Facility model of housing plus services, and to develop recommendations for new approaches that would be more effective. Workgroup members represented stakeholder groups: advocates for those with psychiatric disabilities, advocates for the homeless and ACF owners and operators. The Workgroup had three sub-workgroups:

- The **New Models Sub-Workgroup** was charged with identification of more appropriate and effective models of housing plus service delivery for ACF residents with mental illness.
- The **Health/Mental Health Services Coordination Sub-Workgroup** was charged with identifying the barriers to successful service provision and coordination, and developing strategies for overcoming these barriers.
- The **Payment Sub-Workgroup** was charged with reviewing current payment processes and alternative payment mechanisms, and using this information to develop payment strategies and cost estimates for the recommendations developed by the other two sub-workgroups. A review of current payments to suggest improvements which could be redirected to fund program reforms was also required.

The Workgroup was asked to prepare its final report by October 2002. Each group met numerous times between June and September. Members made site visits to facilities that provided services in new and innovative ways, collected information on how other states provide housing and services to this population, invited presentations by experts in relevant areas, and conducted other activities as well. Each group developed a set of recommendations addressing its charge. The recommendations and findings of each sub-workgroup have been integrated into one report.

## RECOMMENDATIONS

The recommendations of the Workgroup are divided into three major categories: Recommendations for Improving Quality of Life and Services for Current Adult Home Residents, Recommendations for Future Restructuring of Housing and Services for Adult Home Residents, and Potential Fiscal Impact of the Recommendations.

### I. **Recommendations for Improving Quality of Life and Services for Current Adult Care Facility Residents**

- Immediate implementation of an initial assessment of all residents to gather information about resident demographics, strengths and care needs, health, mental health and functional status, and the entities engaged in providing care and services. The on-going assessment will be utilized over time to provide care-planning information including resident goals.
- The immediate implementation of a medication management system using nursing professionals to correct the problems and risks inherent in the current system of aides assisting with medication administration. Options for providing this service range from use of a Home Care Services Agency to authorizing operators to hire nurses on facility staff.
- Immediate implementation of an independent service coordinator (ISC) initiative to ensure that residents in all facilities receive the residential, health, mental health, rehabilitation and recovery services necessary and appropriate to meet their needs and to ensure that such services are of high quality and delivered in a coordinated fashion. Case management services need to be improved. The use of the Office of Mental Health “blended” case management program should be considered for the provision of this and other case management services to residents with psychiatric disabilities.
- Immediate implementation to make trained individuals with successful mental health recovery histories available to provide personalized support to help designated residents move toward recovery, in coordination with the case management plan and goals. Peer Bridgers will be supervised by the contract agency by which they are employed and will work in close collaboration with the service coordinator and case manager.
- NYS should expand Assertive Community Treatment Teams (ACT) to become accessible to residents of all adult care facilities, including those in rural areas.
- NYS should expand and support legal and lay advocacy service to be available to all 12,000 residents in adult care facilities with psychiatric disabilities.

- The Department of Health and the Office of Mental Health should provide rigorous enforcement of adult care facilities and mental health service/clinics regulations. Such enforcement should include reporting on an annual basis of all financial and control relationships with service providers in an effort to make the system more transparent and prevent fraud and abuse.
- NYS should identify and rigorously enforce actions against facilities offering congregate care without a license to the full extent of the law.
- NYS should identify resources to support training and other workforce initiatives (e.g., training on recovery and rehabilitation) for all adult care facility staff.

## **II. Recommendations for Future Restructuring of Housing and Services for Adult Care Facility Residents**

- Activities required for all years presume that the following models are designed, developed and implemented. These models have already been implemented for other individuals with psychiatric disabilities and now need to be made available to current adult care facility residents. New models (there are variations within each), can be grouped as:
  - scattered site housing;
  - single site mixed use facilities; and
  - congregate housing.
- The following chart provides a time table for movement of at least 6,000 residents with psychiatric disabilities from ACFs into community settings of various kinds. Those individuals remaining in congregate care settings will reside in substantially reconfigured homes in terms of size and service provision. Adult care facilities as we currently know them will look dramatically different in the future with operators acting more like landlords, in many cases, rather than service providers.

**Projected Timeline for Movement  
of ACF Residents into Supported Housing**

Timeline	# of Persons With Psychiatric Disabilities Placed in Alternate Housing	Cumulative # of Persons With Psychiatric Disabilities Placed in Alternate Housing	Scattered Sites	Mixed Housing Site Units	
			New	Existing	New
10/02-3/31/03	20	20	0	20	0
4/03 – 3/04	1530	1550	1530	0	0
4/04 – 3/05	800	2350	730	0	70
4/05 – 3/06	930	3280	730	0	200
4/06 – 3/07	970	4250	320	0	650
4/07 – 3/08	875	5125	225	0	650
4/08 – 3/09	875	6000	225	0	650

- NYS should assure that new adult care facilities would have a capacity of no more than 120 beds. NYS should encourage existing adult care facilities over 120 beds to reconfigure to:
  - include small, home-like environments within the facility; and
  - include such housing options as apartments licensed by the Office of Mental Health, single room occupancy residences, respite beds and mixed-use housing.
- NYS should provide adequate funding and facilitation to:
  - ensure over a 10-year period that adult care facility operators have the capital funds to improve the resident’s privacy by providing single rooms with private baths, and
  - enable adult care facility operators to downsize and/or reconfigure.
- NYS should encourage, with necessary financial compensation, conversions of and improvements to existing adult care facilities, and should assist in the development of new projects by facilitating access to capital funds through funding pools, public/private partnerships and prioritization of these projects

seeking section 8, Housing Urban Development (HUD) and other federal funding.

- NYS should continuously review the array of housing options for persons with psychiatric disabilities to assure compliance with the Olmstead decision.
- NYS should fix and implement Limited Licensed Home Care Service Agencies (LLHCSA), in models where appropriate, to professionalize staff and services in order to provide cost effective nursing and personal care services.
- NYS should implement an ongoing advisory process to work with State government to fully develop and implement new models and to monitor progress and continuous quality improvement measures. All appropriate stakeholders including ACF operators, mental health providers, family members, residents, advocates and others should be included on the committee.
- NYS should build on the current Memorandum of Understanding (MOU) to create a Commission on Adult Care Facilities directly accountable to the Governor. This office will direct planning, monitor, coordinate, and oversee implementation across .
- NYS must enact new laws to require review for character and competence of all ACF applications, changes in ownership, conversions and license renewals by the Public Health Council (PHC).
- NYS should contract with an independent organization, to review the current SSI rate paid to adult care facilities for adequacy and accountability to assure the best possible service to residents. The review should be used to guide development of the Executive Budget as well as the work of the Commission on Adult Care Facilities.
- NYS should develop a comprehensive housing vacancy list to ensure that adult care facility residents, hospitals, OMH facilities and others are fully informed about available housing options.
- NYS should initiate work to focus on how ACF residents other than those with psychiatric disabilities, such as the frail elderly, will be able to access new models as appropriate, including Assisted Living Programs (ALP).
- NYS should augment personal resources for all residents receiving Supplemental Social Security Income (SSI) through increases in the Personal Needs Allowance (PNA) and a to-be-created clothing allowance in order to foster self-sufficiency and responsibility. Mechanisms for accomplishing this are not yet fully determined although SSI or Office of Mental Health wrap-around dollars are possibilities.

### III. Potential Fiscal Impact of the Recommendations

The Payment Sub-workgroup developed cost estimates for certain options and recommendations developed by the New Models and Service Coordination Sub-Workgroups.

**Assessments-** Develop an assessment instrument and collect data on all ACF residents to establish a data base on resident demographics and service needs:

- Option I
  - Develop an assessment instrument to gather information and prepare reports through an external contract:

Cost	\$6.25 Million
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- Option II and III
  - Use existing state staff and or interested parties to develop instrument and reports. Use existing providers to gather data.

Cost	\$5.4 – 10.8 Million
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Cost is based on using existing assessment document or minor adaptations of existing instruments. Development of new instrument would result in much higher cost.

#### I. **Medication Management**-Establish a system for oversight of medication management in adult care facilities.

The cost for Medication Management was estimated. The three options provided to implement this recommendation are as follows:

Option A would require Licensed Practical Nurses (LPNs), supervised by Registered Nurses (RNs), to be responsible for direct administration of medication to residents. The cost estimates for this recommendation assume an LPN to resident ratio of 1/50. The ratio of supervisory RNs to LPNs is 1 / 4. Using these ratios, 720 LPNs and 180 RNs would be needed to administer medications to all 36,000 residents of adult homes, enriched housing programs and residences for adults.

Estimated compensation costs for 900 LPNs and RNs, based on competitive nursing salaries and a 30 percent fringe benefits rate, are \$63.2 million. About 30% of this amount, \$19 million, will be billable to Medicaid. However, CHHAs currently bill Medicaid \$12 million annually for nursing services provided to this population. It is assumed that the proposed new medication administration program will replace the current use of CHHA nurses for this purpose. Thus the actual additional costs to Medicaid are \$19 million minus \$12 million, or \$7 million. Federal financial participation

in Medicaid (about 50%) further reduces the cost to the State. State and local share of the \$7 million in new Medicaid expenditures would be a total of \$3.5 million. In addition, the non-Medicaid portion of the medication administration program would be borne by the state. Thus the costs of the new program are:

Total cost	\$63,200,000
Amount billable to Medicaid	\$ 7,000,000
State and local share	\$ 3,500,000

Option B requires RNs to administer all medications that cannot be administered by non-licensed staff. Other medications will be distributed by trained adult care facility staff. RNs will be responsible for oversight of this process at a ratio of one RN to 100 residents.

Since facilities vary by size, the amount of nursing time required for oversight would also vary. However, it is assumed that facilities with fewer than 100 beds require an average of .5 FTE and facilities with 100 beds or more require an average of one FTE. Assuming a compensation cost of \$60,000 per FTE nurse, the cost of this option would be \$19.6 million. Since about 40 percent of the residents are Medicaid-eligible, the total Medicaid cost would be \$7.8 million. State and local share of this Medicaid cost is \$3.9 million. As is the case for Option A, some of these services are already delivered by CHHAs and billed to Medicaid. If we were to assume that some of these new functions would be add-ons but that a congrate rate would be created (see savings section) resulting in some savings.

Total cost	\$19.6 million
Medicaid cost	\$ 7.8 million
State and Local share	\$ 3.9 million

Option C is similar to Option B with the exception that a nurse to resident ratio is not specified. The cost of Option C is assumed to be the same as that for Option B.

A cost estimate was also developed based on a CHHA cluster rate for this service. Under contract, CHHAs would provide nursing supervision of medication administration in adult homes.

It is assumed that this service would be provided for six hours a day in each impacted facility.

Total Cost	\$23.7 million
Medicaid	\$17.7 million
State and Local Share	\$ 8.85 million

There are 216 impacted facilities with about 12,000 psychiatric disabled residents and 6,000 non-mentally ill residents. Assuming a \$50 hourly rate for the CHHA, nursing supervision of medication administration at all 216 impacted homes would cost \$23.7

million annually. Of this amount, 75 percent or \$17.7 million would be billable to Medicaid. If paid on a per Medicaid-eligible resident per week basis, the Medicaid CHHA rate for this service would be \$37.80 per week. The Department of Health would conduct post-payment audits to verify that Medicaid weekly claims are legitimate.

Assuming that CHHA cluster rates would be implemented over a two-year period, year one costs are estimated at \$11.8 million and year two costs, when the rates are fully implemented, are \$23.7 million. First year Medicaid cost would be 5.9 million.

If this service was provided to all residents in the 321 non-impacted homes an additional cost of \$35.1 million would be incurred. Twenty percent of non-mentally ill adult home residents are Medicaid eligible, or \$7 million, would be billable to Medicaid. The balance, \$28.1 million, would be paid from non-Medicaid sources.

Total Cost	\$35.1 million
Medicaid cost	\$ 7.0 million
State and Local Share	\$ 3.5 million

These cost estimates do not provide a full cost analysis of all of the types of providers included in the Services Coordination Sub-workgroup’s recommendations. Their recommendations raised statutory and regulatory issues with several of the approaches such that these approaches could not be used until the issues are resolved. For this reason, cost estimates for the options were based primarily on CHHAs. Since a Long Term Home Health Care Program (LTHHCP) is also a CHHA, cost estimates for LTHHCPs would be similar to those for CHHAs. Direct Medicaid reimbursement to Licensed Home Care Services Agencies (LHCSAs) for nursing services is currently precluded by statute. Substantial changes in the Limited LHCSA program would also be required as described in the following section.

**Independent Service Coordinator**-ensure that adult care facility residents receive appropriate and coordinated case management. The case management model proposed was the blended case management program which consists of a mixture of Intensive Case Management and Supportive Case Management at a ratio of 32-52 residents per case manager. 6,000 individuals in impacted facilities would be served in the first year.

Cost \$22.2 - 27.8 Million

An offset to this cost would be expected as a result of the shifting of responsibility for some functions from existing providers to the Independent Service Coordination.

**Peer Bridger Program**-Use existing dollars that have been allocated for Peer Bridger demonstration programs.

Cost \$500,000

- Expand the Peer Bridger recommendation to all 12,000 clients needing mental health services.

Cost \$4.8 Million

**Assertive Community Treatment Teams-** Implement Assertive Community Treatment teams for all individuals moved to the scattered housing model. The first year would require such services for one-half of 1,530 residents located in such settings.

Cost \$8.0 Million

**New Housing Models**

The New Models Sub-Workgroup provided a seven-year timeframe for transition to new housing models for 6,000 individuals currently residing in adult care facilities. Only 20 of these individuals would transition prior to the next fiscal year. It is expected that this small number of individuals would be absorbed into existing programs without major cost to the system. Other costs associated with New Models were not developed, as they did not have an impact on first year costs of these recommendations. However, as part of the first year it was projected that 200 individuals currently residing in adult care facilities would go to a higher level of care. There would be a Medicaid cost associated with this outcome. Using existing nursing home rates, the projected cost is \$7.0-\$8.0 million.

Cost \$7.0-\$8.0 Million

For year two and beyond recommendations of the New Models Sub-Workgroup, unit costs were developed on the various housing options both from a capital financing and service delivery perspective. Development of longer range cost impacts were not completed pending further analysis of the final reports from the other two Sub-Workgroups.

The unit prices for this housing were estimated as follows:

	Unit Price for New Models Total Cost	Total State Cost	Gross Cost w/SSI
Supportive Housing Community Resident Single Room Occupancy (CR SRO)	\$12,956	\$11,912	\$19,496
SRO Debt Service	\$ 9,800	\$ 9,800	\$ 9,800
Supported SRO	\$13,504	\$12,460	\$20,044

## **Potential Savings:**

Specific system improvements to produce Medicaid savings that could be redirected to pay for program reforms were also developed. Not all options need to be pursued independently but could be included in implementation strategy of the individual recommendations. All options presented do not need to be pursued in their entirety. These savings were considered estimates and some concern was raised that they may be overstated.

- Ensuring that Certified Home Health Care Agencies (CHHAs) do not provide services to adult care facility residents that operators are required and paid to provide. Eliminating CHHA home health aide visits to perform tasks that are properly the responsibility of the operator, would also produce a reduction in the volume of nurse visits to supervise the home health aides.

Potential Savings: \$4.5 Million

- Implementing congregate rates for CHHA services delivered to several residents who live in the same facility.

Potential Savings: \$6.0 Million

- Adjust Assisted Living Program rates to better reflect the actual cost incurred by adult care facilities to deliver ALP services.

Potential Savings: \$6.5 Million

- Establish a primary provider coordination function for recipients to reduce duplication of outside provider primary and mental health.

Potential Savings \$3.0 Million

- As a longer term goal establish a gate keeping function which would authorize services on a capitated basis. A federal waiver would be required.

The Payment Sub-Workgroup did not develop cost estimates for the following recommendations due to lack of specification from the other two sub-workgroups:

- Legal and lay advocacy services
- Personal care services
- Training the ACF workforce
- Compliance with Olmstead
- Enhancements to worker wages and fringe benefits.

### **Other activities to be undertaken include:**

- The Department of Health should complete the cost analysis required and finalize its legislative report on the Limited LHCSA program.
- A study of the need to develop financing incentives for downsized adult care facilities including identification of appropriate level of financing, needs to be completed.
- Reduce over-utilization and inappropriate use of services.
- The annual financial report submitted by ACFs should be revised to include more appropriate data for properly monitoring these facilities.
- Periodic financial audits of ACFs should be scheduled.
- Written protocols for ACF contracts with outside providers which include fair market value standards for space rental arrangements should be established and enforced.
- A technical assistance process needs to be developed to assist ACF operators in understanding and procuring existing state and federal financing dollars.
- Further study of the need to revise state caps on total funding and/or per bed maximums to enhance available capital for new models and refurbishing existing ACFs is required.
- Based on an in-depth review of financial data, the sub-workgroup was not able to make a final recommendation on an increase in SSI for operators. This issue should be further analyzed to better explain variation in existing profit margins and to adjust for changes brought about by other recommendations in this report.
- Application standards regarding inclusion of SSI population in marketing studies of proposals for capacity increases of existing programs and projects for new providers should be created and enforced.
- A directive should be forwarded to local entities involved in the review of applications for new ACFs encouraging their negotiation with project sponsors on commitments to serve SSI and other populations identified as lacking proper access to this level of service.

There are several other recommendations proposed which do not appear to have a major cost impact but a consensus on the actual scope of each proposal would need to be finalized before conclusions on lack of cost impact can be verified. These items are:

- Implement an ongoing advisory process.
- Create and fund an adult care facility oversight committee.
- Review of ACF applications by the Public Health Council.

## **NEED TO COMMIT TO ACTION**

The Adult Care Facility Workgroup concludes that the time to offer this population timely, appropriate, and cost-effective housing, services and health care, is long overdue. Sufficient public resources are currently being spent which, if spent more efficiently and effectively, could generate a high quality of life and quality of care for a long-overlooked segment of the population of vulnerable New Yorkers. New York's historic commitment to its most vulnerable citizens, and simple common sense, demand prompt action on this front.

## INTRODUCTION

### A. Purpose of Report

In the Spring of 2002, at Governor Pataki's direction, the Commissioners of Health and Mental Health, and the Chairman of the Commission on Quality of Care for the Mentally Disabled, embarked upon a comprehensive review of Adult Care Facility policy, program and financing. The overall goal of the review is to modernize the program of housing, supportive services and care so that it reflects current long term care policy objectives:

- Maximize New Yorkers' autonomy, privacy, dignity, choice and community integration;
- Obtain the best possible outcomes for consumers in terms of quality of life and quality of care; and
- Hold providers accountable for producing these outcomes.

An Adult Care Facility Workgroup was appointed (Appendix A) to evaluate the strengths and weaknesses of the current Adult Care Facility model of housing plus services and develop recommendations for new approaches that would be more effective. Workgroup members represented stakeholder groups: advocates for those with psychiatric disabilities, advocates for the homeless and ACF owners and operators. The Workgroup had three sub-workgroups:

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The Workgroup was asked to prepare its final report by October 2002. Each group met numerous times between June and September. Members made site visits to facilities that provided services in new and innovative ways, collected information on how other states provide housing and services to this population, invited presentations by experts in relevant areas, and conducted other activities as well. Each group developed a set of recommendations addressing its charge. The recommendations and findings of each subgroup have been integrated into one report.

## **B. Background**

### **What Are Adult Care Facilities and Who Lives in Them?**

Adult Care Facilities (ACFs) are generally viewed as personal care settings for persons with functional impairments occasioned by age or by physical or cognitive disability. Originally created to serve the well elderly, the traditional ACF has undergone many changes in its long history. While there are by statute five different types of ACFs, this report focuses on the three types regulated and monitored by the Department of Health: Adult Homes, Enriched Housing Programs and Residences for Adults. The report does not address the other two types: Shelters for Adults which provide temporary services, and Family-Type Homes which each serve one to four residents. The Office of Temporary and Disability Assistance and the Office of Family and Childrens' Services monitor shelters and family-type homes, respectively. For the remainder of this report, the term "adult care facility", or ACF, will refer only to the three types of facilities for which the Department of Health has responsibility.

Table 1-1 shows the number of Adult Homes, Enriched Housing Programs and Residences for Adults in New York State as of September 2002. There are 449 Adult Homes with 34,755 beds. Adult Homes are established and operated for the purpose of providing long-term residential care, room, board (three meals and a nutritious snack per day), housekeeping and some personal care and supervision to five or more adults unrelated to the operator.

Adult Homes serve persons at least 18 years of age. Most residents, however, are much older than 18. Adult Homes are congregate settings in that they can accommodate large numbers of residents in one building — up to two hundred residents in one facility, typically with one or two residents to a bedroom. It should be mentioned, however, that several facilities "grandfathered" from the supervision of the Board of Social Welfare are permitted to care for over 400 residents, and other "grandfathered" facilities are permitted to maintain three or even four residents in one bedroom. Residents do not have their own kitchens or bathrooms. A minimum number of staff (depending on the census) must be on duty 24 hours a day.

There are 80 Enriched Housing Programs (EHPs) with 5,116 beds. EHPs provide long-term residential care to five or more persons, primarily 65 years of age or older, in community-integrated settings resembling independent housing units. Most programs are located in individual apartment settings that have kitchens and private bathrooms. Services provided are the same as those in Adult Homes with the exception of supervision and personal care. An Enriched Housing operator is required to provide only one meal a day, which must be a hot congregate meal, and the operator must assure that there is sufficient food available in the apartment for the other two meals. The operator must ensure that any resident needing assistance with self-administration of medications receives the required assistance.

There are eight Residences for Adults, with a total licensed capacity of 345 beds. These facilities serve a population that is younger than that served by Adult Homes and Enriched Housing Programs and generally needs a different array of services, including

mental health services provided under the auspices of the Office of Mental Health. Services that must be provided by the operator of the Residence include room, meals, housekeeping, case management and 24 hour-a-day supervision. Operators are not required to provide personal care. While most resident rooms are single, some are double occupancy. Bathrooms are shared and there is a communal dining room for meals.

A. Table 1-1  
**Number and Capacity of Adult Care Facilities**

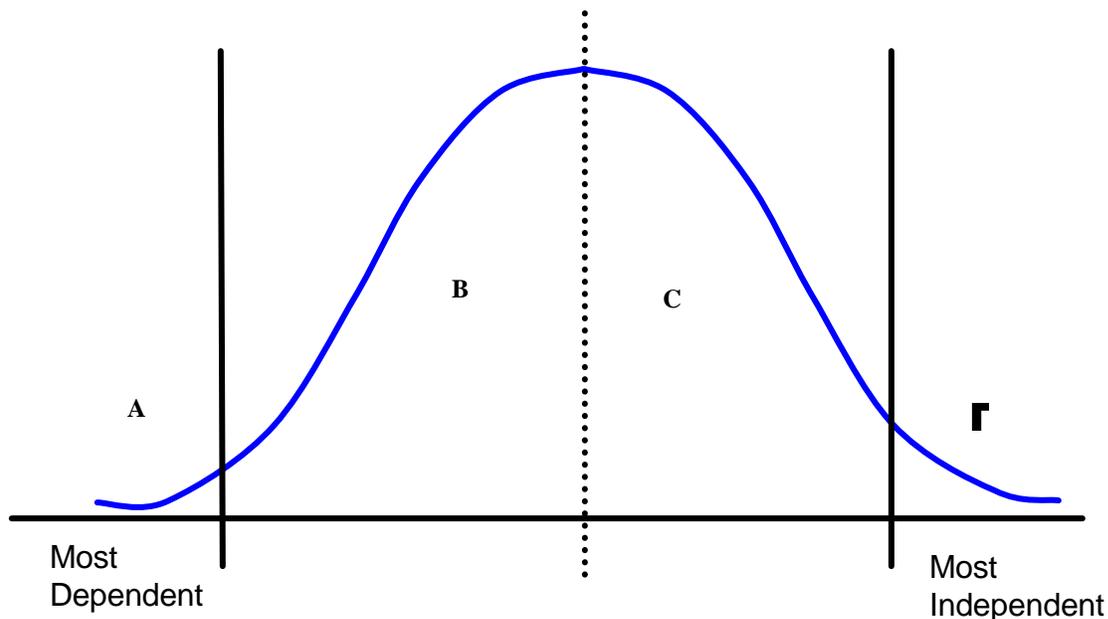
<b>ACF TYPE</b>	<b>NUMBER</b>	<b>BEDS</b>
<b>Adult Homes</b>	449	34,755
<b>Enriched Housing Programs</b>	80	5,116
<b>Residences for Adults</b>	8	345
<b>TOTAL</b>	537	40,421
<b>Impacted Facilities and Beds*</b>	216	18,090

\*\*"Impacted" means that at least 25% or 25 (whichever is less) of the facility's residents have a psychiatric disabilities diagnosis.

With a 14% statewide vacancy rate, about 36,000 people live in these facilities at any given time. It is estimated that over half of these residents are Medicaid-eligible and most of this group (about 15,000) also receive Supplemental Security Income (SSI) payments. An estimated 12,000, or nearly one-third of the total resident population, have a diagnosis of serious and persistent psychiatric disability.

There is little reliable and current clinical data on these 12,000 residents. That will be remedied though implementation of the recommendations in this report. As illustrated by the bell curve shown below (Table 1-2), the Workgroup assumes that this population is nearly normally distributed across a continuum of functional ability ranging from very dependent on human assistance in activities of daily living (ADL) and instrumental activities of daily living (IADL), to largely independent of human assistance in these areas. As is characteristic of a bell curve, the vast majority of residents would fall near the middle of the curve, indicating that they are neither severely dependent on nor completely independent of human assistance.

**Table 1-2**  
**Hypothesized Distribution of ACF Residents with Psychiatric Disabilities**  
**Total = 12,000**



The Workgroup divided the population into four groups based on level of disability:

- Group A includes about 200 residents at the most dependent end of the continuum. These residents are sufficiently impaired by psychiatric disabilities and non-mental medical co-morbidities (e.g., diabetes, advanced dementia, cardiovascular heart disease), as to need access to 24-hour a day nursing care.
- Group B is 5,800 residents who will need or desire a congregate setting with a high level of support.
- The 5,200 residents in Group C could enjoy a higher quality of life in a more integrated community care setting than ACFs currently provide.
- Group D is 800 residents who maintain compliance with their medical regimes, are largely independent in self-care activities and could live independently in a non-congregate care setting with varying levels of support, services and housing subsidies. These residents may benefit from living in a scattered site living arrangement with services of an Independent Case Manager or Assertive Community Treatment Team, both of which are described in a later Chapter of this report

It is also assumed that all residents in Groups A and B, and many in Group C, require assistance with medications. Many people in Groups B and C need personal care. Adult care facility operators must provide personal care as necessary to residents to maintain health, and are required to assign, at minimum, sufficient staff to provide 3.75 hours of personal care weekly.

This population of 12,000 residents with psychiatric disabilities is concentrated in about 40% of ACFs and live in “impacted” homes. In such homes at least 25% or 25 of the residents have a psychiatric disabilities diagnosis:

- 216 of the 537 licensed ACFs are impacted. Impacted ACFs account for 18,090 beds of the total 40,216 beds available statewide.
- Approximately 60%, or 131, impacted ACFs are located in the metropolitan New York area, which includes the five boroughs of New York City (NYC) and the surrounding counties, including Nassau and Suffolk.
- Non-impacted ACFs tend to be smaller than impacted ACFs. 80% of non-impacted ACFs are 100 beds or less compared to 70% of impacted ACFs. 20% of non-impacted ACFs are over 100 beds compared to 30% of impacted ACFs.
- Of the 22 ACFs that have 200+ beds, 75% are in the metropolitan NYC area.

It is evident that most of the 12,000 residents that are the focus of this report live in or near NYC, and a substantial proportion live in facilities with the largest capacity.

### **Payment for ACF services**

As this group of 12,000 residents is overwhelmingly a very low income population and nearly all of them need an intense and costly level of services and supports, a discussion of payment for ACF housing and services is appropriate and is included here.

In New York, many ACF residents pay for room and board through the Supplemental Security Income (SSI) program. ACF rates for SSI recipients are established in state statute and cover room, board and other required services. Additional support services for SSI-eligible residents such as personal and home health care, and mental health and medical care, are reimbursed through Medicaid. The Supplemental Security Income Program for ACF residents is as follows.

The federal Supplemental Security Income (SSI) program is a means-tested program that supplements the income of aged, blind and disabled persons who meet income and resources criteria. As noted above, SSI recipients are also automatically eligible for Medicaid. In addition to the basic federal SSI payment, States have the option to supplement those payments in accordance with federal rules. New York has

chosen to set the amount of an SSI recipient's state supplement according to the type of living arrangement chosen by the individual and its geographic location. The three types of ACFs regulated by the Department of Health are for these purposes categorized as Congregate Care Level II facilities. The 2002 State supplement for Level II is \$435 per month (for an individual) in the New York City metropolitan area and \$405 upstate, amounts unchanged since 1988. For example, effective January 1, 2002, an eligible resident in Living Alone status with no other income would receive the \$545 monthly federal benefit, plus a State supplement of \$87 dollars, for a total SSI check of \$632. The same eligible resident in an upstate ACF would receive the \$545 federal SSI benefit plus a State supplement of \$405, for a total SSI check of \$950. In a NYC ACF, this individual would receive a \$435 State supplement in addition to the federal payment, for a total of \$980. Of this \$950 or \$980 depending on where the resident lives, the resident is entitled to keep at least \$122 as allowance to pay for personal items, and the operator usually charges the resident the remainder of the total SSI payment. In NYC, the remainder is \$858 per month.

### **Quality Problems in Adult Care Facilities**

Until the late 1960s, ACFs were predominantly small facilities established for the frail elderly and operated by individuals or not-for-profit organizations. Then, changes in the discharge and admission policies of psychiatric facilities led to profound changes in the composition and service needs of the resident population. Simultaneous with this, legislative action designed to extend state oversight to many uncertified situations led to changes in both construction requirements and in the types and sizes of ACF operations. One manifestation of this was that many "mom and pop" operators chose to discontinue their operations and were functionally replaced by larger facilities. ACFs, in addition to serving the elderly, have expanded their customer base to include many persons who are younger and mentally disabled or mentally retarded, as well as persons who are blind or physically disabled.

Problematic care and conditions at some ACFs is not a new phenomenon. A certain segment of the industry has a long history of problems stretching back as far the late 1970's. A 1977 report by the Office of the State Attorney General cited poor conditions in Adult Care Facilities. Following its review of Adult Homes in the late 1980s, the State Commission on Quality of Care for the Mentally Disabled issued a report in 1990 to the State Legislature in which it said it "found a significant number of Adult Homes with serious deficient conditions that adversely affected the day-to-day living conditions, safety, supervision and health of the residents." And in 1993, New York City area newspapers ran several stories that cited poor conditions and practices in certain Adult Homes. It is evident that over the past three decades, while many ACFs have consistently provided high quality care, a certain segment of the industry continues to be chronically deficient, and due to the complexity of the problem solutions have not been easily identified or implemented.

The Department of Social Services had oversight authority for ACFs until 1998, at which time the program was moved to the Department of Health. In the past five

years the Department has made significant progress both in improving quality of care in ACFs, and in strengthening the State's oversight of the program. Yet much remains to be done.

As noted above, a model of congregate care designed more than 30 years ago for the frail elderly is not appropriate or effective for many of the types of residents who now live in ACFs, especially those with mental illnesses.

### **C. IMPROVING THE QUALITY OF LIFE AND SERVICES FOR CURRENT ADULT HOME RESIDENTS**

The major goal of the workgroup was to improve the quality of life for adult care facility residents. The strategies listed below are felt to accomplish this goal.

#### **Assessments**

##### **Purpose**

Adult Care Facilities represent a small but important segment of residential care in a comprehensive and diverse service system. Significant differences exist in facility characteristics. Facilities differ dramatically in size, physical plant, staffing levels, atmosphere, method of operation and the training and level of professionalism of the staff.

The adult home resident population is just as diverse. These facilities serve the young and old, the cognitively intact and cognitively frail, the psychiatrically disabled, the physically well and the physically disabled. It is widely recognized, however, that little uniform and reliable data about the 29, 500 residents of adult homes exists. This is not due to the lack of tools available to collect and sift information about those in need of various services but to the existence of more than a dozen different instruments currently in use across programs. These include the DMS-1, the M11-Q, the M11-S, the Outcome and Assessment Information Set, the Home Assessment Abstract, the Nursing, Functional and Social Assessment and the PRI and Screen, to name just a few. These forms are, by themselves, not comprehensive enough to capture the type and level of information needed to make broad programmatic and care planning decisions about residents of adult care facilities.

The intent of this proposal is to set forth a plan to gather information about adult care facility resident demographics, strengths and care needs, the individual health, mental health and functional status and the entities engaged in providing care and services. An initial comprehensive individual assessment is proposed. This assessment will provide meaningful information to more appropriately plan services and care alternatives within the community-based system. Also proposed is the development of an annual functional assessment to supplement, but not duplicate, the medical and mental health evaluations.

This proposal recognizes that the initial assessment herein described is intended to provide a preliminary “snapshot” of the current health and mental health status of each resident, his/her current array of programs and providers, and some assessment of his/her functional and community living skills. It is expected that a more complete person-centered plan – including social, residential and treatment goals – will be developed over time, out of the relationship forged with the Independent Service Coordinator and the Peer Bridger.

### **Population to be served**

All residents of adult care facilities would be assessed.

### **Setting/Timeframes for implementation**

Recognizing the complexity of the planning and conduct of the assessment of approximately 36,000 people across the State, we propose a two-phase process to be completed within 12 months of the acceptance of this proposal:

**Phase 1 - Planning:** to be implemented as soon as possible and concluded within five months. This would include:

- Identification of an advisory group or guidance team to oversee the process;
- Identification and accessing funding;
- Identification of a currently existing instrument(s) or development of a new or revised instrument to be used to conduct the assessment;
- Identification of the method of assessment – who would be interviewed, how many interviews would be necessary, involvement of record reviews and identification of which records, etc.;
- Identification of who should conduct the assessment and their qualifications;
- Training of assessors; and
- Pilot testing of the instrument for validity, reliability and clinical accuracy, unless existing instrument(s) are used.

**Phase 2 – Conduct the assessment and produce reports:** upon conclusion of Phase 1 and completed within six months. This would include:

- Data collection;
- Editing, validation and collection of missing data;
- Keying data; and
- Processing data into meaningful individual and aggregate reports.

### **Staff**

Health and mental health professional nurses and social workers are proposed to be the assessors. Providers of direct service to residents should not also conduct the

assessment. Multiple contacts may be necessary to accurately complete portions of the assessment.

### **Assessment Instruments**

Many instruments already exist and are in use in various residential, health and mental health programs in NYS. The workgroup did not identify a single instrument that adequately addresses the health, mental health and functional needs, strengths and goals of a resident. Instruments such as the Outcome and Assessment Information Set (OASIS) currently in use by home care programs could be used to assess the health needs of a resident. Similarly, the assessment forms under development by the OMH for single point of accountability which encompasses case management and housing could serve as the mental health needs assessment. These forms, however, would have to be supplemented by a third form to collect additional information. This alternative should be less costly than the creation of a new instrument.

### **Options for Implementation**

- #1 - Issue an RFP for instrument development, assessment of residents and report generation and macro analysis.
- #2 - State staff develop assessment and methodology or select existing instruments, fund existing community-based health and mental health programs to collect data, State staff data enter, develop the report(s) and provide macro analysis.
- #3 - State staff and interested other parties jointly develop methodology and tools (including possible selection of existing instruments), State funds existing community-based health and mental health programs to collect data, State staff key data, develop the reports and provide macro analysis.

### **Medication Management**

#### **Purpose**

Many of the approximately 36,000 people who live in ACFs have chronic medical conditions that require treatment and monitoring. Approximately 41% also have a diagnosis of serious and persistent mental illness and require the attention of mental health professionals. It is common to see individuals in ACFs with diabetes, chronic respiratory problems, cardiac conditions or high blood pressure treated with medication. Those receiving mental health services are often treated with psychotropic medications to relieve symptoms as well. Studies have shown that ACF residents, on average, receive six to nine medications daily. Presently ACFs rely on unlicensed staff to manage this high volume of medications, which in some homes require pharmacy deliveries daily, and sometimes more than once a day. Department of Health inspection reports cite the need for improved medication management in many of the adult homes

to ensure that residents receive without interruption the correct medications as ordered by their physician.

The intent of this proposal is to ensure that medication management, administration, and oversight in ACFs is provided by nursing professionals, sometimes with the assistance of trained and certified medication staff. This increased professional presence will address many of the problems with medication management cited in DOH inspections and will provide additional protections to residents as the professional staff will be versed in the intended effects and the side effects of the medications and will be reporting these to residents' primary physicians.

### **Population to be served**

All residents of adult homes.

### **Setting/Timeframes for implementation**

Recognizing that the implementation of professional nursing services for medication management in ACFs will require a phase-in period and that size has a direct bearing on the complexity of medication management, a two-tiered implementation schedule is proposed.

**Phase 1**—to be implemented as soon as possible and concluded within 12 months: Enhanced medication management would be provided in ACFs of 51 beds or more, giving preference to those homes where serious and/or repeated deficiencies in medication management practices have been identified by or to the Department of Health. One hundred eighty seven ACFs with a total census of total census of 22,873 persons would be included in this phase of implementation.

**Phase 2**—to be implemented beginning 12 months from acceptance of this proposal and concluded within a year of its start up date. Enhanced medication management would be provided in ACFs, with 50 or fewer beds, giving preference to those homes where serious and/or repeated deficiencies in medication management practices have been identified by or to the Department. This phase will consist of 223 homes serving a total of 6, 577 residents.

Any home which is able to provide enhanced medication management using one of the three options described below earlier than these timeframes is encouraged to do so. For example, if a home of 40 residents is able to hire professional nurses within the first nine months of this program, it is encouraged to do so, rather than waiting until the second year of implementation.

## Staff

Under Option A, nursing staff will provide medication management services including, but not limited to, receiving and recording all medications coming from the pharmacy in a timely manner, ensuring the secure storage of medications (including controlled substances), disposing of medications in a manner prescribed by the Department of Health and administration of medications according to professional standard, the observation and reporting of intended effects and side-effects of medication to the physician. In addition, the RN would conduct regular quality assurance activities to monitor compliance with medication management policies and procedures.

Under Options B and C, the registered professional nurse (RN) would also be responsible for the training and supervision of unlicensed staff engaged in medication assistance.

## Options

An acceptable means for achieving the goal of safe and effective medication management would be through a home care agency. This would be achieved by requiring homes to either obtain or contract with a Limited Licensed Home Care Services Agency (LLHCSA), a Licensed Home Care Services Agency (LHCSA), a Certified Home Health Agency (CHHA), or a Long-Term Home Health Care Program (LTHHCP). However, homes where patterns of serious and uncorrected deficiencies in medication management practices have been identified would not be allowed to comply with this requirement by obtaining such licensure or certification. Such homes would be required to contract with a separate home care agency.

Enhanced medication management will be provided using one of three options outlined below. The principle difference between the options is in the intensity of on-site nursing coverage.

**Option A:** An RN will supervise LPNs, who will be responsible for the direct administration of medication to residents of the home.

- Each LPN will:
  - ensure that medications are available on-site;
  - administer medications to no more than 50 residents;
  - complete necessary documentation; and
  - ensure that medications are accounted for, stored and disposed of according to DOH regulation.
- The RN will conduct quality assurance reviews of the medication system and will ensure that:

- policies and procedures are clear, correct, complete and implemented as stated;
  - the medication documentation system is complete and correct;
  - that doctors orders are on file and easily available;
  - controlled medications are accounted for by periodically monitoring;
  - medication counts; and
  - communication is maintained with the physician and other appropriate parties.
- Other duties of the RN will include:
    - problem-solving with the pharmacy;
    - coordination of activities with the Independent Service Coordinator; and
    - performance of any of the duties regularly assigned to the LPN staff when needed.
- Both the RN and LPN can:
    - maintain communication with the pharmacy;
    - address medication issues with residents (e.g. refusals, side-effects); and
    - coordinate activities and issue reports to the adult home operator/administrator.

**Option B:** In this setting, the registered professional nurse (RN) will administer all injections and other medications (i.e., eye drops, creams, etc.) that cannot be performed by non-licensed staff. Other medications will be distributed by trained and certified ACF staff. The RN will ensure the policies and procedures for medication management are in place, and train and certify the home's medication staff. It is expected that an RN would be responsible for no more than 100 residents. For example, in rural parts of the State, an RN's responsibility may encompass two 25-bed homes and one 50-bed home. For homes with more than 100 residents, an LPN must also be employed for every 50 residents above the initial 100. Either the RN or an LPN must be onsite for all distributions of medication. The RN will conduct quality assurance checks to ensure that all aspects of the medication management system are implemented in compliance with the policies and procedures. This option enables a nurse to be onsite for all distributions of medication in large homes, while being particularly helpful in rural settings where one RN may need to cover more than one home.

**Option C:** In this setting, the RN will administer all injections and other medications (i.e., eye drops, creams, etc.) that cannot be performed by non-licensed staff. Other medications will be distributed by trained and certified ACF staff. The nurse will ensure that policies and procedures for medication management are in place and train and certify and the home's medication staff. He/she will conduct quality assurance checks to ensure that all aspects of the medication management system are implemented in compliance with the policies and procedures. This option gives homes

the ability to utilize non-licensed staff to distribute medications and may be particularly helpful in rural settings where one RN may need to cover more than one home. Option B is available only to those homes that did not evidence serious and/or repeated deficiencies in medication management, as per their last complete Department of Health inspection report.

Any home choosing to implement Option C must notify DOH in writing and receive written DOH approval. The Department of Health retains the right to require a home to implement Option A if the home has shown serious and/or repeated deficiencies in the area of medication management.

The table on the following pages provides skeletal information on several possible options for implementing and funding this proposal.

## **Staff**

The staffing configuration suggested below is based on the premise that one LPN will give medications to no more than 50 residents and that the supervising RN need not be on site at all times when medications are administered.

**Option A:** Nurses would be on-site seven days a week, for two shifts per day. Nursing staff would not be expected to work the night shift. A single RN would supervise the LPNs and perform other duties cited in this proposal. A full-time RN would be required in any home of 100 or more residents. A sufficient number of LPNs would be hired so that each LPN would be distributing medications to no more than 50 persons. For example, in a home of 300 residents, nursing staff would consist of 1 FTE RN and 18 FTE LPNs to provide coverage 16 hours a day, seven days a week. [2 shifts x 7days=112/hrs/week/50 residents=2.8 staff/50 resident (112/40), 16.8staff/300 residents.] A home of 30 residents would require a part-time RN and 3 FTE LPNs to provide the same coverage.

This option raises some questions and concerns. It is not clear that all of the time that the LPNs are on site would be taken up with medication management. The question arises as to what duties these nurses would undertake when not engaged in these activities. One would need to be careful not to assign them duties which would give the perception that they were providing “continual medical or nursing care,” as this would change the character of the ACF as defined in statute. The staffing ratio described raises questions about its costliness and about the availability of sufficient nurses to meet this requirement. One might consider raising the ratio so that one LPN was administering medications to 75 persons or even 100 persons with the assistance of the RN.

**Option B:** Assuming one RN is covering more than one home, each home would have to provide sufficient non-licensed staff to safely carry out all medication management duties, recognizing that the RN would have little time to assist with actual medication distribution. For example, in a home of 30 residents, a minimum of 3 non-

licensed staff would be required (2 FTE for weekdays and 1 FTE for weekends which allows for several hours of overlap of shifts for medication preparation). A full-time RN would be required in any home of 100 or more residents. In addition, homes of 100 or more residents would also be required to have an LPN for every 50 residents above the 100. For example, in a home of 300 residents, nursing staff would consist of 1 FTE RN and 4 FTE LPNs, in addition to FTE non-licensed staff.

**Option C:** Assuming one RN is covering more than one home, each home would have to provide sufficient non-licensed staff to safely carry out all medication management duties, recognizing that the RN would have little time to assist with actual medication distribution. For example, in a home of 30 residents, a minimum of 3 non-licensed staff would be required (2 FTE for weekdays and 1 FTE for weekends which allows for several hours of overlap of shifts for medication preparation.)

### **Regulation and Funding**

DOH will continue to provide oversight of medication management in ACFs, regardless of the option in place.

Each option carries some regulatory/statutory challenges. Under certain conditions, Option A may require the Department to waive the portion of the ACF regulations that invests the ACF with the responsibility for medication management. Options B and C will require statutory amendment of the Nurse Practice Act and Social Services Law (SSL) law as well as the adoption of credentialing standards and a standardized training curriculum. The table below cites other considerations as well.

Comparison of Vehicle Options for Implementing Medication Management Proposal

PROGRAM	REGULATORY/ STATUTORY CHANGE	FUNDING SOURCE	B. PROS	CONS
<p><b>LLHCSA</b></p>	<p><b>Policy change to broaden the list of meds beyond the administration of injectible medications.</b></p> <p>Statutory or possibly policy change to allow LPNs to administer meds.</p> <p>Review and modify AH regs to delineate revised responsibility for medication management between the AH and LLHCSA.</p> <p>For Options B and C: statutory change to allow RNs to oversee AH med staff.</p>	<p>Medicaid</p>	<p>Infrastructure in place.</p> <p>District gate-keeping function for provision of the personal care services would exist.</p> <p>Rate structure less costly than CHHA or LTHHCP.</p> <p>Less restrictive programmatic eligibility requirements.</p>	<p>Not implementable without policy change (related to medication admin.). Statutory and regulatory change needed for reimbursement piece of proposal – new rates, rate codes, etc. would be needed.</p> <p>Provider type exists presently only for Medicaid eligible population.</p> <p>LLHCSA is funded through the Personal Care program. Therefore, residents must first meet PC eligibility.</p> <p>A portion of the population may not qualify for LLHCSA services because they do not meet PC service eligibility criteria (e.g., medical stability, non-compliance)</p> <p>PC is an entitlement. Change in rules for AH residents would also apply to all PC eligible.</p> <p>Potential denial of eligibility by district. Districts are not required to participate in this program.</p> <p>Statute is due to expire 3/31/03 and must be extended.</p> <p>Cost and program efficiency not yet determined, as required of the Department.</p> <p>Staffing by LPNs and RN may not be feasible in existing job market.</p> <p>Blurred distinction between residential and service</p>

PROGRAM	REGULATORY/ STATUTORY CHANGE	FUNDING SOURCE	B. PROS	CONS
<b>LLHCSA</b>				<p>provider.</p> <p>Issue of impacting districts existing DOH Medicaid targets.</p> <p>Issue of the impact on district staffing needs if prior authorization required – district option to contract (statutory/regulatory change may be required). LLHCSA’s in NYC contract with NYS DOH, not with NYC – may have impact on DOH staffing.</p> <p>Small number of licenses granted to date.</p>
<b>LHCSA</b>	Review and modify AH regs to delineate revised responsibility for medication management between the AH and LHCSA.	Medicaid Private Pay	<p>Can be accomplished administratively.</p> <p>Establish a congregate rate for service delivery.</p>	<p>Prior authorization of district needed.</p> <p>Need to establish rate and billing mechanism for billing MA.</p> <p>Staffing by LPNs and RN may not be feasible in existing job market.</p>
<b>CHHA</b>	Review and modify AH regs to delineate revised responsibility for medication management between the AH and CHHA.	Medicare Medicaid Private Pay	<p>Can be accomplished administratively.</p> <p>Infrastructure in place.</p> <p>Broad eligibility; MD order.</p>	<p>Costly, fee-for-service.</p> <p>No cost containment incentives.</p> <p>Moratorium on new approvals.</p> <p>Impacts districts existing DOH MA targets.</p> <p>Need to establish a congregate rate for service delivery.</p> <p>Staffing by LPNs and RN may not be feasible in existing job market.</p>

PROGRAM	REGULATORY/ STATUTORY CHANGE	FUNDING SOURCE	B. PROS	CONS
<b>LTHHCP</b>	Review and modify AH regs to delineate revised responsibility for medication management between the AH and LTHHCP.	Medicaid	<p>Infrastructure in place.</p> <p>County gate-keeping function.</p> <p>Comprehensive service package (including non-Medicaid services, assessments and coordination).</p> <p>Waiver already in place.</p>	<p>Restricted to nursing home eligible individuals.</p> <p>Potential denial of eligibility by district.</p> <p>Costly.</p> <p>Fixed number of slots. Moratorium on new approvals</p> <p>Waiver amendment required. Renewal every 5 years.</p> <p>Impact on district staffing needs if prior authorization required. Impacts districts existing MA targets.</p> <p>Staffing by LPNs and RN may not be feasible in existing job market.</p>
<p><b>OTHER:</b></p> <p>AH hires RN directly *****</p> <p>Public health nurses administer meds in AH *****</p> <p>Article 28 Clinic provides med. Mgmt.</p>	<p>Need to revise the SSL to permit an AH to hire a nurse to either administer medications and/or train and supervise AH staff to do so. *****</p> <p>For all 3 options, review and modify AH regs to delineate revised responsibility for medication management between the AH and provider group.</p>		<p>All residents eligible.</p> <p>Infrastructure in place.</p> <p>*****</p> <p>*****</p> <p>Advantage in nurse recruitment, due to being hospital-based.</p>	<p>New statutory authorization likely.</p> <p>Blurred distinction between AH and nursing home – potential Impact on federal SSI reimbursement. *****</p> <p>Expected reluctance of district to accept this responsibility. *****</p> <p>Cost uncertain. Cannot provide services off-site (issue, if clinic is to come to AH to deliver service).</p> <p>For all, staffing by LPNs and RN may not be feasible in existing job market.</p>

## **Independent Service Coordinator**

### **Purpose**

In addition to room, board and some assistance in daily living, residents ACFs receive an array of other services, including general and specialty medical care, nursing services, mental health care, rehabilitation services, and others. These services are frequently provided by independent practitioners or licensed agencies that have no organizational ties to each other, thereby creating difficulties in service coordination. While ACFs are required and expected to provide case management services, it is generally acknowledged that the increasing care needs of today's ACF residents makes the provision of case management complex and the coordination of such services extremely difficult for ACF staff. This appears to be especially problematic in impacted homes in the down-state region, where large-size residences rely on hosts of independent service providers -- some homes may have two or more mental health agencies or practitioners serving residents, several physicians providing primary medical care, and a variety of specialists and rehabilitation therapists visiting the home to serve residents.

The lack of service coordination results in a disconnect among the providers – some individuals receive services they may not need, and some do not receive needed services. Examples have included private psychiatrists changing the medications of patients without discussing the patients' conditions or changes therein with the patients' primary mental health therapists; inpatient hospitals changing individuals' treatment regimes without informing the ACF at the time of discharge; and specialists performing treatments, including surgery, without the knowledge and assent of individuals' primary care physicians. In the most egregious situations, the absence of service coordination may lead to the exploitation and victimization of residents.

It is proposed that independent service coordination (ISC) be provided to residents of ACFs utilizing a variety of models including:

- the Office of Mental Health's case management program for residents of ACFs who are mentally disabled and/or living in impacted homes; and
- programs licensed or certified by the Health Department, for residents of homes who are not mentally disabled but who, for reasons of age or disabilities, require service coordination.

The two goals of independent service coordination are:

- to ensure that residents receive the residential, health, mental health, rehabilitation and recovery services that are necessary and appropriate to their needs, as determined by professional care providers, and consistent with their wishes and desires; and

- to ensure that such services, often provided by independent service agencies/entities, are of high quality and delivered in a coordinated fashion.

It is expected that the independent service coordinator will:

- **Work closely with the adult home case manager in ensuring that residents receive the services they need and desire. It is expected that the ACF case manager's duties will be reduced with the assumption of some case management responsibility by the ISCs.**
- **Meet with the ACF resident to discuss and understand his or her service needs and wishes, as well as his or her satisfaction with current services and/or desire for changes in services.**
- Periodically meet with all service providers involved in an ACF resident's life, including the ACF administrator, case manager, and other providers of service to discuss services provided since the last meeting and any anticipated service needs congruent with the resident's needs/desires; any need for changes; and how any changes, or continued services, can be best coordinated. The providers should cooperate with the ISC coordinator in carrying out these responsibilities. Meetings can occur in at least two fashions. If the ACF has regular meetings of all service providers to discuss individual residents, the ISC should be present, playing an active role. If the home does not have such regular meetings, the ISC should meet individually with each service provider or his or her designee (e.g., a private physician's nurse or PA) to discuss the resident's needs and the coordination of service provision and/or changes in services. In either case, the ACF resident should be invited/encouraged to attend the meetings to speak on his/her behalf.
- Based on the input of all the above parties, develop a written plan of coordinated services that will be shared with all the parties and periodically reviewed and updated/revised by the ISC as service needs change, or at least quarterly.
- Receive reports (verbal or otherwise) of any changes in the array of services provided to an ACF resident, and request additional information if necessary, to assure that such changes are necessary, appropriate, consistent with the resident's wishes and implemented in a coordinated fashion, through contact and conversations with the resident and service providers involved in his/her care.
- Receive reports (verbal or otherwise) of any acute or new services, e.g., trips to the ER, surgery, hospitalizations for mental health or other reasons, and request additional information if necessary.

- Notify the appropriate licensing/certifying agency of the failure of any service provider to cooperate in sharing information and/or to submit the above mentioned reports so that the matter can be resolved.
- Report concerns/complaints about the adequacy of services provided to the ACF resident to the appropriate provider and, if necessary, the appropriate state licensing/certifying agency and, if necessary, to an independent advocacy agency, in order to seek resolution.
- Make reports to licensing, investigating or advocacy agencies concerning patterns of service delivery that raise questions about the necessity and appropriateness of the service.
- Receive reports on actions taken by licensing, investigating, or advocacy agencies concerning providers involved in a resident's life to determine how such reports may or may not impact on the resident's service network and the need for changes in service delivery. If there appears to be a need for change in service delivery, the service coordinator will notify all parties involved.
- Serve as a resource to a resident to aid in his or her own informed decision making, by having a working knowledge of, and providing contact, referral and other information about services available in the local community, including services such as: medical care (general and specialty); traditional mental health care; and recovery services, including vocational and educational services.

### **Population to be served**

Independent service coordination will bring necessary value to residents of all ACFs. Various options and mechanisms for delivering such coordination to the entire ACF population was explored. The adaptability of existing options of service coordination for the elderly is not simply achieved. Further exploration of these mechanisms for adaptation and development is needed. Conversely, options and mechanisms for the mentally disabled are both developed and adaptable. As such, it is recommended that a program of ISC be initiated initially in impacted homes for individuals with mental illness utilizing the OMH's existing Comprehensive Case Management program. Accordingly, these individuals will also provide case management to that population. Discussions are ongoing on how best to provide ISC services to residents of ACFs who are not mentally disabled.

### **Specifics**

Since 1985, the OMH has offered and monitored several models of Medicaid-reimbursable case management services for individuals with mental illness with the aim of coordinating their services to foster their recovery and improve the overall quality of

their lives. The OMH's Comprehensive Medicaid Case Management program, with its proven track record and existing infrastructure (in terms of program requirements, set staffing ratios, funding mechanisms, etc.) presents a vehicle and opportunity for the provision of independent service coordination to most, if not all, residents of ACFs who are mentally disabled and Medicaid eligible.

OMH's case management services are provided by a variety of entities: state operated facilities, localities, Article 28 facilities, and private not-for-profit agencies. The OMH's case management guidelines prescribe the minimum qualifications of staff employed by these entities. These can range from a minimum of two years case management experience with no academic credentials, to masters level professional or Registered Nurse degrees, depending on the intensity of the service provided or whether it is provided in a "team approach" or on a one-on-one basis.

OMH offers several models for the provision of case management services. OMH's guidelines spell out staff-to-client ratios, which may range from 1:12 to 1:30, depending on the case management model. It is anticipated that the most appropriate model for use in ACFs would be the blended/flexible model which uses a team approach and has a staff-to-client ratio of approximately 3:52, which is between the 1:12 staff-to-client ratio of the intensive case management model and the 1:20/30 ratio of the supportive model. This OMH model allows for the inclusion of peer support services to enhance the team in providing service coordination.

Most importantly, the OMH's guidelines for case management services delineate the duties of the case manager or case management team. These dovetail with the expectations of independent service coordination articulated above and include: assessing and reassessing, directly and indirectly through collateral sources, the individual's functional, medical, social, psychosocial and other needs; developing a comprehensive written plan of service that addresses the interdisciplinary needs of the individual; providing or securing services appropriate to the client; crisis intervention; monitoring and follow-up, i.e. assuring that services are delivered consistent with the client's wishes and needs; and exit planning, for when the individual no longer needs the services.

To assure the independence of the proposed ISC function, it is recommended that the agency funded by OMH to provide this service within an ACF not provide other direct services to residents of the home, unless there are no other providers of ISC services in the area and contingent upon the approval of the OMH and the Department of Health. For the remaining, non mentally disabled ACF population, ISCs would be available and function very similarly to those to those operating within the OMH case management model

Some of the available implementation mechanisms include the existing Long-Term Home Health Care Program (LTHHCP), a Certified Home Health Agency (CHHA), applying for a separate federal Medicaid Home and Community Based Services (HCBS) waiver, or contracting out such services to capable not-for-profit organizations

It is also proposed that where independent service coordination is provided through the OMH case management model (or other models in homes serving the frail and elderly), the ACF be relieved of many of the service coordination and/or case management functions articulated in section 487.7 of Title 18 of the Official Compilation of Rules and Regulations of the State of New York.

## **Implementation**

Utilizing the OMH's case management program, it is possible that the most immediate benefit of ISC can be delivered to a readily identifiable population of residents receiving mental health services in ACFs. Three criteria characterize the means for identifying this population for immediate implementation, while plans for a timely statewide implementation of ISC to all other ACF residents are developed:

- **Size of Home:** It is generally acknowledged that meaningful service coordination for residents of ACFs is difficult, and the larger the home, the more difficult the task becomes. Larger homes should be viewed as a priority for ISC services. However, if it is demonstrated that a smaller home has a compelling need for immediate ISC services, based upon review of the two other criteria set forth below, smaller homes also could be considered a priority for ISC services.
- **Service Delivery Patterns:** Medicaid billing records, as demonstrated by the Commission on Quality of Care's Layering of Services report, show some very expensive and very complex service delivery patterns to residents of ACFs, raising questions about the necessity and adequacy of these services. Service delivery patterns should also be considered in determining where ISC services should be offered.
- **Conditions in Homes:** Adult care facilities are not expected to directly meet of all the needs of all their residents. They are required to serve only those residents whose needs for room, board and some assistance in daily living they can meet, and then make arrangements with other service providers to address outstanding needs. Surveys of homes that document of poor conditions suggest that these homes are having difficulty in meeting residents' most basic needs, and would raise questions about these facilities' abilities to meet higher order needs through linkage to and coordination with outside providers. Thus, consideration of conditions in homes may be useful in determining where to place ISC resources.

## **Timeframes for Implementation**

The Sub-Committee recommends that over the next two years, ISC be made available to residents of ACFs with priority being given to those homes with histories of repeated violations in the areas of resident admission/retention and resident services. This will require the immediate development of a curriculum for an intensive training

program to educate and empower OMH case managers to provide service coordination within an ACF environment. It is acknowledged that the OMH case manager will face new challenges and opportunities in the provision of service coordination to the adult home population whose service needs cross several systems of care.

The responsibilities of the ISC and the ACF case manager, including relief for the home of certain regulatory case management functions, will need to be delineated. Independent Service Coordinator's (including OMH case managers) must receive from providers the information they require to ensure service coordination.

Also during this time, the Services Coordination Subcommittee should be expanded to include DOH staff and others specializing in long term care for the frail and elderly to examine models for service coordination in ACFs serving this population. Initial and ongoing assessments of individuals living in ACFs should be conducted to determine their level of need and suitability for transfer to new models of care.

Based on these assessments and plans for new models development, a two-year plan should be prepared for the expansion of independent service coordination, utilizing OMH's case management program for impacted homes and other models for homes serving the frail & elderly (and for mentally disabled residents who may not be eligible for OMH case management services). The plan should identify the homes and resources needed for a year-by-year expansion of the program.

Service coordination can be expanded or contracted as new models of care are brought on line.

## **Regulation**

The provision of ISC for individuals with mental illness in ACFs, would fall under the jurisdiction of OMH, which funds and monitors existing case management programs. Service coordination in homes serving the frail & elderly would be under the auspice of DOH. Prior to the implementation of ISC activities in the ACF, it will be critical that:

- clear definitions be provided of the respective roles and responsibilities of the ISC and the ACF operator with respect to service coordination and case management (18 NYCRR 487.7(g) and 487.9(d)), and to the maximum extent practicable, duplication of responsibilities should be avoided; and
- the Department of Health and the Office of Mental Health will need to review and approve requests for appropriate waivers.

In the longer term, the need for regulatory amendment of ACF case management requirements will be considered.

## **Peer Bridger Initiative**

### **Purpose**

The purpose of this initiative is to adapt a model of peer support services for ACF residents that has, over the last seven years, helped support individuals to capably move towards recovery and transition successfully from institutions into their home communities.

### **Population to be served**

Adult care facility residents with psychiatric disabilities would be served.

### **Staff**

Individuals who have demonstrated successful management of their own psychiatric disability and who possess the knowledge, judgment and relational skills to have graduated from a specialized 3-week Peer Bridger support training program prior to engaging residents in direct services. Peer Bridger are closely supervised by the contract agency.

### **Specifics**

Peer Bridger, working in conjunction with Independent Service Coordinators would lend their personal experience, skill and training to offer ACF residents:

- Personalized support services in support of newly developed recovery goals; Individual and self-help group support, offered several times a week;
- Community escort services;
- Linkages to community services and natural supports;
- Independent living skill training;
- Empowerment training and advocacy support; and
- Crisis support services.

Peer Bridger develop trusting relationships with ACF residents with psychiatric disabilities, serving in a variety of support roles, as a:

- role model;
- mentor;
- teacher;
- connector;
- advocate;
- supporter;
- ally; and
- source of encouragement and hope.

The Bridger is not expected to be a member of the treatment team, or take on the roles of case manager or crisis worker. However, Peer Bridger can closely complement the work of case managers, helping to support a more comprehensive, coordinated approach. Their role, would be reflected in the residents' plan of coordinated services developed by the ISC.

Bridger perform a variety of functions in their peer relationships, which are represented in their weekly time sheets, including:

- skill teaching;
- social and emotional support;
- recreation companionship;
- advocacy; and
- leading several weekly mutual peer support meetings (on-site in the ACF)

The typical Bridger relationship develops according to the following pattern:

- Personal relationship building emphasizes the development of trust, hope, mutual respect encouragement and emotional support.
- As the above becomes solidified, Peer Bridgers encourage deeper involvement in peer support groups, exposure to community resources, and mastery identified desired skills.
- Following movement from the ACF into the community, intensified peer supports are paramount (e.g. deeper involvement in skills teaching, learning personal triggers to prevent relapse, increased connections to community supports and resources, and regular, honest communication).
- Peer Bridger may encourage more frequent contact to promote increased involvement support and social contact.
- Peer Bridgers help set the stage and lay the ground work for independence through revisiting the skill inventory and addressing those skills not yet quite developed. Meetings in the community are emphasized. Support for the establishment of a wider circle friendships and enhanced social activities in the community are encouraged. Positive risk-taking and greater independence are supported.

Peer Bridger typically move from spending the majority of their time providing social support and companionship to teaching coping and community adjustment skills and linking their 'matches' with important community resources. Some examples of these include:

- helping to open up and use a checking account at a local bank;
- assistance with budgeting;

- help in following through with medical needs;
- help with menu-planning, shopping (sometimes cooking)
- getting comfortable frequenting local movie theaters, art galleries, libraries, malls, YMCAs, churches and other social centers;
- learning bus routes;
- help cleaning room or apartment;
- assistance in following through with getting/keeping necessary entitlements; and
- regular visits to talk, have coffee, give advice as needed.

### **Timeframe for implementation**

OMH could contract with area peer support agencies to hire, train and deploy Peer Bridger within 6 months.

### **Regulation**

No legislative or regulatory changes are needed. Bridger programs would file with OMH monthly reports on numbers served, services provided and outcomes realized.

### **Advocacy**

Legal and lay advocacy are essential service supports that should become available in the first year and be available continuously thereafter. NYS should expand and fully support legal and lay advocacy service for all 12,000 residents in ACFs with psychiatric disabilities.

### **Personal Needs Allowance and Clothing**

NYS should augment personal resources for all residents receiving SSI through increases in the Personal Needs Allowance (PNA) and a to-be-created clothing allowance in order to foster self-sufficiency and responsibility. Mechanisms for accomplishing this are not yet fully determined although supplemental SSI or OMH wrap-around dollars are possibilities.

## **D. RESTRUCTURING THE HOUSING AND SERVICES FOR ADULT HOME RESIDENTS**

The charge to the included reviewing housing and service options, or the array of models that would better address the complex needs of the 12,000 residents diagnosed with psychiatric disabilities and, at the same time, enable them to live in the most integrated community setting. The focus on community integration reflects not only the Supreme Court's Olmstead decision, but also the growing commitment to consumer-driven and person-centered service planning principles.

Absent good assessments of current residents of adult care facilities working assumptions were developed about the makeup and needs of this population. As illustrated by a bell curve, it is assumed that this population is nearly normally distributed across a continuum of functional ability ranging from very dependent on human assistance in activities of daily living (ADL) and instrumental activities of daily living (IADL) to largely independent of human assistance in these areas. As is characteristic of a bell curve, the vast majority of residents would fall near the middle of the curve, indicating that they are neither severely dependent on nor completely independent of assistance.

The estimated distribution of current residents is as follows:

- **Group A:** About 200 at the most dependent end of the continuum are sufficiently impaired by psychiatric disabilities and non-mental medical co-morbidities (e.g., diabetes and heart disease), as to need access to 24-hour a day nursing care.
- **Group B:** 5,800 residents will need or desire a congregate setting with a high level of support.
- **Group C:** 5,200 residents could enjoy a higher quality of life in a more integrated community care setting than ACFs currently provide.
- **Group D:** 800 residents maintain compliance with their medical regimes, are largely independent in self-care activities and could live independently in a non-congregate care setting with varying levels of support, services and housing subsidies. They may benefit by a scattered site living arrangement and services of an Intensive Case Management (ICM) or Assertive Community Treatment Teams (ACT)

Many of the 12,000 individuals identified can be moved into various types of supportive housing. The primary goals of supportive housing programs are to help residents maintain their housing and maximize their capacity for independent living. Services in supportive housing are meant to be flexible and adjust to the changing needs of residents rather than residents adjusting to fit into the supportive service program. The following is a list of services that are critical in achieving residential stability and maximizing an individual's capacity for independence:

1. Medical and health Services;
2. Medication monitoring and management;
3. Daily living skills training or assistance-particularly meal preparation, housekeeping, developing support networks and socialization;
4. Counseling and support;
5. Resident involvement in on-going development of the residential community including house rules and services offered;
6. Conflict resolution;

7. Referrals to other programs and benefits;
8. Access to employment;
9. Assistance in meeting lease obligations;
10. Assistance with budgeting and paying rent; and
11. Privacy.

II.

III. In addition to the above supports, many of the models proposed below include other types of supports for persons diagnosed with psychiatric disabilities.

### **Housing Options**

Several proposed basic categories of housing options or models are described below. Each individual category has subtypes with variation in service modality (Appendix B).

#### **Scattered Site Model**

This housing model is characterized by apartments that are integrated into the community and supported by services that the individual resident requires. *Pathways to Housing* is an example of this model that separates housing from treatment. It treats homeless persons diagnosed with psychiatric disabilities by providing individual apartments and then treats the psychiatric disabilities through intensive and individualized programming. When clients are admitted, the staff assists them with locating and selecting an apartment, executing the lease, furnishing the apartment and moving in. Tenants select the location of their own apartment from available units on the open market. Most apartments are owned by private landlords, leased by the agency and sub-leased to clients individually. The Office of Mental Health oversees the service portion of this model and 70% of each tenant's rent is subsidized through grants from city, state and federal governments and section 8 vouchers. No more than 30% of the individual's income or SSI is required for rent. This approach has the advantage of not requiring capital funding.

These residents receive mental health case management and treatment services from ACT teams which provide psychiatric care, nursing, case management, rehabilitation, personal care and peer specialist services in a twenty-four hours/seven days a week (24/7) model of care. Personal care and skilled nursing could also be provided through a Licensed Home Care Services Agency (LHCSA) or Certified Home Health Agencies (CHHA). Peer bridging will be available to all residents.

#### **Single Site Mixed Use Housing Model**

This housing includes apartment buildings that are integrated into the community and have onsite supportive services, including case management and mental health supports, as needed for residents. All of these apartments include kitchenettes and private baths. Home care services are provided as necessary. Supports are designed to maximize residential stability and assist tenants in becoming integrated into the

community and to function as independently as possible. Tenants sign a lease and pay 30% of income or SSI for rent, which may be subsidized by section 8 vouchers. Examples of this model are *Times Square*, *The Rio and Euclid*, (Appendix C). OMH provides oversight of the service portion of this type of program. OMH licensed apartments are also examples of this type of housing. Current ACFs should be provided resources and other assistance to convert to such settings.

### **Service Enriched/Single Room Occupancy (SE/SRO)**

This is permanent housing with private studio-type apartments complete with kitchen sink, microwave, refrigerator, and private bath. Congregate dining facilities are also available on site, and most people eat many of their meals offered by the SRO. Core services include 24-hour desk security, community living aides on each floor. These aides are trained to administer medications and to assist in the cleaning of individual's apartments, with a focus on engaging and teaching people these skills. Core services would also include a case manager assigned to each individual. The case manager would work with the resident to design a treatment plan. The SRO provides housekeeping for the building. An example of a Service Enriched SRO is the facility run by DePaul, which is described in Appendix C. Peer bridging will be available for all residents.

Although many of these programs are viewed as stand-alone facilities, it is suggested that many of the options described above can be mixed within a single site in order to address the varying needs of residents. Current Adult Homes would be good candidates, as they reconfigure, to develop mixed modalities within a single site.

In keeping with the principles which guide these recommendations, SE/SRO would be integrated settings.

### **Congregate Housing Model**

In this type of housing, all residents live in one building with common meals and varying amounts of services/ supports. This option is similar to the ACF model currently in place but an operator could provide varying degrees of support and the facility would be much smaller, serving no more than 120 residents. In some cases, modifying the services would require regulatory change and the reimbursement structure would need to be altered to include and/or exclude various services.

The present health and mental health care systems provide a wide range of services that are needed by ACF residents. While these services are theoretically available, in some cases ACF residents had no access for various reasons, and in other cases services were duplicated or fragmented due to poor case management. In some cases, perverse financial incentives result in over-utilization, poor service delivery, or unnecessarily expensive care. All of the options proposed below would include "hotel" services such as property management, building maintenance, cleaning of common area, heating and cooling, garbage removal, snow removal, capital improvements,

general laundry, rent collection, security, marketing, office and front desk, accounting, legal, personnel, taxes and debt services. It is envisioned that all will eventually convert to private rooms and private baths. The proposed types of congregate housing include:

- Room and Board Adult Care Facility: This type of ACF would provide all of the “hotel ” services and congregate dining. Home care including nursing and personal care would be obtained through an outside agency as would case management, mental health, peer bridging and recreation.
- Supportive Congregate Housing: Supportive Congregate Housing can provide permanent housing for persons who live with significant barriers to independence in activities of daily living and who could benefit from the availability of on-site services addressing their ADL needs and clinical services 24 hours/day. The barriers to independence may result from serious and persistent psychiatric disabilities, physical frailty, the trauma of homelessness, or mild cognitive and mental illnesses (e.g., mild dementias or personality disorders).

Supportive Congregate Housing is designed to be permanent housing, recognizing that some persons will move on to more independent housing. However, many persons will enhance their independence and deepen their quality of life while continuing to live in the structure of the congregate setting. Supportive Congregate Housing is designed to build communities for 50-100 persons with 24-hour staffing to provide a range of ADL supports and clinical services (Appendix D).

### **Timeline for Implementation**

There are currently about 36,000 residents in ACFs that will have the opportunity to become part of a new model. However, initially the focus will be on the 12,000 residents with psychiatric disabilities. The selection of the particular model for the individual resident will be the result of a health, mental health and social assessment conducted with each resident leading to self-determined personal needs and goals. The result will be an individualized, recovery-focused, community based housing, with a mental health and social services plan for each resident that is developed in an atmosphere of fully informed choice.

It is the thesis of this report that 6,000 of the residents with psychiatric disabilities could reside in a more integrated setting. As stated previously, assessments will be key in determining the individual’s strengths and wishes pertaining to his/her housing and living situation. In the absence of assessments, the following projections are based on the best knowledge of those with experience and expertise in this area, including residents themselves. Of the 6,000 who will move, 800 residents will move to subsidized independent housing or to housing with families or friends with support and services. About 5,200 persons will move to additional scattered sites, mixed housing sites and service enriched SROs within a seven year period.

These assumptions lead inevitably to the conclusion that alternative housing options should be made available to that segment of the population that is both able and interested in living in other types of housing. The Office of Mental Health has a long track record of bed development and currently funds, in whole or in part, a system of approximately 20,000 beds in the community that offers a range of living opportunities for adults with chronic psychiatric disabilities (Appendix E). While this system currently operates at a very high occupancy (95%), some beds may be available based upon improved utilization. The types of housing in this system are:

- Licensed treatment programs

These may be configured as congregate settings (5,399 facilities with 2,285 beds in NYC) or scattered site apartments (4,088 apartments with 1,812 beds in NYC), that offer rehabilitative services designed to enhance the individual's ability to move on to more independent settings.

- Licensed supportive programs

These are configured as congregate or SRO settings (1,443 facilities or units with 821 beds in NYC) that place lesser expectations on residents for transition while seeking to engage individuals in rehabilitative support services appropriate to their needs and desire.

- Supported housing

These are unlicensed permanent housing offered as independent apartments or SRO units within larger buildings (9,953 apartments or units with 4,557 beds in NYC).

Table 1-3 provides a proposed schedule for movement of residents of adult care facilities who are both interested in and capable, with the appropriate supports, of living productively in other types of existing housing. While the great majority of the units identified below must be developed, some existing units that may be available are also identified. These would serve to provide immediate options to those most agreeable to accepting other housing while additional resources are being brought on line.

The numbers under new units in the scattered site and SE/SRO columns represent estimates of the number of units that can reasonably be brought up yearly in each category. These estimates are grounded in OMH's experience and can be considered reliable, absent of other problems. The projections are front-loaded on the scattered site options because of the comparative rapidity with which this type of housing can be developed.

**Table 1-3**

**Movement of Adult Care Facility Residents into Supported Housing**

Timeline	# of Persons With MI Placed in Alternate Housing	Cumulative # of Persons With MI Placed in Alternate Housing	Scattered Sites  New	Mixed Housing Site Units	
				Existing	New
10/02-3/31/03	20	20	0	0	20
4/03 – 3/04	1530	1550	1530*	0	0
4/04 – 3/05	800	2350	730	70	0
4/05 – 3/06	930	3280	730	0	200
4/06 – 3/07	970	4250	320	0	650
4/07 – 3/08	875	5125	225	0	650
4/08 – 3/09	875	6000	225	0	650

**Size of Adult Care Facilities**

NYS should assure that new ACFs will have a capacity of no more than 120 beds, and the State should encourage existing ACFs that have more than 120 beds to reconfigure to include: (1) small, home-like environments within the facility, and (2) such housing options as OMH-licensed apartments, SROs, and respite beds.

NYS should provide appropriate financial resources and facilitation to provide the means for ACF operators to obtain capital financing to improve the resident's privacy by providing single rooms with private baths over a 10-year period. The State should also provide appropriate financial resources and facilitation to enable adult care facility operators to downsize and/or reconfigure.

NYS should encourage, with necessary financial compensation, conversions of and improvements to existing facilities, and should assist in the development of new projects by facilitating access to capital funds through funding pools, public/private partnerships and prioritization of these projects seeking section 8, HUD and other federal funding.

**Housing Vacancy List**

NYS should develop a comprehensive housing vacancy list to ensure that ACF residents, hospitals, OMH facilities and others are fully informed about available housing options.

## **Unlicensed Facilities**

NYS should identify and rigorously regulate to the full extent of the law unlicensed facilities that offer congregate care.

## **Workforce**

NYS should identify resources to support training and other workforce initiatives for adult care staff, and NYS should fix and implement Limited Licensed Home Care Service Agencies (LLHCSA), in models where appropriate, to professionalize staff and services in order to provide cost effective nursing and personal care services.

## **E. Potential Fiscal Impact**

Fiscal impacts were developed for most of the recommendations. To accomplish this goal, the Workgroup reviewed information and presentation on the following:

- Data on the number of adult care facilities and beds;
- The Institution for Mental Diseases (IMD) issue and its ramifications for future planning;
- Medicaid expenditures in adult care facilities;
- The “Layering of Services Report” from the Commission on Quality of Care for the Mentally Disabled;
- Existing managed care and waiver authorities and currently operating programs;
- Limited Licensed Home Care Services Agency;
- Supplemental Security Income (SSI) payment structures;
- Existing financing options available for mental health programs;
- Available Federal and State capital financing programs; and
- Payment mechanisms for county operated adult care facilities.

The short-term cost impact of these initiatives was fully developed. For long range recommendations costs were developed to guide future deliberations.

## Assessments

The process for implementing resident assessments would occur in two phases. Phase one would be assessment tool development. Phase two would assess residents using the tool; the data would be edited, keyed and processed; and meaningful reports would be produced for future policy development as well as to assist with identifying residents to be relocated.

There are three options for developing an assessment tool and collecting the information:

- Option I: The State would issue an RFP for both phases of the project.
- Option II: State staff would be responsible for phase one (assessment tool development). Responsibility for phase two would be shared between State staff and provider staff. Provider staff would complete assessments and send the data to the State. State staff would create the database and reporting capability.
- Option III: This option is identical to Option II with the exception that in phase one, State staff *and other interested parties* would develop the assessment tool. Provider staff would implement it and send the data to State staff. State staff would create the database and reporting capability.

Option I outsources both phases of the project and thus is the most costly of the three options. The estimated cost to develop an assessment tool is \$150,000. This is a low estimate based on the assumption that existing assessment tools would be used or slightly revised. Tool development costs would be substantially higher if a new assessment was developed. The time required to complete the assessment will vary across residents. The per assessment cost is estimated to range from \$150 to \$300 and will average about \$167 per resident. Option I costs are:

Assessment tool development	\$ 150,000
Assessments for 36,000 residents	\$ 6,000,000
Development of database and reports	<u>\$ 100,000</u>
Total cost	\$ 6,250,000

Options II costs are comparable to those for Option III. Since State staff would be used for all but the actual performance of the assessments, the cost of both options would be the cost for provider staff to assess residents. It is assumed that all residents are Medicaid-eligible. Providers would bill the State for each assessment at the time it was conducted, based on the amount of time required to assess the resident. The cost of Options II and III is:

Billed cost per assessment	\$150 - \$300
Number of residents assessed	36,000
Cost	\$5,400,000 - \$10,800,000

## Medication Management

Cost for Medication Management was estimated. The three options provided to implement this recommendation are as follows:

Option A would require Licensed Practical Nurses (LPNs), supervised by Registered Nurses (RNs), to be responsible for direct administration of medication to residents. The cost estimates for this recommendation assume an LPN to resident ratio of 1/50. The ratio of supervisory RNs to LPNs is 1/4. Using these ratios, 720 LPNs and 180 RNs would be needed to administer medications to all 36,000 residents of ACFs, enriched housing programs and residences for adults.

Estimated compensation costs for 900 LPNs and RNs, based on competitive nursing salaries and a 30 percent fringe benefits rate, are \$63.2 million. About 30% of this amount, \$19 million, will be billable to Medicaid. However, CHHAs currently bill Medicaid \$12 million annually for nursing services provided to this population. It is assumed that the proposed new medication administration program will replace the current use of CHHA nurses for this purpose. Thus the actual additional costs to Medicaid are \$19 million minus \$12 million, or \$7 million. Federal financial participation in Medicaid (about 50%) further reduces the cost to the State. State and local share of the \$7 million in new Medicaid expenditures would be a total of \$3.5 million. In addition, the non-Medicaid portion of the medication administration program would be borne by the state. Thus the costs of the new program are:

Total cost	\$63,200,000
Amount billable to Medicaid	\$ 7,000,000
State and local share	\$ 3,500,000

Option B requires RNs to administer all medications that cannot be administered by non-licensed staff. Other medications will be distributed by trained adult care facility staff. RNs will be responsible for oversight of this process at a ratio of one RN to 100 residents.

Since facilities vary by size, the amount of nursing time required for oversight would also vary. However, it is assumed that facilities with fewer than 100 beds require an average of .5 FTE and facilities with 100 beds or more require an average of one FTE. Assuming a compensation cost of \$60,000 per FTE nurse, the cost of this option would be \$19.6 million. Since about 40 percent of the residents are Medicaid-eligible, the total Medicaid cost would be \$7.8 million. State and local share of this Medicaid cost is \$3.9 million. As is the case for Option A, some of these services are already delivered by CHHAs and billed to Medicaid. If we were to assume that some of these new functions would be add-ons but that a congrate rate would be created (see savings section) resulting in some savings.

Total cost	\$19.6 million
Medicaid cost	\$ 7.8 million
State and Local share	\$ 3.9 million

Option C is similar to Option B with the exception that a nurse to resident ratio is not specified. The cost of Option C is assumed to be the same as that for Option B.

A cost estimate was also developed based on a CHHA cluster rate for this service. Under contract, CHHAs would provide nursing supervision of medication administration in ACFs.

It is assumed that this service would be provided for six hours a day in each impacted facility.

Total Cost	\$23.7 million
Medicaid	\$17.7 million
State and Local Share	\$ 8.85 million

There are 216 impacted facilities with about 12,000 psychiatric disabilities residents and 6,000 residents without these disabilities. Assuming a \$50 hourly rate for the CHHA, nursing supervision of medication administration at all 216 impacted homes would cost \$23.7 million annually. Of this amount, 75 percent or \$17.7 million would be billable to Medicaid. If paid on a per Medicaid-eligible resident per week basis, the Medicaid CHHA rate for this service would be \$37.80 per week. The Department of Health would conduct post-payment audits to verify that Medicaid weekly claims are legitimate.

Assuming that CHHA cluster rates would be implemented over a two-year period, year one costs are estimated at \$11.8 million and year two costs, when the rates are fully implemented, are \$23.7 million. First year Medicaid cost would be \$5.9 million.

If this service was provided to all residents in the 321 non-impacted homes, an additional cost of \$35.1 million would be incurred. Twenty percent of ACF residents without psychiatric disabilities are Medicaid eligible. Thus \$7 million would be billable to Medicaid. The balance, \$28.1 million, would be paid from non-Medicaid sources.

Total Cost	\$35.1 million
Medicaid cost	\$ 7.0 million
State and Local Share	\$ 3.5 million

These cost estimates do not provide a full cost analysis of all of the types of providers included in the recommendations. The recommendations raise statutory and regulatory issues with several of the approaches such that these approaches could not be used until the issues are resolved. For this reason, cost estimates for the options were based primarily on CHHAs. Since a Long Term Home Health Care Program (LTHHCP) is also a CHHA, cost estimates for LTHHCPs would be similar to those for CHHAs. Direct Medicaid reimbursement to Licensed Home Care Services Agencies (LHCSAs) for nursing services is currently precluded by statute. Substantial changes in

the Limited LHCSA program would also be required as described in the following section.

### **Independent Service Coordinator Program**

The Independent Service Coordinator (ISC) initiative would ensure that adult care facility residents receive the residential, health, mental health, rehabilitation and recovery services necessary and appropriate to meet their needs and to ensure that such services are of high quality and delivered in a coordinated fashion. It is recommended that a blended case management program be used. The Blended Case Management (BCM) program relies on both the Intensive Case Management (ICM) and the Supportive Case Management (SCM) service levels and case manager support, depending on the individual's needs. BCM programs serve a range of 32 to 52 people. The average cost per person varies from \$3,700 - \$4,640.

Initial implementation would be in impacted homes with an expectation that one-half of the population in these homes would be served in the first year. There is a concern with the practical aspects of identifying sufficient staff in the first year. However, assuming that enough ISCs can be identified and hired, first year costs are based on one-half of the impacted home population, or 6,000 residents. It should be noted that providers may already perform some of the functions that are included in BCM. The responsibility for these case management activities would be reassigned from providers to the ISC. Provider rates would be reduced accordingly. The amount of the reduction has not been estimated, but as it would be paid to the ISC, it would reduce the cost estimate shown below:

Annual BCM cost per person	\$3,700 - \$4,640
Number of residents	6,000
Total cost	\$22,200,000 - \$27,840,000

A cost estimate was not developed for all residents who receive Supplemental Security Income. However, it appears that this option as costed above properly reflects the cost for the number of individuals needing BCM as outlined in the recommendations. Additionally, the full cost of other case management was not calculated. However, it does not appear that cost estimates need to be developed for these other options because they are not included in short term recommendations.

### **Peer-Bridger Initiative**

The existing Peer Bridger program has been targeted primarily to individuals in State psychiatric center inpatient programs who are being discharged to the community. The model to be created will aid in the transition of individuals from adult care facilities to other housing models. The recommendation is that initially \$500,000 should be allocated for demonstration programs.

Cost	\$500,000
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The recommendations support peer bridgers for 12,000 clients. Based on a \$400 cost per individual this proposal would be expected to cost \$4.8 million.

Cost \$4,800,000

**New Housing Models**

The New Models Sub-workgroup provided a seven-year timeframe for transition to new housing models for 5,200 individuals currently residing in adult care facilities. Only 20 of these individuals would transition prior to the next fiscal year. It is expected that this small number of individuals would be absorbed into existing programs without major cost to the system. Other cost associated with New Models were not developed, as they did not have an impact on first year costs of these recommendations. However, as part of the first year it was projected that 200 individuals currently residing in adult care facilities would move to a higher level of care. There would be a Medicaid cost associated with this outcome. Using existing nursing home rates this would be projected to have a total cost of \$7.0 – \$8.0 million. If a large percent of these individuals needed inpatient psychiatric services, this projection would be higher. This would be offset by individuals who may be eligible for higher level but reject this choice in favor of non-institutional placement. It was also noted that some of these individuals could be served in assisted living programs or an ACF with a LLHCSA as more cost-effective alternatives.

Cost \$7.8 Million

For the year two and beyond recommendations, unit prices were developed on the various housing options both from a capital financing and service delivery perspective. Development of longer range cost impacts were not completed pending further analysis of the final reports from the other two sub-workgroups.

The unit prices for this housing were estimated as follows:

	Unit Price for New Models Total Cost	Total State Cost	Gross Cost w/ SSI
Supportive Housing	\$12,956	\$11,912	19,496
CR SRO	\$16,620	\$11,400	23,160
SRO Debt Service	\$ 9,800	\$ 9, 800	9,800
Supported SRO	\$13.504	\$12.460	20,044

## **Refurbishing Existing Adult Care Facilities**

The recommendations call for the refurbishing of existing ACFs. Such transfers of existing adult care facility residents to new and existing models of housing would be gradual over a multi-year period. While there was general agreement that there was a need to refurbish facilities that are downsized, the payment committee identified several factors which should be considered in the long-range fiscal implications of these recommendations:

- New facilities are being developed and becoming operational on an on-going basis. Such growth is resulting in marketplace pressures on facilities with less than optimal housing to close. The new facilities have many of the amenities described in the recommendations. The impact of this new capacity should be considered in determining the number of existing adult care facilities to be refurbished.
- The pricing of reconstruction of existing facilities can vary dramatically. In some instances, this cost can be higher than a replacement facility or new facility.
- Several cost centers including leases, taxes, and utilities may not be reduced as existing facility capacity is decreased. Therefore, financial feasibility of renovation projects needs to be carefully considered at the application phase in regard to these operational costs.
- The impact of resident relocations may vary dramatically by the facility, both as a result of downsizing and the extent of other changes in services being recommended in this report. Some facilities may have large decreases and others just a few. The dynamics need to be considered in the approach taken.

In light of these factors a more in-depth review should be undertaken to better target the number of facilities to be refurbished, and the extent to which incentives are required to fund this effort.

### **Sub-Workgroup Recommendations That Are Not Costed**

Recognizing that the reports of other two sub-workgroups have not yet been finalized, there are several areas that have been included in draft documents which do not appear to have sufficient detail for the payment committee to consider the fiscal impact. These areas are:

- Legal and lay advocacy services for ACF residents;
- Assurance of compliance of housing options with Olmstead;
- Provision of training of ACF workforce;
- Personal care services; and
- Enhancement to worker wages and fringe benefits.

There is a strong recommendation to continue with an advisory group to oversee the implementation of the final recommendation of this report.

There are several other recommendations proposed which do not appear to have a major cost impact but a consensus on the actual scope of each proposal would need to be finalized before final conclusions on cost can be rendered. These items are:

- Implement an ongoing advisory process;
- Create and fund an adult care facility oversight committee;
- Review of ACF applications by the Public Health Council; and
- Fully oversee and regulate adult care facilities.

### **Additional Financial Recommendations**

#### **Over-utilization and Inappropriate Use of Services**

Current payment for services in adult care facilities includes outside agencies such as home care providers and mental health providers who directly bill various payers. Concerns with these arrangements have been raised in regard to:

- Over-utilization and duplication;
- Lack of coordination and accountability; and
- Unreasonable profits.

In addition to activities related to better coordination and oversight of services, additional steps should be taken to address these concerns:

#### **Recommendations**

- The annual financial report submitted by adult care facilities should be revised to include more appropriate data for properly monitoring these facilities. Such revisions should be consistent with generally accepted accounting principles. This product should be developed by December 31, 2002 and used to collect calendar year 2002 data.
- Periodic financial audits of adult care facilities should be scheduled.
- Written protocols for adult care facility contracts with outside providers which include fair market value standards for space rental arrangements should be established and enforced.

#### **Capital Financing**

Much of the recent development of new ACF capacity in New York State has been targeted to the upper income segment of the market, with capital costs initially financed by conventional mortgages or through internal resources of corporations. These costs are ultimately financed through rents and fees charged to, in most cases, private paying consumers. The one exception has been the 4,200 assisted living beds of which about 85 percent has been devoted to SSI populations.

A review of housing financing programs applicable to adult care and supportive housing includes a number of program options that have evolved over many years (**see Appendix F**). Access to the financing does not appear to be a problem as much as the sheer complexity of the process and the attendant development costs. Although some of the complexity is due to the lack of clear demarcations between housing, housing with supportive services and more “medically-oriented” facilities, much appears to be due to the multiplicity of financing programs with unique administrative structures and objectives.

Private companies and non-profit organizations have shown that they can provide innovative housing alternatives at a reasonable cost for persons with moderate incomes. But the ability of these developers to provide housing with service options for low-income residents who cannot afford to pay the full cost of services can depend on government assistance. Such assistance comes in various forms, including flexible reimbursement, favorable tax policies, low-interest financing and direct subsidies.

There was concern raised by that financing for facilities devoted to psychiatrically disabled SSI populations was not available due to the low SSI reimbursement rate. While this is true for existing ACFs it should be noted that many of the new models suggested have access to such capital and additional state subsidies.

## **Recommendations**

- A focused technical assistance component for this initiative needs to be developed; and
- State caps on either total funding or per bed maximums should be evaluated in an effort to enhance available capital for new models and refurbishing of existing adult care facilities.

## **Supplemental Security Income Program**

The Federal SSI program is a means-tested program that supplements the income of aged, blind and disabled persons who meet income and resource criteria. SSI recipients are automatically eligible for Medicaid. In addition to the basic Federal SSI payment. States have the option to supplement those payments in accordance with Federal rules. New York has chosen to tie an SSI recipient’s State supplement to the type of living arrangement and geographic location of the individual. Adult homes and enriched housing programs (as well as Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD) community residents) are for these purposes categorized as Congregate Care Level II facilities. The 2002 State supplement for Level II is \$545 per month (for an individual) in the New York City metropolitan area and \$405 upstate. An eligible resident in a certified upstate ACF would receive the \$545 Federal SSI benefit plus a State supplement of \$405, for a total SSI check of \$950. Of this \$950, the resident is entitled to keep \$122 as a personal needs allowance and the operator usually charges the resident the remaining \$828.

The State subsidy has remained unchanged since 1988. The Federal portion is increased annually through a Cost of Living Adjustment (COLA) adjustment. The 2002 benefit levels for all categories are included in (see Appendix G).

Since only a portion of the SSI beneficiaries in Congregate Care Level II are ACF residents, an increase of \$1 per day in the State Supplement costs New York State \$13 million. If the State were to break out the ACF population from that of the other Level II recipients, the number of categories would exceed the Federal limit. The State would then be required to administer the SSI program. This has not been viewed as an acceptable alternative.

Another possible option is to reclassify Congregate Care Level II residents to Level III. While this would increase the monthly rate by \$54 upstate and \$58 in NYC, the personal needs allowance would be reduced to \$84. Therefore, other actions would be required along with this increase to increase the personal needs allowance by carving out a portion of this increase. The State cost impact for such a change would be \$650,000 to \$700,000 annually.

One of the major barriers to reviewing the adequacy of SSI revenue for facility operators is the lack of a database that profiles ACF financial information. While the Department is in the process of entering all financial data received from adult care facilities for calendar years 1998 and 1999 to establish such a database, it is not yet available. The availability of this data is an important first step in gaining an understanding of the financial factors contributing to the issues raised by workgroup members regarding shortfalls in revenue and the impact on providing necessary services. Although there have been concerns regarding this issue for a number of years, there do not appear to be any studies of financial information that adequately document the fiscal impact of the current SSI payment on facility expenses.

In an attempt to begin this process, data from 1999 financial reports on 316 adult care facilities was profiled (this represents 74 percent of all facility reports). Facilities with assisted living beds were not included in these calculations. For upstate facilities we were also able to review for-profit vs. not-for-profit differences. This data should be considered preliminary at this time. Not all facilities are included in that further efforts to finalize the database are continuing. This information is presented in Tables 3 and 4.

Moreover, while the financial reports summarize the financial position of ACFs as reported to the Department, the Commission on Quality of Care for the Mentally Disabled's layering of services study found instances where operating profits were hidden through non-arm's length payments to the operator which created "costs" that were in reality profits.

The following observations can be made:

- A large percentage of adult care facilities are profitable.
- The total revenue per day is much higher than would be explained by SSI revenue.
- New York City facilities greater than 100 beds appear to have the lowest revenue per day but the highest net income per bed.
- Of the 29 facilities in New York City with capacity above 100 beds (without ALP beds), 24 indicated a surplus and 5 had a deficit. All facilities with SSI percentage of greater than 90 percent showed surpluses of revenue vs. expense except one. All seven facilities with ALP beds were profitable.
- Of the 13 facilities in New York City with capacity below 100 beds, nine were profitable and four had deficits. Of the four with deficits, two had a SSI percentage of 6.6 percent and 12 percent, respectively. Facilities with the highest percentage of SSI recipients were all profitable.
- A greater percentage of upstate facilities with substantial (above 20 percent) SSI populations appear to be suffering an annual loss.
- We also were able to profile preliminary data for impacted facilities (Table 4). Initial analysis also indicated major differences by region and facility size.

The following conclusions can be made:

- More data analysis is required to reach any conclusions, especially as it relates to impacted homes.
- It would appear from the raw data that revenue factors other than SSI rates of payment influence the level of profit.
- The extent to which facility occupancy rates impact on overall net income also needs to be included in the analysis.

There are several other aspects of data reviewed as part of this effort that preclude final conclusions on the need for such an increase until the mechanism for implementing other recommendations of the full workgroup are finalized. This is especially true as it relates to which entities will be accountable for the services rendered in such settings. Although one workgroup member seriously questioned the validity of the data presented as it related to impacted facilities having per diem revenues substantially higher than \$28.50 per day, this data was based on certified financial statements submitted by existing providers.

On light of the above discussions further study is required prior to a formal recommendation.

TABLE 3  
Adult Care Facility Financial Data (1999)  
All Facilities

Region	# of facilities	Average per diem revenue	Average per diem expense	Net income	# of facilities w/loss	# of facilities greater than 20% SSI w/loss	# of facilities w/profit greater than 20% SSI
<b>Nassau/Suffolk</b>							
100+	18	67.04	65.60	1.44	5	1	4
Less than 100	36	39.43	39.62	(.20)	8	4	20
<b>Rockland/Westchester</b>							
100+	9	44.52	44.06	.46	2	0	5
Less than 100	23	48.22	48.04	.18	7	4	12
<b>Upstate</b>							
100+ Not-for-Profit	12	49.95	48.85	1.10	3	0	6
For Profit	17	45.31	43.92	1.38	6	3	6
Less than 100 Not-for-Profit	54	61.38	59.81	1.56	23	12	8
For Profit	110	56.72	54.15	2.57	34	28	43
<b>New York City</b>							
100+	29	36.92	34.24	2.68	5	3	21
Less than 100	13	57.18	55.77	1.40	4	2	7

**TABLE 4**  
**Adult Care Facility Financial Data (1999)**  
**Impacted Facilities**

<b>Region</b>	<b># of facilities</b>	<b>Average per diem revenue</b>	<b>Average per diem expense</b>	<b>Net income</b>	<b># of facilities w/loss</b>	<b># of facilities greater than 20% SSI w/loss</b>	<b># of facilities w/profit greater than 20% SSI</b>
<b>Nassau/Suffolk</b>							
100+	11	59.30	53.99	5.31	1	0	4.
Less than 100	18	29.92	28.42	1.50	2	2	14
<b>Rockland/Westchester</b>							
100+	6	29.90	26.77	3.13	0	0	6
Less than 100	16	46.54	42.53	4.01	3	2	12
<b>Upstate</b>							
100+ Not-for-Profit	4	45.14	44.66	0.48	1	0	3
For Profit	4	29.64	32.22	(2.58)	2	2	2
Less than 100 Not-for-Profit	9	40.87	43.21	(2.34)	5	5	4
For Profit	45	36.27	35.78	0.49	18	15	25
<b>New York City</b>							
100+	20	34.19	31.52	2.67	2	2	16
Less than 100	8	54.97	53.19	1.78	2	1	6

## Access to Adult Care Facility Services

Although the number of ACF beds throughout the State continues to increase, there are concerns that access to this resource is somewhat limited for low income and SSI populations including the mentally impaired. Some local authorities do negotiate with organizations developing such facilities to provide such access as part of their role in the application process. Local Offices on Aging and county social services districts are required to provide formal letters of support to applicants for new facilities. Since additional beds will continue to be developed and further saturation of this marketplace will occur, there is a need to ensure that a portion of this capacity is targeted to low income and SSI recipients.

To address concerns regarding the closing of smaller facilities and the impact on access for SSI recipients to adult care services, the workgroup reviewed data on the number of facility closures and the number of new facilities opened between 1999 and June of 2002 and compared it to the previous ten-year trend. This review identified the following:

- The average size of facilities closing in the last three years is 39 beds. A number slightly larger than the previous ten year period.
- For the 70 new facilities opened in the last three years the average bed size was 63 beds or 10 beds smaller than the previous decade.

The chart below depicts this trend:

	# of Years	Closures	Total Beds	Beds per Closure
<b>Closures</b>				
1988-97	10	70	1915	27
1999-02	3	39	1509	39
<b>New Facilities</b>				
1988-97	10	83	6017	73
1999-02	3	70	4404	63

\*Average bed size is smaller

- A review of the changes in SSI recipients indicated a 1.3 percent annual increase in Congregate Level II recipients. This increase was higher than .6 percent annual increase total NYS SSI recipients.
- Since 85 percent of ALP residents are SSI recipients and with the expectation that approximately 1,000 additional ALP beds are scheduled to become operational, about 850 additional SSI recipients are expected to be served.

As indicated in the chart below, 77 percent of facilities do serve some SSI residents. There is very little variation statewide.

**SSI RECIPIENTS  
JUNE 2001 CENSUS REPORT**

<b>Region</b>	<b>w/SSI</b>	<b># SSI Residents</b>	<b>Total Facility</b>	<b>% of Total Facilities with SSI</b>
Capital District Regional Office	99	1,529	128	77%
Central Field Office	36	768	47	77%
Metropolitan Area Regional Office	177	10,598	233	76%
Western Regional Office	103	2,284	132	78%
<b>TOTAL</b>	<b>415</b>	<b>15,179</b>	<b>540</b>	

In some instances increasing in regional capacity and low rates of occupancy have resulted in many of the newer facilities taking some SSI recipients and offsetting these costs from other revenue streams. This trend is more predominant in newer not-for-profit facilities than for-profit. However, data is not available to distinguish how many of these SSI residents also have mental needs.

It should also be noted that the committee did review information on the six adult homes operated by county government. Since public facilities are not eligible for SSI funds, these facilities are authorized by statute to receive public assistance. These facilities are reimbursed on a per diem basis based on actual cost (50 percent state, 50 percent local). The current rate of reimbursement averages about \$68 per day. Data was not available to do a comparison of the services included or the utilization of other Medicaid services. Further study of these costs should be included in the overall study of SSI payment issues.

**F. Potential Fiscal Savings**

**Medicaid Savings**

Medicaid data was obtained from the Department of Health’s Office of Medicaid Management for calendar year 2000 for ACF residents identified as having a mental illness diagnosis. This data was compared to several “benchmarks” to determine potential areas of cost savings. Additionally, based on past studies by the Commission on Quality of Care for the Mentally Disabled, the Medicaid data was used to help quantify potential savings.

The study shows that when compared with a similar SSI population not in adult care facilities, the ACF residents cost \$42.0 million more than the control group. This was taken as outer bounds of estimated savings achievable for this population and selected estimates were developed of savings that would fall within the larger range.

Based on discussions with the group, several options for possible savings and “efficiency” in these programs were proposed. Facts of the five selected options for achieving savings span from the low end of \$3.0 million to the high end of \$6.5 million. It was a clear expectation of the group that any savings achieved would be re-targeted to defray the cost of other workgroup recommendations. This is summarized in Table I:

**Table I**

**Adult Care Facility Savings/Costs**

**A. Comparison of Costs for Adult Care Facility Residents vs. a Controlled Group of Non-Adult Care Facility Residents**

<u>Population</u>	<u>Recipient</u>	<u>Gross</u>
Adult Care Facility Residents	\$16,500	\$173.0 million
Comparable Group	\$12,600	\$131.5 million

**B. Options for Achieving Efficiencies**

	<u>Annual Savings</u>
· Reforming Home Health Care	
· Implementing congregate care rates for nursing services	\$6.0 million
· Reducing home health aide services	\$4.5 million
· Reducing Assisted Living Program rates	\$6.5 million
· Enhanced care coordination	
· Recipient Restriction Program (short term)	\$3.0 million
· Medicaid care coordination model (long term)	\$6.5 million
· Primary Provider Option (long term)	\$ 0

**Adult Care Facility Home Resident Medicaid Costs**

Based on current data, there are approximately 36,000 individuals residing in ACFs statewide. Our analysis focused on the Medicaid population in ACFs. The Department of Health reports, derived from the Department of Health/Office of Medicaid Management Audit Fiscal and Planning Datamart for calendar year 2000, identified 10,400 Medicaid eligible residents in the adult care facilities with Medicaid costs reaching approximately \$173 million statewide (Table 2). This equates to a total Medicaid cost of about \$16,500 per resident.

The majority of residents, and thus costs, apply to the “Metro” area, which includes the five boroughs of New York City and Orange, Putnam, Rockland and Westchester Counties. The Metro area was comprised of 5,743 individuals, or about 55 percent of the total statewide population. Total costs were \$124.9 million, or about 72 percent of the total statewide cost. On a per resident basis, Metro area residents incurred costs of \$21,752 per resident annually. Focusing only on New York City residents, annual per person costs for 4,500 residents was \$23,500. Interestingly, “upstate” residents (all counties north of Westchester and Rockland Counties)

comprised a small proportion of the total. Upstate residents accounted for about one-third of the total population but only 16 percent of the total costs, or \$8,315 per person.

Aggregate Medicaid data was obtained and broken out by various categories of service. Based on an analysis of the categories of service, the majority of costs (82 percent) can be identified into four major categories:

<u>Category of Service</u>	<u>Total Cost</u>	<u>% of Total</u>
Non-Institutional Long-Term Care	\$38.1 million	22 %
Inpatient Services	36.6	21 %
Outpatient Clinic Services	34.4	20 %
Pharmacy Costs	32.3	19 %

Although concerns have been raised about the coordination and delivery of other services, such as physician, podiatry and “other services,” given the large percent of costs in the four categories noted above, the group decided to concentrate its efforts in these areas alone.

At the request of the committee members, the group performed a three-benchmark analysis for purposes of evaluating the Medicaid expenditures in adult care facilities. Data for calendar year 2000 was used for this purpose.

- Benchmark: Population of Non-Institutionalized SSI Over 21

The first review focused on a non-institutional population residing outside of the adult care facility. A comparison of Medicaid annual expenditures against costs of SSI eligible persons over 21 years of age, with the age weighted to be consistent with the adult care facility group, showed that on average the adult care residents were \$4,000 costlier per person than the control group.

- Benchmark: Persons in Intensive Case Management Programs

This analysis compared people living in adult care facilities who were receiving services with those in the home not receiving Intensive Case Management (ICM) services. This comparison did not indicate any savings with the presence of the ICM service. Residents identified in ICM programs had average Medicaid annual costs of \$37,000 in adult care facilities compared to \$26,500 that were not in these programs. The Serious and Persistently Mentally Disabled (SPMI) were also reviewed and similar results were found. Individuals who were seriously psychologically disabled and in an ICM in the adult care facilities cost on average \$46,000 per year, while those not in the ICM cost \$36,000 annually. While current available data does not suggest savings with the inclusion of ICM, national data indicates a potential for savings where more modified case management programs have successfully controlled medical costs.

- Benchmark: Persons in Long Term Home Health Care Programs

A third comparison analyzed Medicaid costs of persons living in adult care facilities and also in the Long Term Home Health Care Program (LTHHCP) and compared them to adult care residents without the LTHHCP. The data shows the average annual costs of the LTHHCP group to be \$26,380 per year while the non-LTHHCP cohort cost \$16,308 annually per person. We, therefore, could not conclude that being in the LTHHCP in the adult care facility would necessarily lead to Medicaid savings. However, there was some concern raised with the current LTHHCP referral practices in New York City which only placed individuals with high service needs in ACFs.

Data to support the above conclusions is in Table 2 that follows:

**TABLE 2: SIDE-BY-SIDE AVERAGE EXPENDITURE COMPARISON  
ADULT HOME POPULATION CALENDAR YEAR 2000  
DATA SOURCE: DOH/OMM AFPP DATAMART (CLAIMS PAID THROUGH JANUARY 2002)**

	AH POPULATION (1)		BENCHMARK ONE (2)		BENCHMARK TWO		BENCHMARK THREE		BENCHMARK FOUR	
	STATEWIDE	NYC	CONTROL GROUP (SSI, 21+ age weighted, non-inst.)		NYC MH		NYC SPMI		LT HOME HEALTH CARE	
			STATEWIDE	NYC	ICM	NON-ICM	ICM	NON-ICM	LTHHC	NON-LTHHC
TOTAL Recipients	10,433	4,510	300,382	198,890	159	3,580	65	1,016	248	10,185
TOTAL Expenditures	172,637,523	106,227,602	3,784,736,451	2,505,365,349	5,880,753	92,726,534	2,993,642	36,641,044	6,542,157	166,095,365
AVERAGE Expenditures per Recipient	16,547	23,554	12,600	12,597	36,986	25,901	46,056	36,064	26,380	16,308
<b>Services</b>										
Physician	289	347	198	195	433	371	435	376	467	284
Podiatry	18	13	5	4	3	14	0	0	42	17
Psychology	52	59	4	3	25	73	6	19	310	46
Eyecare	11	14	11	12	12	15	10	13	14	11
Nursing	3	0	40	22	0	0	0	0	0	3
OPD Clinic (hospital outpatient)	1,075	1,591	647	817	2,218	1,829	3,339	2,839	816	1,081
ER	50	54	54	54	132	56	209	87	91	49
Mental Health	692	922	n/a	n/a	1,317	1,103	1,959	61	398	699
Day Treatment	370	496	n/a	n/a	393	607	681	0	109	376
FS Clinic (D&T center)	2,223	3,542	725	853	5,585	4,194	6,001	6,635	1,473	2,242
Mental Health	2,054	3,436	n/a	n/a	5,451	4,087	5,778	49	1,076	2,078
Day Treatment	1,480	2,434	n/a	n/a	4,237	2,878	4,288	0	994	1,491
OMH Clinic	35	35	13	13	103	40	218	67	8	36
OMR Clinic	2	0	17	n/a	0	0	0	0	0	2
SSHSP	0	0	5	6	0	0	0	0	0	0
EI	0	0	n/a	n/a	0	0	0	0	0	0
Inpatient	3,504	5,586	2,452	3,266	12,219	5,990	19,488	14,274	4,892	3,470
Mental Health	2,112	3,630	n/a	n/a	10,527	4,105	16,738	11,182	1,755	2,120
OMH Inpatient	79	45	n/a	n/a	0	56	0	53	0	81
OMR Inpatient	0	0	n/a	n/a	0	0	0	0	0	0
RTF	0	0	n/a	n/a	0	0	0	0	0	0
Dental	85	124	104	115	151	133	160	141	59	85
Pharmacy	3,124	3,560	2,177	2,268	4,958	3,971	4,542	4,246	4,031	3,102
Non-institutional LT Care	3,652	6,145	2,533	2,926	4,165	6,565	4,051	5,210	11,591	3,459
Personal Care	147	161	1,594	1,860	90	84	0	65	261	144
Home Health Care	2,045	3,868	513	638	3,894	4,414	3,809	4,296	1,180	2,066
LT Home Health Care	228	182	389	404	99	183	242	17	9,605	0
ALP	1,230	1,933	31	19	80	1,883	0	832	542	1,247
Laboratory	8	9	13	16	20	10	41	24	18	8
Transportation	572	825	200	220	1,121	944	1,356	1,184	825	566
HMO	44	55	385	490	68	29	166	61	60	43
CTHP	0	0	n/a	n/a	0	0	0	0	1	0
DME and Hearing Aid	104	118	116	120	105	116	87	57	261	100
Childcare	0	0	n/a	n/a	0	0	0	0	0	0
Prepaid Mental Health	630	722	65	47	872	871	496	269	511	633
Referred Ambulatory	23	16	44	38	11	17	8	23	43	23
ICF-DD	50	8	297	150	0	10	0	9	0	52
Community Rehab	207	132	2,105	649	687	136	1,220	216	65	211
Case Management	153	134	157	100	3,705	5	4,063	6	259	151

## **Options for Efficiencies: Medicaid Cost Savings Based on Services Rendered to Medicaid Eligible individuals**

### **Reforming Home Health Care**

Non-institutional long-term care was the single largest cost category. This category includes personal care, home health care, long-term home health care and the Assisted Living Program. Costs in this area ranged from a low of \$6,240 per resident for personal care to a high of \$16,458 per resident for participating in the Assisted Living Program

### **Home Health Aide Services**

The Commission on Quality of Care for the Mentally Disabled report on “Layering of Services” identified that Certified Home Health Agencies (CHHAs) are providing services to residents of adult care facilities that the adult care facility is responsible for providing; e.g., CHHA, home health aides performing housekeeping, laundry tasks, etc. It is recommended that the Department issue a “Dear Provider” letter to all CHHAs identifying what services a CHHA may provide to adult care facility residents, and under what circumstances. The Department should follow-up with periodic audits to assure compliance with this directive and take corrective action against both the adult care facility and the CHHA when violations occur.

**Savings:** Savings attributed to this recommendation is \$4.5 million or about one-half the current home health aide expenditures.

### **Nursing Services**

In addition to home health aide services, CHHAs also bill Medicaid for nursing visits made to adult care facility residents. It is estimated that nursing services comprise of about 60 percent of total home health care costs provided to adult care facility residents or approximately \$12 million. The Commission on Quality of Care for the Mentally Disabled’s study also identified that on average, CHHAs bill Medicaid about \$72 per nursing visit. A nursing visit code/rate is used by the CHHA to bill visits for the purpose of: nurse supervision of the home health aide; patient assessment for long term care program eligibility determinations; or direct patient care. The Commission on Quality of Care for the Mentally Disabled’s study revealed that a number of Medicaid billed nursing visits to these homes were attributed to bi-weekly nursing supervision visits of the home health aides who were inappropriately providing housekeeping/chore services. One workgroup member questioned whether these instances of documented problems could be generalized to the entire population receiving home care services. In addition to cost savings associated with eliminating some nursing supervisors and inappropriate home health aide services, additional savings could also be obtained by establishing congregate rates for CHHA services delivered to multiple clients in a single site. This economy of scale concept has been applied to other long term care

programs/services, e.g. personal care services (shared aide rates) and private duty nursing services and is more reflective of the actual time and cost associated with the provision of service to multiple patients in a congregate setting.

**Savings:** Cost savings attributed to reducing nursing costs are estimated at 50% of the current nursing costs or \$6.0 million.

### **Assisted Living Program**

The Commission on Quality of Care for the Mentally Disabled's study of large impacted homes in the New York City area identified that the actual cost of providing services to some adult home residents participating in the Assisted Living Program was less than 50 percent of the Assisted Living Program's current Medicaid reimbursement. An audit of Assisted Living Programs should be conducted to determine what services included in the Medicaid capitated rate are actually being provided to adult care facility residents and then restructure the rate methodology for appropriate reimbursement. Some concern was also voiced that in conducting a study of the reasonableness of ALP reimbursement the impact of reduced dollars on program financial feasibility needs to be carefully reviewed. It was also suggested that additional savings could be made by expanding the ALP capacity which would result in further diversion from nursing home placement.

**Savings:** Potential savings attributed to the reduction in the Assisted Living Program rate is approximately \$6.5 million.

### **Enhanced Care Coordination**

#### **Short Term Option**

#### **Recipient Restriction Program:**

Establishing a primary provider option for recipients who use many duplicate services could be established fairly quickly if the existing Restricted Recipient Program (RRP) structure is modified. The RRP is based on a Federal waiver of freedom of choice, whereby a state may lock in a recipient, for a reasonable period of time (to a primary provider(s) for control purposes). This is applied to recipients who use Medicaid services at a frequency or rate which exceeds medical necessity, as defined by the state. In New York State, this is defined in Department regulation to be duplicative, contraindicated, excessive or conflicting care, (or for abusive practice, such as forging a prescription). New York State currently can lock in a recipient to one clinic, or one physician, one pharmacy, one inpatient facility, one dentist, or one durable medical equipment dealer. In addition, non-emergency transportation services, laboratory, and pharmacy must be ordered by the primary physician or clinic. By Federal regulation it is not possible to restrict access to an emergency room.

The case management/gatekeeper capability of RRP can be used to bring immediate coordination of care to the adult care facility population. A longer term goal would be to implement a population based gatekeeper function as described in the options below.

**Savings:** Savings attributed to a 5 percent reduction or approximately \$3 million in pharmacy, primary care, and clinic services are anticipated. Savings are partially offset by cost of additional resources to operate the program. Estimated net savings: \$3.0 million.

## **Long Term Medicaid Care Coordination**

### **Primary Care Case Management/Physician Case Management**

A system under which an entity contracts with the State to furnish case management services which include the location, coordination, and monitoring of health care services. Currently there is one fee-for-service model in Broome County. All other existing Primary Case Management (PCCM) programs are partially capitated. The capitated services are the primary care services. The practitioners in this program are to be the gatekeeper and coordinator of health care. These programs presently do not coordinate behavioral care. With a gatekeeper function, coordinated care would be expected to lead to more appropriate medical decisions, which could result in lowered medical expenditures.

To implement this program on a mandatory basis for the adult care facility population, State legislation would be needed. Current law permits a partial capitation model in rural areas only that have no full risk managed care program. Data shows that much of the high cost in adult care facilities exists in New York City. Additionally it's not clear that present statute allows a fee-for-service based on a managed care model. To implement this option as mandatory would require Federal approval.

**Savings:** It is expected that improved medical decisions will eliminate the duplicative and unnecessary care. Due to the administrative costs and increased access to more appropriate health care, a voluntary program would not yield savings.

### **Medical Care Coordinator Program (Mandatory)**

Earlier legislation authorized the Medical Care Coordinator Program (MCCP). This law allowed the State to lock in all federally non-participating recipients to specific providers. Due to legal challenges, the program was not implemented. Unlike the RRP, MCCP was not a medically based program and did not require any medical review. An MCCP type program can generate significant cost reductions for this group.

Re-instituting this program may be a lengthy process since this would require obtaining a Federal waiver of freedom of choice. Variations on this structure could grow from the PCCM model (above).

**Savings:** Savings attributed to a 10 percent reduction in pharmacy, primary care, and clinic services. Savings are partially offset by the cost of additional resources to operate the program. Net estimated savings: \$6.5 million.

### **Recommendation**

Each of the savings items is presented as an option. One or more of these proposals could be considered in the implementation plan either as an individual item or melded into the pricing or payment process for Services Coordination or New Model recommendations. Savings from any of these options should be used to offset any new costs in implementing.

### **G. Program Administration**

The Adult Care Facility Workgroup was appointed to evaluate the strengths and weaknesses of the current ACF model of housing plus services and develop recommendations for new approaches that would be more effective. A critical goal of this review is to develop and implement managerial and communication processes that integrate the regulatory responsibilities of the three that share oversight authority for ACFs and residents who need mental health services, i.e., the Department of Health, the Office of Mental Health and the Commission on Quality of Care for the Mentally Disabled. The following are recommendations concerning the planning, administration, and evaluation of the ACF program.

#### **Adult Care Facility Surveillance/Enforcement**

The Department of Health (DOH) and Office of Mental Health (OMH) should provide rigorous enforcement of adult care facilities and mental health services/clinic regulations. Such enforcement should include reporting of all financial and control relationships with service providers on an annual basis in an effort to make the system more transparent and prevent fraud and abuse.

The Workgroup proposes that the State should identify and rigorously regulate facilities offering congregate care without a license to the full extent of the law. In addition, it is proposed that the State identify resources to support training and other workforce initiatives for all ACF staff.

### **Role of Public Health Council**

New York State must enact laws to require review for character and competence of all ACF applications, changes in ownership, conversions and license renewals by the Public Health Council (PHC).

### **Office/Commission of Adult Care Facilities**

New York State should build on the current Memorandum of Understanding (MOU) between DOH, OMH, and CQC to create a Commission on Adult Care Facilities directly accountable to the Governor. This office will direct planning, monitor, coordinate, and oversee implementation across (see Appendix H).

### **Advisory Committee**

New York State should implement an ongoing advisory group to work with state government to fully develop and implement new models, monitor progress and continuous quality improvement measures. All appropriate stakeholders including adult home operators, mental health providers, family members, residents, advocates and others should be included on the committee.