New Horizons policy forum

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Long-Term Care Reform in New York State: A Background Paper

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New Horizons policy forum is a series of articles presented from the perspective of practitioners of care. In this forum, you will find a discussion of significant issues that impact older adults in our society, as well as a dialog on making sense of public policies and translating them into practice.

Village Care is embarking on a radical transformation of its current services into a system of care that will serve more seniors in a more efficient manner, and as we head down that road this policy forum will offer an opportunity to share with others the many choices and pathways that are confronted.

The forum is a way to enliven and enrich the debate about long-term care in our state. We invite others to submit outside commentaries for inclusion after a review by Village Care of New York. To inquire about submitting a paper for publication, please send an email to policyforum@vcny.org.

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Long-term care (LTC) is part health care and part social service. It encompasses a broad array of services delivered in home, community and institutional settings by paid professionals and paraprofessionals—as well as unpaid family caregivers and other 'informal' helpers—to frail and disabled individuals with complex, multifaceted problems who need assistance with activities of daily living (ADL) on a prolonged basis.

Dramatic demographic and epidemiological changes over the past few decades have transformed health care needs, making LTC for the frail elderly and younger people with disabilities and chronic conditions, a major policy issue. It is at the state level—because of the important role the states play in health planning and regulation, as well as Medicaid financing—where serious LTC system reform efforts have been undertaken.

Historically, New York State has invested heavily in nursing homes, as well as in home- and community-based LTC. The State has also taken the lead in developing new and innovative LTC delivery models, including the Long-Term Home Health Care Program (sometimes referred to as the "nursing home without walls"), Managed Long-Term Care Program, and Traumatic Brain Injury Waiver. Nonetheless, policymakers now believe that only comprehensive reform can effectively address the many complex challenges of LTC.

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The Many Complex Challenges of Long-Term Care

» New York's elderly population is increasing and, along with the rest of the country, is also experiencing a rising life expectancy. The growth in the number of older New Yorkers—from 2.3 million aged 65 plus in 1995 to 3.3 million in 2025—will create an upsurge in LTC demand and increase strains on LTC services (NYS Office for the Aging, May 1999).

» It is difficult to predict the extent of any upsurge in LTC demand, since the growth in the number of older adults is tempered by a continuing decline in disability rates. Nevertheless, the growth in the number of persons living past 85, projected to reach nearly 400,000 in New York State by 2025, will undoubtedly generate some increasing demand for assistance.

» The current LTC system is disjointed and uncoordinated, and is characterized by uneven quality. As a result, needed care is difficult to access, navigate and manage, especially as needs change.

» Public LTC spending for skilled nursing facilities, in-home nursing, aides, personal care, and other community services—is experiencing dramatic growth. Gross Medicaid costs for LTC—a significant share of the overall Medicaid budget—are expected to reach nearly $12 billion in State fiscal year 2005-2006, which would represent a year-to-year increase in the order of 9 percent over the previous fiscal year (NYS Commission on Health Care Facilities in the 21st Century, February 2006).

» The nursing home sector—which consumes the lion's share of Medicaid funding—is facing declining occupancy levels and lengths of stay, translating into roughly 7,000 excess LTC skilled nursing beds in New York State (ibid). A number of providers have responded by "right-sizing:" reducing their skilled beds and growing their non-institutional capacity, but these are individual efforts and have not gone far enough.

» At the same time, New York State spends over four times as much on its Personal Care program than does every other state in the country, with the exception of California. (Kaiser State Health Facts, 2006)

» The Supreme Court's landmark Olmstead decision in 1999—which holds that states can not discriminate against people with disabilities by providing LTC services only in institutions—strongly encourages states to reevaluate how they can better organize and deliver LTC services that meet the needs of persons with disabilities in the most integrated settings appropriate to their needs. This strongly parallels the wishes of most LTC recipients to remain at home and in the community.

» There are growing signs that aging Baby Boomers and future consumers will be better informed about LTC options, will place a premium on services that promote autonomy and self-direction and will demand greater personal choice in terms of how, when and where their care is delivered.

These concerns provide the policy and programmatic context for reforming New York State's LTC system. Clearly, the demand is there for a totally redesigned system, one with a vision that breaks with the traditional model that relies heavily on more costly institutional care. Such a system would: Foster functional independence; support independent living; respect consumer choice; provide easy access to a comprehensive, flexible and coordinated range of service options; involve consumers and caregivers in LTC decision-making; reform Medicaid eligibility; make private insurance more affordable and accessible; enhance coordination with the acute care-oriented Medicare program, and incorporate innovative new methods and technologies. This is indeed a long list of reforms—all of which must be considered not only from a programmatic perspective, but with fiscal concerns in mind—and a tall order for the State.

This background paper summarizes the various initiatives—both policy- and planning-oriented, and program-based—that together encompass

New York State's overall effort to redirect, rebalance and reform its LTC system; it also sketches related drivers of LTC reform. In addition to outlining each of these initiatives, we provide a status report as to where things stand as of October 31, 2006.

Most Integrated Setting Coordinating Council (MISCC)
Established by law in June of 2002 (and signed by Governor Pataki in September of that year after aggressive public advocacy and a sit-in by people with disabilities), the MISCC is responsible for ensuring compliance with the Olmstead decision and Title II of the Americans with Disabilities Act (ADA) by developing and implementing a plan to reasonably accommodate the desire of disabled New Yorkers of all ages to avoid institutionalization and be placed in the most integrated setting possible.

Council members include the commissioners of the Department of Health (DOH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), the Office of Mental Health (OMH), the director of the state Office of the Aging (SOFA) and five other State agencies. In addition, the group includes three consumers of services with disabilities (one each appointed by the governor and the legislative leaders), and three outside experts on the work of the Council (appointed by the same people).

The Council began meeting in the winter of 2003, and carries out its work through a committee structure. Public Forums were held throughout the state in the winter of 2004 to gather testimony from people with disabilities, as well as from representatives of advocacy groups and provider organizations.

Status: MISCC's work to date has been controversial—at least from the perspective of the disability rights community. Concerns have been expressed about the integrity of the data analysis and planning processes. More importantly, the plan—legally required by December 2005—has not as of yet been submitted. While several draft reports have been prepared, it is not known when the overall plan will be issued, and to what degree the blueprint will specifically affect the State's LTC reform framework and design.

Health Care Reform Working Group
Governor Pataki convened the Working Group in 2003, and tasked the group to review New York's health care system, and make recommendations with respect to controlling costs, improving efficiency and effectiveness, maximizing federal funding, curtailing fraud, creating provider incentives, and identifying financing reforms.

Status: The Working Group submitted an interim report to the Governor in January of 2004; the Final report followed in November. Largely focusing on the current LTC system in New York State, the Working Group embraced the tenets of the Olmstead Supreme Court decision, and made the following recommendations:

» Create a Single Point of Entry into the LTC system (NY ANSWERS);
» Modify Medicaid eligibility requirements, including the home care look-back provisions and the elimination of spousal refusal;
» Develop enhanced home- and community-based services through the support of demonstration projects;
» State take-over of the local share of Medicaid LTC costs from the counties;
» Integrate LTC population into Medicaid managed care, and,
» Establish a preferred drug program, work to increase the federal Medicaid cost match, and undertake other cost-saving measures.

According to the interim report, implementation of these recommendations would save the State $4.2 billion over the next five years, and $2 billion specifically from the State take-over of LTC costs.

Programmatic Initiatives

Commission on Health Facilities in the Twenty-First Century

Established by law in 2005, the purpose of this "downsizing commission" was to: 1) undertake a rational, independent review of health care capacity and resources in the state; 2) ensure that the regional and local supply of hospital and nursing home facilities is configured to best respond to community needs for quality, affordable and accessible care; and, 3) promote the stability of the health care infrastructure through meaningful efficiencies in the delivery and financing of care.

Status: The Commission has issued several insightful documents, including an overall look at LTC, consideration of nursing home design of the future and county-by-county opportunities to shift LTC resources to community-based settings. Its final report, which was released on November 28, 2006, cites major problems in New York's health care system, and also recommends a series of highly-targeted hospital and nursing home closures and bed reductions. Included is a reduction of 3,000 nursing home beds—3% of the statewide supply—and the creation of 1,000 additional non-institutional "slots"—largely Medicaid Assisted Living Program (ALP) beds—to meet LTC needs. No financing recommendations were made.

Nursing Home Transition and Diversion Waiver Program

Legislation signed into law by Governor Pataki in 2004 authorized DOH to apply for a Medicaid waiver for enhanced nursing home transition and diversion activities.

The waiver request, which has been submitted to the federal Centers for Medicare and Medicaid Services (CMS), would provide financial assistance to move to community-settings those adults with disabilities who would otherwise be cared for in a nursing facility and who, considered as an aggregate group, can be served at less cost in a community setting. Financial assistance will cover home modifications, assistive technology, basic home supplies (such as linens and cookware), independent living skills training and service coordination activities. The State's goal is to transfer or divert 5,000 Medicaid-eligible clients from nursing home care to community-based care over three years. A network of state-contracted non-profit Regional Resource Centers (RRCs) would administer eligibility determination, needs assessment, service plan approval and maintenance, and information reporting; the State has accepted applications for RRCs and Quality Management Specialists but no selections have been made.

Status: CMS recently notified the State that it intended to deny its Medicaid waiver request because of federal objections related to proposed spousal budgeting for program participants. Since DOH cannot change these rules without state legislation (which was not successful during the past legislative session), a decision was made by the State to withdraw its June 12, 2006 response to the CMS request for additional information. This action "stopped the clock," thus giving New York State additional time to prepare a new response. In the meantime, DOH has decided to apply to CMS for federal funding under the Money Follows the Person (MFP) demonstration. If the State proposal is successful, transitional services would be provided over a 3½ year period to 2,800 people with disabilities living for at least six months in institutional settings. DOH would contract with the existing network of Independent Living Centers (ILCs) to coordinate services delivered by qualified home and community-based providers. In addition, the State will establish a related Housing Task Force in 2007.

NY ANSWERS: A Point-of-Entry (POE) System for LTC in New York State

A major recommendation of the Health Care Reform Working Group interim report in January of 2004 was to design and implement a single point-of-entry into the LTC system in order to assist individuals and families in accessing information and needed services, particularly in community settings. Major elements of the proposed POE system include:

» Comprehensive, unbiased information about available services;
» Screening of consumers, regardless of payer source, to ascertain general LTC needs and financial status and referral to available service options;
» Comprehensive LTC needs assessment;
» Service/care coordination and utilization management;
» Public education program to inform consumers about LTC options, and
» Interdisciplinary team approach to the ongoing management of services.

Subsequently, Governor Pataki directed SOFA and DOH to issue a Request for Information (RFI) to gather input from consumers, caregivers, advocates, trade associations and providers. Further information was gathered at listening sessions conducted by SOFA throughout the state during the summer and early fall of 2004. Based on information gathered from these outreach activities, the SOFA director and DOH Medicaid director jointly developed a detailed vision for implementing a locally based but statewide POE system.

The proposed framework for NY ANSWERS (**A**ccess **N**ew **Y**ork **S**ervices **W**ith **E**ffective **R**esponsive **S**upports) is as follows:

» Initially, local POEs will focus on information and assistance with accessing available services, screening, serving as a general resource for planning for LTC needs, and providing information on public and private LTC financing options.

» SOFA and DOH will work together to specify standards, requirements, outcomes and measures to be incorporated into a Request for Proposal (RFP) for the fully functional POE.

» POEs will be local entities operating under a contract with SOFA and adhering to statewide policies and procedures. Local governments will be given the first right of refusal in bidding to be the POE for their respective county.

» Statewide contractors, under the direction of SOFA and DOH, will provide infrastructure support (for example, information technology), as well as perform program monitoring and training.

» Throughout the implementation phase, POEs will be expected to seek stakeholder/community input on the project.

Status: Phase 1 of the POE plan calls for voluntary information, screening and referral services to begin some time in late 2006 for Medicaid recipients, SOFA clients, and others. Phase 2, which would be implemented 2-3 years after the implementation of Phase 1, will include mandatory assessment, care planning and service authorization for Medicaid recipients.

Residential Health Care Facility Rightsizing Demonstration Program. Originally enacted in December 2004 and more recently amended, this gives the state health commissioner authorization to establish a voluntary program to "trade" licensed skilled nursing facility beds for alternative licensed LTC services. The goals would be to discourage inappropriate nursing home placement, generate Medicaid savings and assist nursing homes in maintaining viability during a period of declining occupancies.

The demonstration program accomplishes the above goals by enabling facilities to seek DOH approval to either:

» Temporarily decertify beds for up to five years; or
» Permanently convert beds to less restrictive LTC services, including Medicaid ALP beds, adult day health care programs and/or LTHHCP slots.

The Rightsizing Demonstration is currently the only vehicle available to expand the state's Medicaid Assisted Living Program . The existing program has an administrative cap of 4,200 beds statewide, so that no new ALP beds are

available, despite the program's ability to care for many individuals more efficiently than in skilled nursing facilities. Therefore, a number of LTC providers have employed the Rightsizing Demonstration to enter the ALP business.

Status: On May 30, 2006, DOH approved the temporary decertification or permanent conversion of 831 beds in 13 nursing homes as part of the first round of the program. The applications deadline for the second round closed on August 15, 2006.

Long Term Care Restructuring (“Mega Waiver”)

The so-called "Mega Waiver" would be a Section 1115 Medicaid waiver designed to fold all existing Section 1915(c) waivers—LTHHCP, Traumatic Brain Injury, Care at Home and the proposed Nursing Home Transition and Diversion Program—as well as all existing LTC services in the State Medicaid Plan (nursing home, personal care, certified home health agency, adult day health care, Assisted Living Program, private duty nursing, etc.) into a single waiver program.

According to DOH, this would allow greater flexibility in terms of eligibility and services, as well as assist the State in obtaining greater federal financial participation in the costs of Medicaid LTC; it will also seek federal match for non-Medicaid services (e.g., those now funded through federal Administration on Aging dollars and targeted to the income group that is higher than Medicaid but still unable to afford LTC assistance). The initiative also complements the work of the Commission on Health Care Facilities for the 21st Century.

First recommended in the January 2004 interim report of the Governor's Health Care Reform Working Group, the restructuring to be detailed in the Mega Waiver—if approved by CMS—would take 3-5 years to implement.

Status: Thus far, the health commissioner has convened a LTC Restructuring Advisory Council, consisting of 14 public officials and stakeholders, and has held a series of regional information meetings. In addition, SOFA and DOH issued a Request for Information (RFI) in July 2006 to solicit comments with respect to seven key areas of LTC restructuring:

» Community Resources.
» Service Coordination and Management.
» LTC Service Programs.
» System Oversight.
» Infrastructure.
» Cost Neutrality.
» Implementation.

The plan is to commence drafting the Mega Waiver application during the first half of 2007. The issues that impacted the transition and diversion waiver—namely, federal objections related to proposed spousal budgeting for program participants—will impact the Mega Waiver as well.

There are two additional drivers of change:

Others Drivers of LTC Reform

Medicaid Advantage Plus

The Managed Long Term Care Program (MLTCP) was authorized by the Long-Term Care Integration and Finance Act of 1997. Today there are approximately 15,000 clients enrolled in the partially capitated program, partially, meaning that only Medicaid services are capitated, while Medicare services (primarily physician and hospital services) continue to be paid on a fee-for-service basis. While 2006 legislation permits additional MLTCPs, DOH has embraced a more fully integrated model for the dually eligible population (individuals with both Medicare and Medicaid coverage). New York State received approval from CMS in December 2004 to enroll dual eligibles age 21+ in new Medicaid Advantage plans, which combine Medicare Advantage Plans with Medicaid Managed Care. Starting in 2007, the State will roll-out Medicaid Advantage Plus—a plan specifically targeted to dually eligible beneficiaries with LTC needs who are certified for nursing home admission. This new option will

bring together Medicare Advantage—particularly Special Needs Plans (SNPs) focusing on dually eligible, nursing home certified individuals—with Medicaid-funded MLTCP services. Medicaid Advantage Plus participants will have to be enrolled in participating Medicare Advantage plans in order to receive Medicaid-funded LTC and wrap-around services

Status: To date, DOH has defined the core benefit package for Medicare Advantage Plans to participate in Medicaid Advantage Plus. The program excludes major long-term care clients, including those receiving adult day health care services and those in nursing homes or assisted living programs.

Federal-State Health Reform Partnership (F-SHRP)

CMS approved New York State's request on September 29, 2006, to join in a federal partnership to reform and restructure the State's health care delivery system under a new five-year 1115 demonstration waiver.

Under F-SHRP, the federal government will invest up to $1.5 billion ($300 million per year) in a series of agreed-upon reform initiatives. The overall goal is to promote efficient health care delivery by consolidating and rightsizing hospital bed capacity; shifting LTC emphasis from institutional care to home- and community-based services; expanding advanced health information technology, and improving ambulatory and primary care provision. The State must meet pre-established performance milestones, and generate savings sufficient to offset the federal government's investment.

A key LTC performance objective relates to the April 2008 implementation of NY ANSWERS—the Single Point-of-Entry system. A timeline is also required for implementation of the recommendations of the Commission on Health Care Facilities (see above). A formal evaluation is required when the demonstration expires on September 30, 2011.

Status: The waiver took effect on October 1, 2006.

Summary and Implications

The above initiatives are summarized in Table 1 and Table 2. Taken together, they represent an extraordinary effort on the part of the State of New York to totally remake the LTC sys

Table 1 Long Term Care Reform in New York State: Policy- and Planning Related Initiatives (as of November 28, 2006)

	MOST INTEGRATED SETTING COORDINATION COUNCIL (MISCC)	HEALTH CARE REFORM WORKING GROUP	COMMISSION ON HEALTH FACILITIES FOR 21st CENTURY
Mission	Ensure compliance with Olmstread decision and Title III of Americans with Disabilities Act (ADA) by developing and implementing plan to reasonably accommodate disabled New Yorkers of all ages to avoid institutionalization and be placed in the most integrated setting possible	Review NYS's health system, and make recommendations with respect to controlling costs, improving efficiency and effectiveness, maximizing federal funding, curtailing fraud, creating provider incentives, and identifying financing reforms	Undertake rational, independent review of health care resources in state; ensure that regional and local supply of hospital and nursing facilities is configured to best respond to community needs for quality, affordable, accessible care; and, promote stability of health care infra-structure through meaningful efficiencies in delivery and financing of care
Policy/Planning Body	15-member Council, including ex-officio State agency representatives (9), consumers (3) and outside experts (3) appointed by Governor and Legislative leaders	6-member Working Group appointed by Governor	24-member Commission, including regional representatives (6) appointed by Governor and Legislative leaders; Regional Advisory Committees appointed by Commission
Product (s)	Committee meetings; public forums; plan required by December 2005 (not yet submitted)	Final Report on LTC system submitted to Governor (November 2004)	Various reports on LTC system, future of nursing homes, and nursing home bed supply; final report issued on November 28, 2006

tem. These new directions are driven by a set of strongly held tenets about how the system should be
reorganized and resources reallocated. They are also flexible enough to take advantage of, and accommodate, emerging federal demonstrations and funding opportunities. It is in this vein that Medicaid Advantage Plus and F-SHRP represent two additional and powerful levers of LTC change.

It is unclear as to whether the reform and restructuring envisaged by the State will achieve all of the desired LTC system outcomes, particularly with respect to the dimensions of consumer access, choice and quality. One major concern that emerges is the lack of an evaluation framework to measure success or failure. Nonetheless, the LTC landscape will be dramatically changed over the next five years or so, and the State likely will exercise even greater control over the system and the Medicaid purse strings than it does today. A new administration led by Governor Elliot Spitzer—who vowed as a gubernatorial candidate to take on Medicaid fraud and introduce greater efficiency into Medicaid-funded health and long term care services—could greatly speed up the process. Furthermore, the possible introduction of pay-for-performance in the LTC field could strengthen these new directions.

What does this mean to nursing homes, home care agencies, CCRCs, supportive housing and other LTC providers? It is difficult to know for sure, but the future LTC system can be expected to change in a significant way the nature of clients served by providers, as well as the manner in which services are organized and delivered. As more and more Baby Boomers enter LTC, they will insist on greater flexibility and choice. And, there is the prospect that the system—where non-profit providers have traditionally played an innovative, leading-edge role—will open up to large, private, investor-owned companies.

Future papers in this series will more closely examine the potential impact of LTC reform on the various stakeholders: consumers, providers, county government, and advocates. Other important factors will be explored, including the outcomes and cost-benefits of these initiatives, as well as emerging changes in the LTC marketplace.

Table 2 Long Term Care Reform in New York State: Programmatic Initiatives (as of November 28, 2006)

	NURSING HOME TRANSITION AND DIVERSION WAIVER	NY ANSWERS: A POINT-OF-ENTRY SYSTEM FOR LTC	RHCF RIGHTSIZING DEMONSTRATION	LTC RESTRUCTURING ("MEGA WAIVER")
Authority	State law (2004) authorizing CMS Medicaid waiver application	Joint initiative of State DOH and SOFA to implement major recommendation of the Health Care Reform Work Group	Sate law (2004), as amended	State Department Health initiative to involve future CMS Medicaid waiver application
Program	Comprehensive program to provide community-based services to 5,000 Medicaid recipients age 18+ who would otherwise be cared for in SNFs; State-contracted network of Regional Resources Centers will administer the program (except for Medicaid eligibility determination)	Point-of-entry system into the LTC system to assist individuals and families in accessing needed services, especially in community	Voluntary program to promote alternate levels of LTC; discourage inappropriate SNF placement; encourage bed reduction; generate Medicaid savings; and, assist SNFs in maintaining viability by enabling facilities to decertify and/or convert existing bed complement	Mega Medicaid waiver will fold all existing and proposed LTC waiver programs into one program in order to allow grater flexibility in terms of eligibility and services, as well as increased Federal match for Medicaid and certain non-Medicaid services (for higher income group)
Status	Waiver application submitted; CMS objections to spousal impoverishment aspects of plan; State has "stopped the clock" for more time to respond to concerns; in meantime, DOH is applying for federal demonstration funding under the Money Follow the People (MFP) program to serve 2,800 disabled people thru network of Independent Living Centers	DOH Medicaid Director and SOFA Director have developed detailed vision based on earlier RFI and statewide listening sessions	DOH approved temporary decertifications/permanent conversions of 831 beds in first round; second round closed on August 15, 2006	RFI issued in July 2006 (with September deadline); application will be submitted in first half 2007; implement-ation will take 3-5 years from federal approval

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