

HEALTH CARE REGULATORY MODERNIZATION INITIATIVE
Background Paper: Need Methodologies and Innovative Models

Problem Statement:

The objective of the Certificate of Need (CON) and licensure of providers across the healthcare spectrum is to promote the delivery of high quality health care, and ensure that services are aligned with community need. The CON process provides the Department of Health (DOH) oversight to ensure quality and calibrate investment in duplicate beds, services, and medical equipment which in turn limit associated health care costs.

The Department oversees the CON and licensure process for Residential Health Care Facilities (RHCF), Adult Care Facilities (ACF), Assisted Living Residences (ALR), including the Enhanced Assisted Living Residence (EALR) and Special Needs Assisted Living Residence (SNARL), Certified Home Health Agencies (CHHAs), Licensed Home Care Service Agencies (LHCSAs), and Hospice providers, among others. For the purpose of this Regulatory Modernization Initiative workgroup the provider types listed above will be the primary focus.

Certificate of Need methodologies and licensure standards for Nursing Homes, ACFs, ALRs, CHHAs, LHCSAs, and Hospice providers are outdated. The Department has a statutory responsibility to have an updated, streamlined process for these provider types that balances quality, demand, and overall cost. There is also a desire to incorporate innovative models of care to meet the needs of all communities including rural communities. For the ALP program, the Department has not used a traditional CON process.

The goal of this workgroup is to explore the possibility of new need methodologies and licensing policies, while incorporating the Olmstead Plan principles and the Health Across all Policies framework.

Background:

Certificate of Need programs are aimed at restraining health care facility costs and facilitating coordinated planning of new services and facility construction. Many CON laws initially were put into effect across the nation as part of the federal Health Planning Resources Development Act of 1974. Below is a description of the long term care provider types that will be the focus of this workgroup:

- **Nursing Home** – Nursing Homes are defined as facilities that provide care for 24 or more consecutive hours to three or more nursing home residents who are not related to the operator by marriage or by blood, who need regular nursing services, or other professional services, but do not need the services of a general hospital. The term includes all facilities subject to Article 28 of the Public Health Law and provides residential skilled nursing care and services both short term (rehabilitation) and custodial care.
- **Adult Care Facilities** – Adult Care Facilities provide temporary or long term, non-medical residential care services to adults who are substantially unable to live independently. Resident dependence may be the result of physical or other limitations associated with age, physical or mental disabilities, or other factors. Residents of adult homes, enriched housing, and ALPs are provided with personal care and services on a long term basis.

Most residents are in need of supervision and personal care services necessary to enable the resident to: maintain good personal health and hygiene, carry out the basic activities of daily living, and participate in the ongoing activities of the facility. Personal care includes direction and assistance with grooming, dressing, bathing, walking, mobility, eating, and assisting with self-administration of medications. Residents must not require the continual medical or nursing services provided in acute care hospitals, in-patient psychiatric facilities, skilled nursing homes, or health related facilities. Adult Care Facilities are not licensed to provide nursing or medical care unless licensed as an EALR.

- Assisted Living Residences - An ALR is a certified adult home or enriched housing program that has also been approved by DOH for licensure as an ALR. An operator of an ALR is required to provide or arrange for housing, twenty-four-hour on-site monitoring, and personal care services and/or home care services in a home-like setting to five or more adult residents. Assisted Living Residences must also provide daily meals and snacks, case management services, and are required to develop an individualized service plan (ISP).
 - Enhanced Assisted Living Residence – An EALR allows residents to remain within the ALR as they require assistance with age-related issues and requires services and/or assistance beyond what the ALR can provide. Residents in an EALR may require: assistance with mobility, assistance with medical equipment, or assistance in the management of incontinence. Residents in an EALR must not require 24-hour skilled care, unless the resident arranges for appropriate care to meet their needs, the physician and home care agency agree that the resident can be safely maintained in the EALR, the operator agrees to provide or arrange for services and is willing to coordinate care and the resident agrees to the plan of care.
 - Special Needs Assisted Living Residence – A SNALR is a type of facility that specializes in a certain condition or diagnosis, such as Alzheimer’s disease or other dementias. Services provided in a SNALR are tailored to individualized resident needs residents and may require 24-hour supervision and additional assistance in completing activities of daily living (ADLs). Services provided and the environment of the SNALR are highly specialized to meet the needs of those resident requiring specialized care, including individualized behavioral plan to deal with the cognitive changes of disease progression.
- Assisted Living Programs – An ALP is a Medicaid funded bundle of services that combines an ACF and LHCSA. ALPs were established in the mid-1990s and have been approved through a series of requests for proposals over the last 25 years. ALP programs serve individuals who are eligible for nursing home placement, but is able to serve residents in a less intensive setting, at a lower cost. ALP programs provide: personal care, room, board, housekeeping, supervision, home health aides, personal emergency response systems, nursing, physical, occupational, and speech therapy, medical supplies and equipment, adult day health care, home health services, and case management services. There are some areas of the State that do not have an ALP.

- Certified Home Health Agency – A CHHA provides intermittent health care and support services to individuals who need intermediate and skilled health care. CHHAs also have the ability to provide long term nursing and home health aide services and can either provide or arrange for other services, including physical, occupational, and speech therapies, medical supplies and equipment, social work, and nutrition services.
- Licensed Home Care Service Agency – LHCSAs offer home care services to clients who pay privately or have private insurance coverage. These agencies may also contract to provide services to Medicare/Medicaid beneficiaries whose cases are managed by another provider or entity, such as providing home health aide services to a CHHA patient or providing a licensed practical nurse for a Medicaid prior-approved private duty nursing shift.
- Hospice – Hospice provides palliative and supportive care to meet the special needs arising from the final stage of illness and during dying and bereavement. A resident of an NH who becomes terminally ill may receive hospice services. To establish eligibility for hospice care, the patient's physician and the hospice medical director must certify that the patient is terminally ill; the patient or authorized representative must elect the hospice benefit in writing; and a hospice plan of care must be established. The vast majority of hospice care is delivered in the home, however, there are hospice residences and inpatient care, and hospice services can also be rendered in NHs, ACFs, or ALRs.

There are many variables affecting providers on the establishment, renovation, or restructuring of services, including navigation of licensure laws and regulations, as well as obtaining approval of a CON. Processing an application for new construction may take anywhere from 18 months to 2 years to receive full approval, including the local permits and DOH licensing. The approval of an application will also depend on factors such as financial feasibility, the character and competency of the members of the operator, as well as whether the correct documentation for the legal structure and program information have been submitted.

The processes for licensure and need methodologies for these specific provider types are contained in laws (Public Health – Articles 28, 36, 40, and 46-b and Social Services – 461-B) and regulations (Title 10: Dept. of Health). CON applications are reviewed based on the following criteria: public need; financial feasibility; character and competence; and construction. The exception is there is no need calculation for LHCSAs pursuant to State law. For NHs, DOH utilizes a bed need methodology when considering applications. For the most recent NH bed need methodology, the planning target year was 2016. Adult Care Facilities and ALRs use the Common Application as their process for determining licensure. The Common Application governs both the licensure and certification of providers planning to construct or renovate an ACF. Processes similar to the NH CON process, such as review of the applicant's character and competence or legal and financial standing, are all considered when determining issuance of licenses and operating certificates.

Other States

In recent years, many states have either scaled back their CON regulatory structure, placed a moratorium on the usage of their program, or have completely done away with them. The federal mandate was repealed in 1987. Since then, 14 states have discontinued their CON

programs, with New Hampshire being the most recent to repeal in 2016; therefore, 36 states currently maintain some form of CON program, including the District of Columbia.¹

Across the nation, as some states choose to place their CON programs on a moratorium, or discontinue them outright, there are differing and innovative models to ensure that there is an appropriate number of quality long term residential and home care providers in the State. Such models include streamlining need methodologies by limiting bed need to a per-county cap based on percentage of the population aged 65+, with the ability to add additional beds up to 10% of facility capacity without CON approval; allowing the merger of already approved and licensed facilities without an additional CON review; applying CON only in limited cases, such as when the project exceeds a certain capital expenditure threshold or providing an exception to the CON requirements for capital expenditures for the sole purpose of renovating or replacing on the same site; or expanding an existing NH that does not increase overall bed capacity.

These models allow facilities to undertake renovation, add beds when needed, and provide the State with a means to limit overall bed capacity without going through the CON review process.

Additional Considerations

Due to the 1999 Olmstead Supreme Court decision, states must consider an integration mandate. Olmstead requires that public entities “administer services, programs, and activities in the most integrated setting appropriate to the needs of the qualified individuals with disabilities.” Need methodologies and licensure requirements should be crafted to consider and further the Olmstead integration mandate.

Licensure requirements for facilities provide the opportunity to ensure the quality of health care provided since the quality and safety of long term care recipients is dependent upon the individual operator’s actions. The considerations of the character and competency review for facility licensure should provide regulators with a better understanding of how the CON and licensure activities affect quality of care and patient outcomes. The State’s licensure processes for facility operators and owners needs to define and enforce quality standards in an effort to better assess competency, as well as protect care recipients and improve the quality of health care.

Another consideration of the need methodology is whether a distinction in the treatment of custodial and rehabilitation (rehab) beds is necessary. The provision of skilled care required in most rehab beds is medically necessary when provided to improve or to maintain the quality of health of patients or to slow the deterioration of a patient’s condition. Skilled care is prescribed for settings that have the capability to deliver such services safely and effectively. Custodial care beds involve services that address activities of daily living that can be provided safely and reasonably by individuals who are neither medically skilled nor licensed medical personnel. While it is true that NHs may provide a higher level of medical care for patients with skilled nursing needs, patients without skilled nursing needs tend to do better receiving care in home-like settings that have high staffing levels. Further, there may be an incentive to build out more rehab beds, as there is a higher rate of turnover, and the services provided to individuals occupying these beds often garner higher reimbursement due to the skilled nature of the services the patients require, as well as coverage under the Medicare program.

¹ <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

New York has taken many steps to better streamline the current CON process and reduce administrative burdens on applicants. Making the process available online has been one such initiative, as well as the use of the electronic CON system.

Recent Input Received by Stakeholders

In 2016, the Health Planning Committee of the Public Health and Health Planning Council made recommendations for Revisions of the Residential Health Care Facility Bed Need Methodology. Recommendations, including updating the planning target year from 2016 to 2021, were suggested to take effect for a period of 5 years, after which the methodology will be re-evaluated for continued use. Additional recommendations included the following:

- The methodology should seek to ensure access to appropriate and available long term care settings;
- In estimating need, the supply of all provider types (institutional and community-based settings) should be considered;
- Sufficient flexibility should be afforded to allow consideration of local factors, including the special needs of a facility's population and the quality of NHs in the planning area, as well as allow responsiveness to the changing environment;
- The needs methodology should function as a guideline and is not meant to be an absolute predictor of the number of beds needed in each planning area;
- Planning areas, such as county boundaries, may not reflect the full range of considerations relevant to bed need estimates, such as reflecting the sparsely populated nature of rural regions or recognizing the natural boundaries of a densely-populated area with defined communities;
- The methodology should be effective for a duration that is only as long as needed to understand the impact on long term care of ongoing transformative changes and trends in the health care system; and
- Currently, if the overall occupancy rate in a planning area is less than 97 percent, DOH determines whether to decertify beds in connection with a renovation or ownership transfer application and considers "local factors" in this determination. The 97 percent threshold level is high relative to actual experience, particularly because it does not differentiate subacute (short stay rehabilitation) utilization. Therefore, the threshold should be revised to 95 percent for major renovations and for ownership transfers, while retaining consideration of "local factors."

The Hospice and Palliative Care Association of New York State (HCPANYS) released "Examining Hospice Certificate of Need (CON) in New York"² to explore the New York CON process in relation to Hospice. HCPANYS concluded that New York's CON process, coupled with the State's extensive review and inspection system, has been successful in providing the necessary structure to ensure there is an appropriate number of quality hospice providers, and strongly believes that the current CON process has prevented the

² Updated paper released August 23, 2016: <http://www.hpcanys.org/wp-content/uploads/2016/09/CON-White-Paper-Revised-August-2016.pdf>

unbridled growth in hospice services. Recommendations from HCPANYS to PHHPC included the following concerns and issues:

- Opening the Hospice CON to similarly situated healthcare systems focused on providing hospital-based care creates concern whether a hospital would be able to effectively control the market. While discharge planning regulations would appear to counter this, most referrals remain within the hospital system.
- Allowing the Hospice CON beyond a methodology like utilization poses a risk for patients in rural areas, particularly remote rural areas with travel challenges, meaning that these patients may go unserved or underserved.
- Allowing hospices to apply to serve a county will only fully serve the urban or denser population centers of that county, leaving the rural areas of the county underserved.
- Competition created by eliminating CON for Hospice could drive out competition. Many hospices serving too small a population to cover operational costs could lead to a market driven by large Hospice providers who selectively choose patients.
- In addition to updating the Hospice need methodology, DOH should consider modifications to the Administrative CON process. HPCANYS recommends that any hospice CON solely for an office building with no hospice residence or inpatient facility be an administrative CON process.

Questions for Discussion:

To facilitate discussion, it is important to frame this issue in light of the needs of the State's population and how the system should operate in 2027. Below is a series of questions that will facilitate the discussion regarding reform to the CON process.

1. Are the current CON need methodologies consistent with the changing long term care environment and the impending growing demand for services?
 - a. Medicaid payment for long term care is moving to a value based payment and managed care structure. How does the movement to Medicaid managed care and value based payments affect overall provider capacity?
 - b. How does the Olmstead policy overlay fit into the needs discussion, including ensuring that adequate community long term care services are available to address the needs of individuals with serious mental illness and behavioral problems in the least restrictive setting?
 - c. Do the various methodologies anticipate growth of alternative models of care and technology?
 - d. Are there any services or settings that should be exempt from a CON process?

2. What is the role of quality data in the establishment process for these provider types? How can the State use quality as one of the major factors in establishment and change of ownership process?
3. How can the system better support quality home and community based services?
4. How can State policy encourage innovative models of care, especially in rural communities?
5. Does New York State need more CHHAs; and if so, where? Is the current policy regarding LHCSA establishment appropriate and sustainable?
 - a. LHCSA – What is a way the State can monitor and improve quality within existing resources? Are there changes we can make in order to further the enrollment in VBP?
 - b. CHHA – What can the State do to ensure choice in regions where there is limited choice? Is there a public benefit for limiting or encouraging competition among providers?
 - c. Hospice – What can the State do to bring utilization to at least the national average?
6. The NH bed need methodology was recently the subject of a discussion at the Public Health and Health Planning Council. Do the revisions suggested still hold true for the near future? What will be the effect on the structural changes to the Medicaid program (managed care and VBP)?
 - a. Proposed revisions include a new CON process for a 5-year period to determine how innovative models (managed care, VBP, and DSRIP) affect NH usage. Is that the appropriate interval to revisit the methodology?
 - b. Should the CON process be revised to include a separate process for the approval of custodial beds and rehab beds? Also, should there be a separate process or additional considerations for the addition of specialized beds (i.e., dialysis and ventilator)?
 - c. How can the State advance age-friendly and Health Across all Policies priorities into the need and establishment process?
7. Should there be a CON process developed for Medicaid-funded ALP beds?
8. How will the CON process take into the account the needs of high risk individuals with serious mental illness (SMI) and skilled nursing needs in terms of:
 - a. Capacity to serve this population?
 - b. Specialized neuropsychological units with enhanced staff skills to address behavioral health needs?

- c. Enhanced staffing and skills in existing units to address behavioral health needs?
- 9. How can the CON process be used to:
 - a. Develop a trained workforce that serves individuals with mental health conditions requiring community based LTC services?
 - b. Address the shortage of skilled direct care professionals providing long term care services to individuals with SMI?