NYAHSA | New York Association of Homes & Services for the Aging

Defining the Future of Senior Living and Services in New York State

December 2010

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VISION
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ABOUT NYAHSA AND VISION 2020

The New York Association of Homes and Services for the Aging (NYAHSA) represents more than 500 not-for-profit and publicly sponsored providers of senior living and services to an estimated 500,000 elderly, disabled and chronically ill New Yorkers each year. NYAHSA members provide a wide range of services to people of all ages throughout the state, including independent housing, home care, hospice, adult day health care, assisted living and adult care facility, retirement community, nursing home, respite, community services and managed long term care. Our members bring not only a rich history of service, but they are innovators in the field of chronic, short-term and rehabilitative care that meet medical, personal and social needs in a variety of settings and locations.

NYAHSA first embarked on its Vision 2020 process earlier this year. NYAHSA Vision 2020 is a strategic initiative intended to facilitate a continuing dialogue involving the leaders of senior living and services organizations across all service lines. The objectives of Vision 2020 are to frame a vision of what senior living and services will look like in the year 2020; to promote sound public policy initiatives aimed at preparing for the envisioned future; and to help the organizations that provide these services to not only survive but to thrive well into the future and fulfill their missions in an increasingly challenging environment.

During a NYAHSA Chief Executive Officer Summit of member organizations held in April 2010, participants received a strategic overview of the current environment and likely future trends and brainstormed/evaluated possible business models, efficiencies and revenue opportunities that senior living and services organizations can pursue in the future. The NYAHSA Spring Institute held in May featured a pre-conference session on business planning, as well as a facilitated discussion of how to address challenges NYAHSA members are now facing in the environment through organizational responses and public policy changes. Summary results of the input from the April summit were discussed and reinforced in several topical workshops.

During this time, work was underway to crystallize a future policy vision for New York state based on input received from the NYAHSA membership during the Vision 2020 process. NYAHSA formed a Vision 2020 Working Group – made up of its service line Cabinet leadership as well as other Board members and leaders in the field – to work with NYAHSA staff and consultants to refine the vision and develop specific recommendations for state policymakers to begin reshaping the current service system to meet future needs.

An early draft of this report was released and discussed with senior living and services providers during NYAHSA's October 2010 summit, *Bridging Public Policy and Business Solutions*. The event also provided NYAHSA member organizations with practical information on business opportunities, operational efficiencies and funding sources.

NYAHSA Vision 2020 will continue to serve as a platform for encouraging responsible public policy and business solutions for the field of senior living and services.

EXECUTIVE SUMMARY

New York's senior living and services sector provides services to hundreds of thousands of elderly and disabled New Yorkers on an annual basis. These services are often provided by several organizations and reimbursed by multiple funding streams, posing challenges related to access, quality and cost. The senior living and services delivery system can and must do better for growing numbers of aging and chronically ill New Yorkers.

Changes are occurring at a frenetic pace, amidst a backdrop of fundamental demographic, financial, programmatic and systemic challenges. At the same time that consumers and providers are trying to overcome these challenges, advancements in technology and opportunities under federal health care reform are redefining the way health care is delivered. Furthermore, New York is facing a growing demand for senior living and support services at a time when service and funding capacities are reaching their limits. Traditional business models and existing service infrastructures are not equipped to handle these challenges and the rapid pace of change.

Providers struggle on a daily basis with the limitations of the "silos" of care, regulation and reimbursement, and this has a real impact on the experience of the consumer. As consumers attempt to navigate the array of services, fragmentation impacts service selection and utilization. Limited access to affordable care options and capacity constraints frustrate those in need of services. Disjointed program structures and funding, problems measuring quality and duplicative or conflicting program requirements impede progress towards innovative delivery models and higher quality services.

As the demand for senior living and services increases, New York will need to develop a comprehensive policy agenda. The state, in collaboration with senior living and services stakeholders, will need to agree on a clear vision and objectives to fundamentally reshape the system to provide higher quality, more efficient and more affordable services for New Yorkers. In order to transition from where we are today to where we need to be in the future, the senior living and services sector must work together and in partnership with the state to evaluate, develop and implement sustainable solutions. With that in mind, this paper seeks to:

- Identify a vision for senior living and services in New York state in the year 2020;
- Frame operational, systematic and infrastructural challenges currently facing the senior living and services sector; and
- Suggest policy options and sustainable solutions that will allow the system to move toward more enhanced and efficient service models and systems of care.

This document presents a combination of dynamic approaches that the state, with support from the senior living and services sector, can adopt to increase access, improve quality and significantly reduce costs of long term care (LTC) services. This report recommends the following high-level strategies for the state and key stakeholders to undertake to define the future of senior services in New York state:

1. A coordinated approach is needed at the state level to define the future of senior living and services and to then execute that vision through effective regulatory and reimbursement policies.

2. The financing of senior services is overly dependent on public sources and must be stabilized through diversified funding, cost-effective service options and preserving Medicaid for the truly needy.

3. Home- and community-based services, other non-institutional alternatives and new nursing home models should be made more widely available by addressing issues of service capacity, housing supply, capital financing, reimbursement, regulation, program administration, technology and transportation.

4. More flexible use of personnel and support for formal and informal caregivers are needed to ensure access to services.

5. Service delivery must reflect accountability and shared risk among patients, providers and payers.

6. Care and services should be coordinated and organized, using creative models, health information technology and a uniform assessment and standardized service authorization process.

The terms "senior living and services" and the more well-known term "long term care" will be used interchangeably throughout the paper to refer to these services and supports.

OVERVIEW

The history of New York's Medicaid program reflects its constitutional mandate to care for its most needy and vulnerable residents. This commitment to care for the indigent has resulted in New York's Medicaid program covering an incredibly broad range of required and optional health care, long term care and mental health services for an expansive group of individuals based on income and other factors. Unfortunately, this policy – coupled with efforts to maximize available federal funding for these services – has led the media, pundits and politicians to criticize New York for having the highest Medicaid and LTC expenditures in the nation. According to 2007 Centers for Medicare and Medicaid Services (CMS) data, New York has the highest LTC expenditures ($19.3 billion) in the country. The reality is that statistics do not tell the true story of the expansive eligibility and benefits offered in New York, which are not offered in any other state.

Undoubtedly, New York needs to address the growing cost of its Medicaid program. Medicaid expenditures represent over 25 percent of the state's total spending. Although New York is spending more money on LTC and other senior services, consumers do not necessarily have better health outcomes and access to a full range of service options. LTC programs are at capacity and growth projections for New York's elderly predict this population will increase from 2.7 million or 13.6 percent of total population in 2010 to 3.9 million or 20.1 percent in 2030. As consumer demand increases, the dependence on Medicaid funding and the burden on the state's senior living and services infrastructure – which currently faces unprecedented financial, programmatic, operational and systemic challenges – threatens to become unmanageable without major reforms.

The demographics of the aging population are changing, as are their expectations and demands of the senior living and services sector. Consumers are seeking more freedom of choice with regard to how and where they receive services. The foundation of care is shifting from traditional institutions and segregated services to new nursing home models, independent housing with supports, residential care options such as assisted living, an array of home- and community-based services and organized systems of care such as PACE. Programs are growing in response to consumer demand. This shift has resulted in growth for some senior services providers, downsizing of others and an evolving role for informal supports.

Unfortunately, in the absence of a strategic framework to promote collaboration and an organized continuum of services, resources from the health care field, social services sector, entrepreneurial ventures and housing sector have been cobbled together to form the current LTC system. Without an overall LTC policy agenda driving decision-making, policymakers have taken a piecemeal approach to developing programs and have allowed budget cuts to determine policy. This approach has left the elderly and disabled and their families guessing what service options are available in their communities and which options fill their LTC and other needs.

The lack of a cohesive and coherent LTC policy in the state has also left the senior living and services network out of balance. On a daily basis, providers are confronted with the effects of fragmented regulatory and reimbursement systems that do not reflect the changing needs of an

aging population. Federal health reform and emerging payment methodologies are focused on new models of care while services are provided in an outdated system. Stressed bottom lines and limited access to capital have impeded the senior services sector's ability to transition to more efficient and effective models of care.

Amidst these challenges, advancements in technology and opportunities under federal health reform – the Patient Protection and Affordable Care Act (ACA) – will redefine the way health care is delivered and provide opportunities to engineer changes to service delivery systems and more efficient person-centered models of care.

NYAHSA has developed this document to lay out an expected vision for senior living and services in the year 2020 – 10 years from now – and to outline policy options and sustainable solutions that can form the foundation of a comprehensive approach to work toward that vision in a way that will transform the quality of the consumer experience, ensure access to services, address cost and harness the tremendous potential of technology.

A VISION OF THE YEAR 2020

Through NYAHSA's Vision 2020 process, Association leaders arrived at a prognosis for what senior living and services will look like in 10 years. The fundamental elements of that vision are described below:

1. A well-integrated, common-sense, affordable array of services that shift away from the medical model to lifestyle-oriented services.

Consumer-friendly services will be designed and delivered to meet the needs of the consumers and their families, whether local or long-distance. They will be delivered in a way that maximizes dignity and independence. Consumers will be well-educated regarding options and will assume personal responsibility for their health and wellness and for the payment of services. Ultimately, providers will furnish people with a product they want and therefore choose to purchase. Everything else flows from this principle.

Real-life possibilities:

- Provide life experiences, not just services.
- "Mass customizing" to address the needs and preferences of both the senior and the senior's family at different income levels and market segments.
- Services designed around housing, communities and neighborhoods.

2. No provider will be an island.

Not-for-profit, community-oriented organizations will take the lead in developing partnerships and integrated models of service and lifestyles for seniors. These collaborations will include all types of senior living and services organizations, as well as primary and specialty health care providers. The collaborations will enable these providers to lead health care reform, develop new service models and effectively manage complex clinical and social needs. Providers that manage care and services in the most cost-effective and consumer-friendly settings possible will be rewarded. The customer will enjoy improved outcomes.

Real-life possibilities:

- Joint efforts to develop and own new or integrated ancillary business lines – diversifying the services that provider organizations offer.
- Relationships and collaborations among senior living and services providers, hospitals and physicians in response to episodic payments.
- Clinical pathways that transcend service "silos" to prevent adverse outcomes requiring more extensive care.

3. Government will partner with providers.

Together, government and providers will create a comprehensive policy for senior services in which the consumer experiences an integrated and logical system with a diversity of options.

Regulations and funding will be designed to support this larger vision, rather than silos of services designed to fit within the structure of existing regulation and funding. Through collaboration, regulators and providers will develop a system that rewards creativity and innovation instead of hindering it. Such a system would support quality outcomes and improved quality of life for seniors and involve less regulation and more common sense. Informed consumers will define quality; funding will recognize quality outcomes; and abbreviated oversight processes will be established for high quality providers. In order to meet consumers' demands, government will provide innovative organizations and individuals the freedom and resources to do things in new ways.

Real-life possibilities:

- Risks that lead to innovation are rewarded.
- Flexibility and individual choice are promoted through disability-driven payments.
- Private development of innovative models is encouraged.
- Regulations based on the level of services provided, not the building they are provided in.
- Deemed status and streamlined oversight for exemplary providers.
- Survey/oversight focused on identified poor performers based on standardized metrics that eliminate subjectivity and reflect consumer satisfaction levels.

4. New York will have a clear vision and policy for funding aging services, which will look radically different.

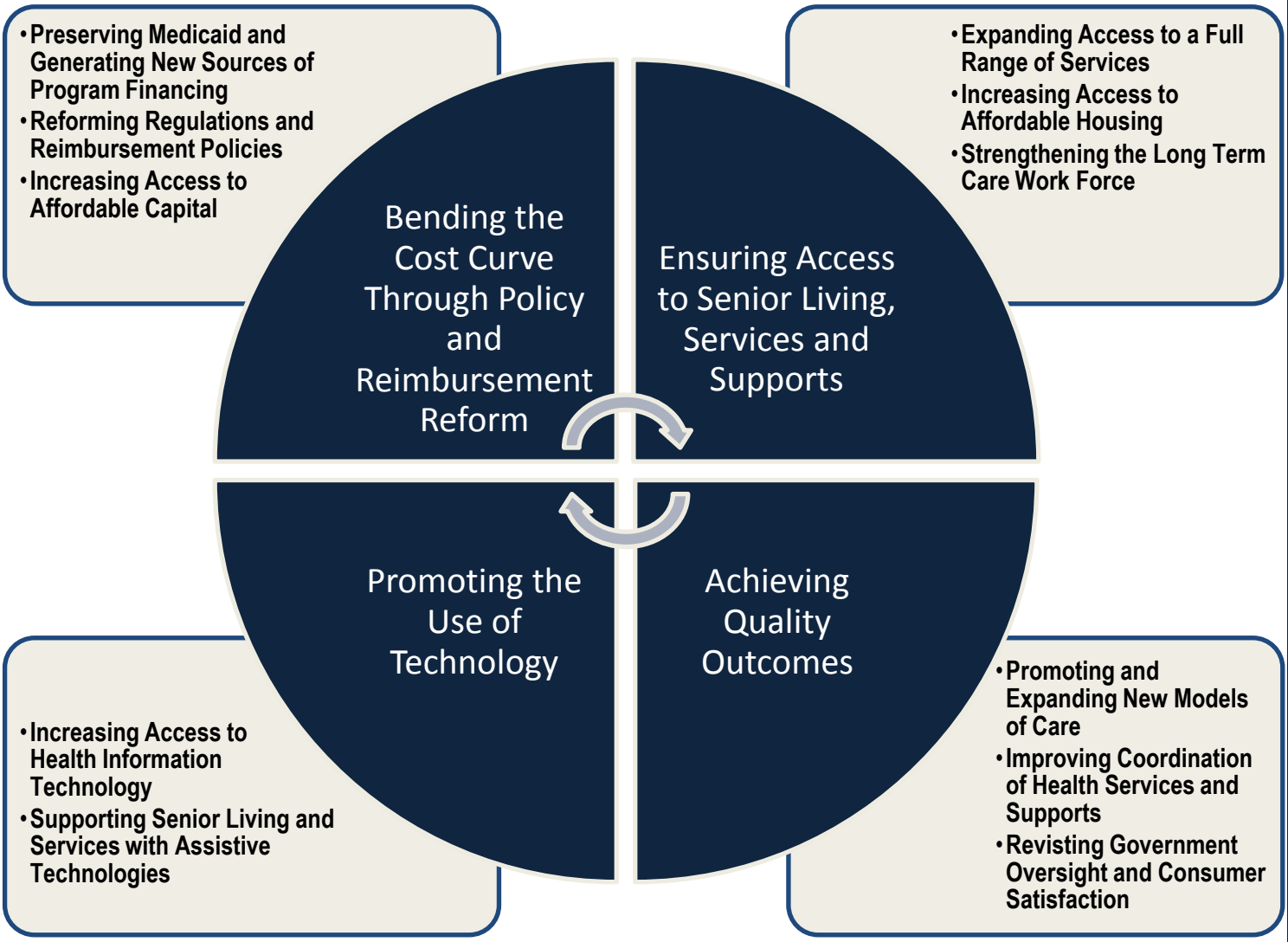
Medicaid is unsustainable as it is currently configured. The future will reflect a balance between the necessary safety net and personal responsibility so Medicaid can resume its intended role within government's capacity to fund it. People will take responsibility for their health and wellness, as well as financial responsibility for services. Government will support this through education, as well as tax benefits and other incentives. The state will identify the baseline services that Medicaid should cover, and tighter eligibility controls and asset divestiture limits will be implemented. Systems such as care management and preventive services will help to keep Medicaid spending under control. The culture of entitlement will evolve to a culture of personal responsibility, and people will be offered a product they want to purchase.

Real-life possibilities:

- Housing with services models instead of institutional care.
- Private resources will supplant/supplement Medicaid payments.
- Payments to providers will be adequate to deliver high quality services.
- Government/private partnerships to support technologies and earlier interventions.

A Framework For Reform

This document organizes recommended policy options and sustainable solutions into four interconnected categories that have been selected based on their meaningful impact on increasing access, enhancing quality and decreasing cost, while moving the system towards the envisioned future in 2020:



These recommendations include a number of initiatives that providers can take the lead on, while others will require partnership with and active intervention by the state. Some of these recommendations result in immediate savings, while others require upfront investments that will result in long-term savings. Some recommendations could be implemented using budget neutral models.

BENDING THE COST CURVE THROUGH POLICY AND REIMBURSEMENT REFORM

In order for the LTC system to transition to higher quality, lower cost and more efficient models of care, service providers must be financially independent and stable. Senior living and service providers must have access to rational and affordable financing options. Program financing options must account for the roles of various payers, provide reasonable and equitable payments to providers and take the financial capacity of government and other payers into consideration. LTC delivery systems should be developed and financed through integrated models rather than regulatory and programmatic silos. Furthermore, public-private partnerships should be encouraged to foster strategic investments in the delivery system. This chapter will focus on policy options and sustainable solutions that bend the cost curve through policy and reimbursement reform by:

- Preserving Medicaid and generating new sources of program financing;
- Reforming regulations and reimbursement policies; and
- Increasing access to affordable capital.

Real Life Case Study

Industrial Development Agency (IDA) financing is critical to the construction of continuing care retirement communities (CCRCs), yet the legislative authority for this financing expired in January 2008. The lack of IDA financing for CCRCs has current and past ramifications. In 1999, the development of Jefferson's Ferry, Long Island's first CCRC, suffered through a six-month delay in financing because legislative authorization for IDA financing lapsed for several months. The delay cost the project several hundred thousand dollars because construction did not begin until December, with associated increases in construction costs ultimately passed onto the residents. More recently, the Amsterdam at Harborside, New York's newest CCRC, rushed to secure IDA financing in the last weeks of December 2007 before the IDA authorization expired. Construction would not have been possible without IDA financing, and since 2007 no CCRCs have been financed in New York state.

Preserving Medicaid and Generating New Sources of Program Financing

Over time, senior living and services have increasingly been financed by public sources, most notably the means-tested Medicaid program. At a cost of more than $50 billion per year and growing, Medicaid has become the state's *de* facto LTC insurance program rather than a safety net for the indigent. As a result, three of four nursing home days are paid for by Medicaid, and even higher percentages of the funding for several home- and community-based programs come from Medicaid. Unfortunately, while Medicaid serves an essential role in providing LTC coverage for low-income individuals, even consumers with financial means have become dependent on the program for their LTC needs. Over-reliance on Medicaid has desensitized the public to the risk of needing LTC services, reinforced an entitlement mentality toward the program, created confusion about who pays LTC bills and adversely affected the marketability of private LTC insurance.

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Another consequence of dependency on public funding is the counter-cyclical nature of Medicaid – in a bad economy, demand is increased while the government's ability to sustain spending is decreased. With the state now projecting a cumulative budget shortfall of more than $40 billion in the next three fiscal years, it is expected that severe Medicaid cuts will be made to balance the budget. Moreover, even though Medicaid is the largest LTC funding source in total dollars, it already significantly underpays providers relative to actual costs. Further cuts in reimbursement will seriously compromise the viability of many senior services programs.

State Policy Options

There are several initiatives that the state, partnering with senior living and services organizations, could undertake to preserve Medicaid and generate alternative program financing:

- **Recommendation 1.1:** The state should prioritize takeover of Medicaid eligibility determination and service authorization activities as part of its five-year plan to assume Medicaid administrative responsibilities from local governments. Millions of dollars could be saved by eliminating duplicative Medicaid administrative bureaucracies among state and local governments. Consolidation of responsibility could also lead to: (1) consistent adherence to state policies; (2) fewer errors and oversights; (3) enhanced expertise and training of administrative staff; (4) better overall management of care without the artifice of county boundaries; and (5) better alignment of service authorization and eligibility determination activities with program financing.

- **Recommendation 1.2:** The state should seek federal approval to provide spousal impoverishment protections to community spouses of home- and community-based

services recipients in concert with curbing the use of "spousal refusal" (see Recommendation 1.3). Federal law does not expressly provide for extending this protection to non-institutional recipients, except for Medicaid waiver services. In addition to obviating the need for spousal refusal, this change would eliminate a potential barrier to the use of these services in lieu of potentially more costly institutional care.

- **Recommendation 1.3:** The use of "spousal refusal" should be eliminated or severely limited by the state. This term refers to the practice of a legally responsible relative who has excess income/resources refusing to make them available to the Medicaid applicant/recipient because the relative is absent or refuses or fails to make the income/resources available. It is being used indiscriminately to avoid financial responsibility, leading to increased Medicaid expenditures.

- **Recommendation 1.4:** Lawmakers should amend current state law to broaden the definition of "estate" for recovery purposes to the extent allowable under federal law. Existing NYS Social Services Law defines an estate as "…all real and personal property and other assets included within the individual's estate and passing under the terms of a valid will or by intestacy." Federal law allows states to expand the definition of an estate to allow Medicaid programs to make recoveries from jointly owned assets that pass directly to the surviving owner without going through a probate estate. New York should exercise this option by amending Social Services Law §369(6).

- **Recommendation 1.5:** The state should revisit issues surrounding real estate in the context of Medicaid coverage, including: (1) seeking federal authority to require anyone who accepts Medicaid coverage and owns real estate to accept a lien against the property to secure the property for later recovery; (2) reducing the dollar value of the real estate equity exemption, which is currently set at the federal maximum of $750,000; and (3) encouraging the use of reverse mortgages to fund LTC costs out-of-pocket.

- **Recommendation 1.6:** The state should pursue Medicaid recoveries at the state level rather than through local governments. By implementing a consistent, aggressive and standardized approach for estate recoveries, the state could generate tens of millions of dollars in additional savings. The state should place responsibility with the Office of Medicaid Inspector General to take over Medicaid recoveries from estates, in personal injury actions and in spousal refusal cases. DOH currently has the discretion to take these functions over from local social services districts. Local governments simply do not have the staffing or financial incentives to aggressively pursue these recoveries.

- **Recommendation 1.7:** The state should consider instituting a Medicaid pre-qualification process. Among other things, this process would gather information on resources potentially available for costs of care and asset transfers made during the previous 60 months when a person is first entering any LTC setting, regardless of the payor at admission. Reportedly, at least one other state uses a similar type of approach.

- **Recommendation 1.8:** The state should take over responsibility for collection of Medicaid cost-sharing amounts. This change would increase the amount of collections,

since the government has greater official standing than providers to insist on payments. State government takeover of this function would also enhance efficiency of efforts, versus separate efforts by each individual provider. The state could mandate how the payment is made (e.g., direct pay), similar to collection methods used in child support.

- **Recommendation 1.9:** The state should pursue federal approval to implement the LTC Financing Demonstration Program authorized in the 2010-11 State Budget. Modeled after the Partnership for LTC, the program would encourage individuals to spend their resources on services in exchange for having other resources disregarded as part of the Medicaid eligibility determination process. This will encourage consumers – including those for whom private LTC insurance is not a viable option – to spend more of their own resources on LTC services.

- **Recommendation 1.10:** The state should promote and facilitate enrollment into the Community Living Assistance Services and Supports (CLASS) Independent Benefit Plan, which was established by ACA. This new voluntary public LTC insurance program will allow chronically ill seniors and persons with disabilities who are unable to perform at least two activities of daily living or are cognitively impaired to receive funds for community living assistance services and supports if they have contributed premiums for at least five years. By supporting CLASS, the state can gradually reduce dependency on Medicaid to finance LTC services and supports.

- **Recommendation 1.11:** The state should work with providers to broaden the role of insurance coverage in financing LTC services. Opportunities include: allowing life insurance benefits to be used on an accelerated basis to pay LTC costs; allowing family members or other third-party purchasers to claim tax incentives for LTC insurance policy premium payments; and ensuring that Medicare beneficiaries, veterans and their spouses are taking full advantage of federal benefits available to them.

- **Recommendation 1.12:** The state should allow family members or other third parties to supplement Medicaid payments to obtain certain amenities such as private rooms and provide tax incentives to these individuals for paying out-of-pocket for LTC services when Medicaid coverage has not been established.

- **Recommendation 1.13:** The state should address duplicative and costly CCRC regulations that hinder new development and continued operation. New York has only 13 approved CCRCs with one in pre-approval status. In comparison, Pennsylvania has more than 150. These communities provide a full range of services to individuals who pay privately for them, discouraging asset divestiture and reliance on Medicaid.

- **Recommendation 1.14:** Senior living and services organizations should work with the state to develop new service lines that support consumers receiving care in the community and to optimize the use of state funds. Providers could collaborate to identify factors that would allow consumers to stay in the community longer if particular community supports were created, expanded and coordinated with Medicaid-funded services. Examples include home-delivered meals, social adult day care, chore services and "life care at home." Expanded services can preserve autonomy, lower Medicaid expenditures and create new revenue streams for providers.

Reforming Regulations and Reimbursement Policies

New York has one of the broadest arrays of senior living and services options in the country. As service types have grown, so have regulatory requirements, costs and complexities. Federal and state authorities provide inconsistent, duplicative and conflicting regulatory oversight. Regulations are often developed incrementally, in which new requirements are imposed in response to some adverse event, with little regard to costs or broader systemic implications. The complex web of regulations and enforcement has limited provider collaboration and development of innovative service models built around consumer needs. While oversight is intended to protect consumers, there comes a point when it diverts precious resources away from actual service delivery and threatens quality.

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While most of the state's programs, services and supports fulfill needed functions, they have been developed around fragmented governmental financing programs such as Medicaid, Medicare and Supplemental Security Income. Fragmentation in financing programs has in turn led to fragmentation in program definition, design, operation, access and administration. The end results have been confused and disengaged consumers, frustrated and underpaid providers and financially challenged payers. Ironically, the state's tendency to heavily regulate many services has also compromised access to affordable services.

With multiple state and local agencies involved in administering senior living and services, a lack of coordination of efforts contributes to duplication, inconsistency of treatment and lack of responsiveness for service recipients and providers. The state has created roadblocks to expanding existing creative models and developing new models and service combinations. For example, ALP providers must comply with three sets of laws and regulations – ALP, adult care facility (ACF) and home care. Continuing care retirement communities (CCRCs) must comply with both Department of Health (DOH) and Department of Insurance requirements.

Financial considerations also determine how programs are administered. Policymakers often view Medicaid and other state-funded programs as a source of funding and payment, not as a health care program for those in need. Lawmakers and regulators overseeing these programs are focused on year-to-year budgetary considerations, rather than long term planning or sound public policy approaches. Invariably, decisions to effect changes in these programs have ripple effects on the entire service infrastructure, not just the state-financed portion.

With the recession looming and New York confronted with massive budget deficits, providers have been faced with payment cuts and additional taxes that ultimately result in decreased access to LTC services. Rather than continue along this path, providers can work with the state to encourage the development of more functional, efficient, effective and coordinated reimbursement approaches for senior services.

State Policy Options

There are a number of initiatives that the state, in partnership with senior living and services organizations, could undertake to rationalize regulatory oversight and reimbursement policy:

- **Recommendation 2.1:** The state should improve coordination of state agency approaches to senior living and services provided through Medicaid and other funding streams. This could involve: (1) establishing a senior-level position in the Executive Chamber tasked with overseeing senior living and services; (2) forming an inter-agency council to address issues of common concern (e.g., individuals with mental health diagnoses who need LTC services, etc.); (3) creating joint accountability for results across agencies; and/or (4) developing inter-agency approaches to program design and administration.

- **Recommendation 2.2:** The state should establish a Center of Innovation within DOH, charged with addressing roadblocks to existing creative models of care and new approaches. Among the functions that could be considered for this new office are: (1) overseeing and responding to opportunities within federal health reform; (2) identifying, evaluating, and reporting other emerging health care trends and their interactions with agency programs; (3) managing strategic, crosscutting initiatives; and (4) coordinating and managing all agency demonstration activities. This office could serve as the DOH point of contact for inter-agency initiatives.

- **Recommendation 2.3:** The state should revisit the process by which regulations are developed and promulgated in the state. "Incrementalism," unfunded mandates, conflict/duplication and requirements imposed outside of regulations often characterize the regulatory process. There needs to be more thorough assessments of benefits versus costs.

- **Recommendation 2.4:** The state, along with senior living and services organizations, should identify regulations that may impede growth of existing and new service models, needlessly increase costs for providers and consumers or conflict with or duplicate other existing requirements. For example, some requirements and regulations for CCRCs and assisted living are duplicative and onerous. Although these services are offered, regulatory barriers have limited program expansion and made continuing operations exceedingly difficult and costly.

- **Recommendation 2.5:** The state should develop an integrated approach to LTC services reimbursement. There are three separate efforts under way to study and recommend new Medicaid payment systems for LTC services – nursing home, Certified Home Health Agency (CHHA) and Assisted Living Program (ALP). The proffered nursing home and CHHA systems are inherently flawed and will lead to significant payment swings and conflicting incentives. There should be a coordinated effort to look at these payment systems together to ensure that overall state health policy concerns (e.g., rebalancing, transition/diversion, quality, efficiency, innovation and access for the hard-to-serve), the potential impact of federal health reform, the need for stability, predictability and adequacy of payment and other considerations are taken into account. The incentives

associated with these payment systems should be properly aligned to reinforce the coordination and interconnectedness of the overall service system.

- **Recommendation 2.6:** Senior living and services organizations should work with the state on reimbursement alternatives that will encourage quality, efficiency and appropriate access to services while ensuring equitable and timely payment.

- **Recommendation 2.7:** The state should increase the amount of rate-setting staff resources within DOH. As the state's rate-setting capacity continues to decline due to staffing constraints, the timeliness of rate-setting activities has reached a crisis point. With growing numbers of providers, more rate changes and recent/anticipated further methodology changes, Medicaid rate issuances are often a year or more behind schedule, making it increasingly difficult for providers to plan and budget, creating worsening cash flow problems.

- **Recommendation 2.8:** Senior living and services organizations should share with each other best practices that address regulatory and reimbursement issues and concerns.

Increasing Access to Affordable Capital

Many senior living facilities were built in the 1970s or earlier and are now in need of significant renovation and modernization. Current physical plants do not meet the needs of today's consumers and in many cases do not comply with updated building codes and new health care regulations. Additionally, many providers are seeking to respond to consumers' demands for new or expanded service lines that require new construction and investments in technologies.

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There is a critical need for new capital to finance the construction or rehabilitation of CCRCs, assisted living, nursing homes and senior housing, and to deploy technologies in residential and home- and community-based settings. Senior services organizations face tremendous challenges in raising the funds needed to undertake these projects, which are integral to rebalancing the LTC system and bringing more out-of-pocket and private insurance dollars to the table. Traditionally, not-for-profit senior living and services organizations have very limited equity capital, which they have derived from either private (e.g., grants, bequests or donations) or public (e.g., government grants, demonstrations and capital cost reimbursement) sources. Access to low-cost capital is critical to their ability to transition or expand services, but these organizations are rarely considered investment-grade borrowers and therefore have very limited financing options.

Under these challenging circumstances, many not-for-profit senior living and services providers are forced to continue operations in older facilities that are more inefficient and expensive to run, without the building layouts, equipment and technologies that would allow for state-of-the-art service delivery.

State Policy Options

There are a number of initiatives that the state, in partnership with senior living and services organizations, could undertake to increase access to affordable capital:

- **Recommendation 3.1:** The state should make industrial development agencies (IDAs) an ongoing financing source for senior living facility construction/renovation. The law allowing IDAs to provide capital financing for senior housing, nursing home and CCRC projects expired in January 2008. This authority should be made permanent, and the $20 million cap on each project should be eliminated or substantially increased. Low-cost IDA financing also saves Medicaid dollars by reducing reimbursable interest costs.

- **Recommendation 3.2:** The state should evaluate effective ways to expand lending programs through state public authorities or otherwise to provide for smaller loans for technology and building projects to below investment-grade organizations.

- **Recommendation 3.3:** The state should provide further grant opportunities through the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) for LTC projects involving nursing home rightsizing, development of residential and community-based service alternatives, updating of facilities and deployment of a wide range of technology initiatives.

- **Recommendation 3.4:** The state should negotiate a new shared savings partnership with the federal government aimed at decreasing Medicaid/Medicare costs and utilizing the associated savings to fund grants to LTC providers through HEAL NY or another mechanism. The partnership would derive savings from the following initiatives, among others: 1) utilization of care coordination models – including a focus on dual eligibles – directed toward achieving shared savings and measurable outcomes related to reducing unnecessary institutionalization and hospital re-admissions, and 2) an enhanced program of Medicaid estate recoveries and eligibility measures.

- **Recommendation 3.5:** Senior living and services organizations should complement existing state efforts to identify new debt-financing opportunities by leveraging the intellectual capital in the private sector. Providers can create a forum for collaboration and open discussions that bring together investment experts, private lenders, providers, government leaders and other representatives. The focus of discussions could include expanding access to private capital while preserving not-for-profit mission and identity.

ENSURING ACCESS TO SENIOR LIVING, SERVICES AND SUPPORTS

Access to LTC services will grow in importance to New Yorkers as overall demand for these services grows in concert with demographic changes. Currently, seniors are sometimes placed in more intensive care settings such as nursing homes because the proper housing, community services and supports are not in place. In many cases, hospitalizations can be prevented if the appropriate supports, services and connections are present. The LTC work force needs to be strengthened and reconfigured to address the community need for services and demand for different levels of care. The state can play a major role in increasing access to high quality and efficiently delivered LTC services through its dual role as a large purchaser of services and a regulator. This chapter will focus on policy options and sustainable solutions that ensure access to senior living, services, and supports by:

- Expanding access to a full range of services;
- Increasing access to affordable housing; and
- Strengthening the LTC work force.

Real-Life Case Study

Ms. L is 103 years old and has lived alone in affordable senior housing since 1997. Since moving in, she has received supports to help her remain independent while aging in place. At her request, subsidized housekeeping, in-home physical therapy, home care, meals-on-wheels and a personal emergency response system are provided. Recently, she asked for remote sensor monitoring technology. She has been able to successfully remain independent in the community with the many supports made available to her.

Expanding Access to a Full Range of Services

"Although home- and community-based services (HCBS) are the fastest growing segment of New York's LTC system, there is still an insufficient service capacity to meet the demand."

The U.S. Supreme Court's *Olmstead* decision has become a standard by which service access and choice can be evaluated. Consistent with *Olmstead*, New York has expanded alternatives to institutional care that seek to preserve the autonomy of seniors and persons with disabilities and provide care in the most appropriate settings. Home- and community-based services (HCBS) programs in New York include CHHAs, Long Term Home Health Care Programs (LTHHCPs), Licensed Home Care Services Agencies (LHCSAs), consumer-directed personal care programs, Adult Day Health Care (ADHC) programs, hospices, MLTC plans, PACE, Medicaid Advantage plans and the Nursing Home Transition and Diversion (NHTD) Waiver program. Although HCBS are the fastest growing segment of New York's LTC system, there is still an insufficient service capacity to meet the demand.

Currently, the financing and logistics of many support services – including housing, transportation, nutrition, caregiver assistance and independent living support – often are not integrated and coordinated with HCBS. The lack of support service options and coordination between HCBS programs often makes nursing home placement unavoidable, even when elderly and disabled individuals could safely receive care in their home or another setting.

Congregate care settings also play a vital role in the delivery of LTC services and allow seniors to "age in place," receiving more extensive services in the same setting as their needs progress. A wide variety of services can be delivered in residential settings, ranging from independent housing with supportive services to ACF/ALP to nursing home to short-term rehabilitative and subacute care. As with community-based care, the congregate care infrastructure faces capacity, regulatory and payment issues.

The nursing home model of care is evolving and remains a critically important component of the LTC array of services. New York's nursing homes have dramatically increased the number of people they serve. Short-term (i.e., rehabilitative and post-hospital) care has become so prevalent that it represents two-thirds of nursing home discharges each year. At the same time, efforts are under way to undo the institutional nature of nursing home care through "culture change" efforts focused on resident engagement and satisfaction, environmental modifications and changing staff roles.

State Policy Options

There are a number of initiatives that the state, in partnership with providers, could undertake to expand access to the full range of senior living and services options:

- **Recommendation 4.1:** The state should reassess the need for LTHHCPs, CHHAs, LHCSAs, ADHC programs, ALPs and hospice care, in a coordinated way based on market trends and state policy goals, rather than current need-based methodologies. To

ensure adequate and focused resources for this project, the state could use an outside contractor and apply for grant funding through the federal Community Living Initiative.

- **Recommendation 4.2:** The state should assess participation in the Community First Choice Options program, an optional Medicaid benefit established through ACA. Under this program, the state would be required to make home and community-based attendant services and supports available to Medicaid beneficiaries with disabilities who would otherwise require this level of care in a hospital, nursing home, or intermediate care facility. Participation in this program would make the state eligible for an enhanced federal medical assistance percentage (FMAP) of an additional six percentage points for reimbursable program expenses.

- **Recommendation 4.3:** The state should apply for the State Balancing Incentives Program, created by the ACA, which would increase FMAP for states that implement programs that successfully promote diversions from institutional-based care and expand the number of people receiving HCBS.

- **Recommendation 4.4:** The state should consider utilizing the expanded authority under ACA that provides states with the flexibility to provide more services. These provisions would allow New York to elect to provide more types of HCBS to individuals with higher levels of need through a state plan amendment, rather than a Medicaid waiver. Income eligibility criteria would be aligned with other HCBS programs by permitting waiver-eligible enrollees to qualify for the option with incomes of up to 300 percent of Supplemental Security Income.

- **Recommendation 4.5:** The state should monitor the status of studies authorized by the ACA that direct the Secretary of Health and Human Services to review how to improve access to home health care for certain patients, including those who are severely ill, have low incomes and live in underserved areas. The secretary is authorized to conduct a demonstration program based on the results of the study. The state and providers could monitor the progress of the secretary's evaluations and decide whether to participate in the demonstration when it is made available.

- **Recommendation 4.6:** The state should move forward with plans to expand the nursing home "rightsizing" demonstration from 2,500 to 5,000 beds, which was included in the 2010-11 State Budget. In addition, the state should provide additional opportunities and incentives to encourage appropriate rightsizing of nursing home beds and expansions of capacity in other service lines. Possible options include reducing Certificate of Need equity requirements for such projects and providing more grant opportunities.

- **Recommendation 4.7:** The state should seek federal approval for the County LTC Financing Demonstration authorized in the 2010-11 State Budget. This program is intended to encourage the transition of county nursing home beds to other LTC options. A county that downsizes or closes its nursing home could use the savings to: (1) expand community-based services; (2) expand senior housing; (3) increase assisted living capacity; and (4) contract with, and pay subsidies to, other facilities to accept hard-to-serve residents. The latter could serve as a model for ensuring a safety net of services across the state.

- **Recommendation 4.8:** The state should provide greater state financial support for the Expanded In-home Services for the Elderly Program (EISEP) and the Community Services for the Elderly (CSE) program. Both programs target non-Medicaid eligible seniors who want to remain at home but need help with activities of daily living. While various in-home services are covered, services such as assisted living are not. Added funding could allow for expansion of these important, money-saving programs through liberalized financial eligibility criteria and possible increases in covered services.

- **Recommendation 4.9:** The state should assess transportation systems to ensure access to care. Reliable and affordable transportation is essential to enabling individuals to remain in the community. Among the issues that should be analyzed are coordination of vendor use, availability of services, insurance costs, availability of congregate services and ability to co-locate services. The 2010-11 State Budget authorizes the use of a brokerage model for Medicaid transportation services. The state could explore reinvesting savings from this program to provide more financial support for the transportation costs associated with providing home health nurse and aide services.

- **Recommendation 4.10:** The state should encourage all individuals to discuss their wishes for end-of-life care with their doctors and families and develop advance directives documenting their preference for care. The state should support this effort by facilitating the process of developing a living will and delegating power of attorney for health care decisions.

- **Recommendation 4.11:** The state should require all hospitals, as a condition of licensure, to have a palliative care consultation program for all adult patients with extended hospital stays longer than seven days.

- **Recommendation 4.12:** Senior living and services organizations should collaborate with the state to promote innovative thinking and intelligent market research to identify what consumers want and help providers better align and market their services.

Increasing Access to Affordable Housing

Senior housing is the least restrictive, most affordable and most flexible congregate living arrangement in the senior living and services array. It offers an ideal platform for efficiently and effectively delivering home care, other health services and social and environmental supports. These services enable seniors to remain independent for as long as possible.

"With a growing affordability gap and major federal funding cutbacks, the current unmet need for affordable senior housing is reaching crisis proportions."

By 2030, New York's overall population will increase by 2.6 percent, while the age 60-plus population will increase by 53 percent and the 85-plus population will grow by 56 percent. In New York City, where five-plus-year waiting lists for affordable senior housing are commonplace, the number of seniors is expected to jump by 46 percent by 2030. In other words, there is a demographic imperative to increase affordable senior housing in New York state.

At the same time, a growing shortage of congregate senior housing and related supports is emerging due to capital financing issues and a lack of service coordination/case management. With a growing affordability gap and major federal funding cutbacks, the current unmet need for affordable senior housing is reaching crisis proportions. In addition, much of the current senior housing infrastructure is more than 30 years old and in need of extensive renovations. Increasing the production of modernized subsidized housing capacity must become a priority.

Discussions need to continue on how senior housing facilities can continue to make supportive services available, while promoting resident independence and not being arbitrarily subjected to licensure as adult care facilities and/or assisted living residences. At the same time, the state needs to provide infrastructure funding for new construction and coordinated services in senior housing, and otherwise help senior housing operators to make these supports available.

State Policy Options

There are a number of initiatives that the state, in partnership with senior living and services organizations, could undertake to increase access to affordable housing:

- **Recommendation 5.1:** The state should form an inter-agency council on senior housing and supportive services to facilitate communication between the state agencies with oversight of these programs (i.e., DOH, NYS Homes and Community Renewal and the NYS Office for the Aging). The coordination of services across various state agencies could align interests and result in more consumer-centric service models.

- **Recommendation 5.2:** The state should apply for federal waivers on a demonstration or other basis to change Medicaid income eligibility standards to include approved levels of housing expenditures as an allowable recipient expense. This would expand access to affordable housing and decrease early and unnecessary admissions to more costly service settings.

- **Recommendation 5.3:** Utilizing existing service programs, the state should restore and expand the Low Income Housing Tax Credit Program, the Low Income Housing Trust Fund Program and the HOME Program. These programs have proved to be effective and can be enhanced to support current gaps and challenges. The state should allocate specific amounts of assistance through these programs to not-for-profit organizations seeking to develop more senior housing capacity for low-income individuals.

- **Recommendation 5.4:** The state should increase funding for Naturally Occurring Retirement Communities (NORCs) and Neighborhood NORCs. Generally, NORCs are neighborhoods or buildings in which a large number of the residents are older adults who have either aged in place or have migrated to these communities with the intention of remaining there. In addition to funding, the state could further support NORCs as a mechanism to support aging in place and reduce reliance on formal Medicaid-funded supports by revisiting the legal definitions of these communities.

- **Recommendation 5.5:** To balance consumer choice and protection with senior housing and services program expansions, the state should clarify what constitutes "independent senior housing" for purposes of determining whether a facility must be licensed as an adult care facility or assisted living program. The current uncertainty has had a chilling effect on innovative efforts to combine independent senior housing with supportive services. Meanwhile, DOH does not have the resources to go after those facilities that are willfully breaking the law and should be licensed.

- **Recommendation 5.6:** Funding should be increased for senior centers and other agencies supported by federal Older Americans Act funds to provide supportive services to those living in the community. In addition, state and federal policy should encourage senior centers to be co-located in congregate senior housing to reduce transportation coordination for seniors attending these centers. Senior centers are vitally important to helping seniors remain independent in their homes and preventing or delaying reliance on Medicaid-funded services. NYC is providing special grants to senior centers to offer innovative programming, initially in lower-income areas. Results of these grants should be monitored and if found to be successful, replicated throughout the state.

- **Recommendation 5.7:** A number of consumers who access senior housing options have chronic health care needs. To empower consumers and allow individuals to stay in the community, senior living and services organizations should work with the state to develop wrap-around service packages that integrate health- and non-health-related support services with affordable housing.

Strengthening the Long Term Care Work Force

"Since delivery of LTC is so highly dependent on hands-on care and services, chronic work force shortages and declining informal supports are a major challenge to ensuring consumer access and choice."

There are persistent work force shortages in the senior services field, which are likely to get worse in the future. Between 2006 and 2016, the NYS Department of Labor projects an increase in the number of home health aides and nurse aides needed in the state by 37.8 percent and 11.6 percent, respectively, greatly exceeding overall growth in the work force. Furthermore, according to the Center for Health Workforce Studies, New York's nursing homes and home health agencies already report significant difficulty recruiting nurses and therapists and retaining certified nurse aides and nurses. For example, although there were an estimated 100,000 certified nursing aides, 131,000 home health aides, and 60,000 personal care aides employed in New York state in 2007, low wages and limited opportunities for advancement have resulted in a 47 percent annual turnover rate for these LTC workers.

Many health care workers do not have adequate wages and health coverage for themselves or their families. In addition, many providers have limited resources to reinvest in educational benefits to develop a quality work force, restructure career ladders, train and upgrade the work force on health information technologies or modify service delivery to reflect the priorities of federal health care reform.

Relatives and friends deliver an estimated 80 percent of all LTC services. However, these informal caregivers are becoming older on average, fewer in number and increasingly burdened by job and child-raising responsibilities. According to the NYS Office for the Aging, the population support ratio (the numbers of persons aged 18-64 vs. aged 65 and up) will fall by about 45 percent between 2000 and 2050, and the dependency care ratio (persons aged 85 and up vs. 45-64) will increase by more than 70 percent during the same period. Informal care giving exacts a heavy toll physically, psychologically and financially, and the importance of encouraging and supporting informal care givers cannot be overstated.

Since delivery of LTC is so highly dependent on hands-on care and services, chronic work force shortages and declining informal supports are a major challenge to ensuring consumer access and choice. As with any complex problem, addressing these challenges calls for multiple approaches.

State Policy Options

There are a number of initiatives that the state, in partnership with senior living and services organizations, could undertake to strengthen the LTC work force:

- **Recommendation 6.1:** The state should create a medication aide program that would allow nursing homes, ACFs and assisted living facilities to employ specially trained aides who would distribute and monitor resident medications. This would allow nurses to spend more time with residents and provide additional career growth opportunities for direct care personnel.

- **Recommendation 6.2:** The state should take steps to facilitate cross-certification of certified nurse aides and home health aides to promote a flexible and adaptive work force. For example, a core training curriculum could be developed that would eliminate the redundancies inherent in moving from one classification to another.

- **Recommendation 6.3:** The state should re-examine scopes of practice of professional and paraprofessional workers to further promote flexibility. For example, certified nurse aides and home health aides should be able to measure and monitor vital signs, such as blood pressure and glucose levels. In ACFs and assisted living (except for enhanced ALRs), nurses cannot perform all of the duties their scope of practice normally allows, forcing an inefficient use of resources. Allowing nurses to act within their scope of practice in these settings would result in reduced hospitalizations, better resident outcomes, less waste of scarce resources and reduced cost to the state and residents.

- **Recommendation 6.4:** The state should support informal caregivers by offering expanded respite benefits, direct financial assistance, greater tax incentives, training programs and education and community outreach programs. This assistance would represent an eminently cost-effective approach for the state through Medicaid expenditure avoidance.

- **Recommendation 6.5:** The state should work with senior living and services organizations, universities and other degree-granting programs to examine cost-effective regional/community-based collaborative efforts to provide worker training, continuing education and evaluation of worker competency.

- **Recommendation 6.6:** The state, along with senior living and services organizations, should develop a work force strategy that achieves parity and equity for direct care wages. Wages could be brought in line to provide comparable compensation for similar services.

- **Recommendation 6.7:** Using incentives provided under the ACA, organizations and institutions of higher education can develop a comprehensive work force strategy in concert with the state that addresses work force shortages in New York. Under the ACA, the Secretary of HHS is required to work with the Secretary of Labor to provide incentives for individuals to train and/or maintain employment as direct caregivers. The secretary will provide grants to eligible entities that carry out career ladder and wage or benefit increases to augment LTC staffing.

- **Recommendation 6.8:** The state and providers should work together to cultivate interest in aging services careers through such initiatives as creating community service requirements in schools and requiring geriatric rotations in nursing and physician education.

ACHIEVING QUALITY OUTCOMES

As previously noted, $19.3 billion is spent annually on LTC services in New York, more than in any other state. The comprehensive package of benefits offered to Medicaid recipients covers a broad range of services and is relatively generous in terms of eligibility for such benefits; however, there exists both a need and an opportunity to improve health care quality while simultaneously reducing the unit cost of providing LTC services.

By coordinating services across the full continuum of care, seniors will be able to receive needed care in a more timely manner and with fewer medical errors resulting in better health outcomes. In addition, LTC service coordination can decrease costs by reducing duplicative tests and procedures and providing care in more appropriate settings. Furthermore, the implementation of federal health reform will expand and enhance integrated models of care that enhance quality through increased accountability.

Within the existing array of services, there are major opportunities to revisit how quality expectations are articulated, encouraged and enforced. Consumer satisfaction can and should be measured and taken into account in quality measurement efforts.

This chapter will focus on policy options and sustainable solutions that achieve quality outcomes by:

- Promoting and expanding new models of care;
- Improving coordination of health services and supports; and
- Revisiting government oversight and consumer satisfaction.

Real-Life Case Study

True care coordination goes way beyond what is now recognized and reimbursed – even though it saves untold dollars in avoiding unnecessary hospitalizations and institutionalization.

As an example, a mentally handicapped, hypertensive, diabetic young adult woman was enrolled into Managed Long Term Care after her parents' death. This averted a much more costly physician-ordered institutionalization, by teaching her how to buy and prepare nutritious food (she had been eating salt-laden takeout) and how to clean the apartment she had inherited.

Promoting and Expanding New Models of Care

As a result of federal health reform and other marketplace developments, many health care providers are working to transition to more efficient and integrated models that enhance opportunities for high quality care. Over the next 10 years, many health care consumers will be enrolled in some type of organized care model, such as patient-centered medical homes (also called "health homes"), accountable care organizations (ACOs), MLTC plans and PACE programs.

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Through the expansion of these risk-bearing models, providers will be responsible and accountable for the quality of care they provide and will have an opportunity to share in the associated cost savings. In addition, through provisions such as the payment changes around readmissions, hospital-acquired infections and community-based discharge planning, many hospitals will restructure their models of care in response to incentives and requirements to manage care in the community. These requirements on hospitals will provide opportunities for partnerships and collaborations with senior living and services providers.

State Policy Options

There are a number of initiatives that the state, in partnership with senior living and services organizations, could undertake to promote and expand new models of care that focus on achieving quality outcomes:

- **Recommendation 7.1:** The state should apply for a federal waiver to allow Medicaid-financed LTC services to be provided by ACOs. Under this model, providers will be accountable and responsible for the quality of care that they provide to Medicaid recipients. Incentives will be aligned to coordinate services across the full continuum of care, and providers will share in the risk and associated savings of managing the care of Medicaid recipients.

- **Recommendation 7.2:** The state should apply for the Medicaid Post-Acute Care Payment Bundling Demonstration Program created through the ACA. This demonstration encourages post-acute care providers, as well as hospitals and physicians, to improve quality and lower costs for the Medicaid program through bundled payments for episodes of care.

- **Recommendation 7.3:** The state should establish health homes for enrollees with chronic conditions, which is a state option authorized under the ACA. Chronically ill Medicaid recipients will be able to designate a provider as a health home as of January 1, 2011. States will be provided 90 percent FMAP for two years for health home-related services.

- **Recommendation 7.4:** The state should assist senior living and services organizations in partnering with hospitals and other acute care providers to participate in the Medicare Shared Savings Program established by the ACA. This program will begin by January 1, 2012, and will reward ACOs that take responsibility for the costs and quality of care of an assigned group of Medicare fee-for-service beneficiaries.

- **Recommendation 7.5:** The state, along with senior living and services organizations, could evaluate opportunities to establish health homes, as defined under the ACA. The law creates a program to provide grants to, or enter into contracts with, eligible entities to establish community-based, interdisciplinary health teams supporting the development of health homes. Senior living and services organizations could integrate health homes into the HCBS delivery system infrastructure. Co-location of health and LTC services provides continuity of care, improves quality, enhances care coordination and allows consumers to manage their chronic conditions in outpatient settings.

- **Recommendation 7.6:** In tandem with federal and state health care priorities, the state, along with senior living and services organizations, should implement programs that target cohorts or homogeneous consumer populations. By identifying cohorts of individuals with similar service needs, the senior living and services sector can promote quality, efficiency and patient-centered care models.

Improving Coordination of Health Services and Supports

The delivery of LTC and other supportive services to seniors and disabled individuals is poorly coordinated. This stems from the myriad programs that currently exist, the lack of appropriate and centralized information and the patchwork of efforts to coordinate services and care. Service navigation and coordination of supports should be embedded in the delivery system to allow consumers or others acting on their behalf to access the services they need. Furthermore, case management and integration of services are essential for assuring continuity of care for growing numbers of frail, chronically ill and disabled individuals.

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Individuals who are chronically ill and/or have short-term illnesses or injuries have frequently changing service needs. They may move between levels of care or need services added or removed from their existing care plans. Coordination of care can be used to better manage the needs of these individuals to improve treatment outcomes and prevent or delay the onset of further impairments. Care coordination attempts to manage services delivered by a single provider, as well as bridge the information gaps between providers, by assigning one individual (often a professional) to coordinate care for an enrollee who has extensive LTC and/or social service needs. Unfortunately, the lack of a reimbursement mechanism has affected access to care coordination. Individuals who are living in congregate care facilities, enrolled in community-based plans or waiver programs, or have the means to hire a geriatric care manager are generally the only people to have someone managing their care.

Individuals eligible for both Medicare and Medicaid, known as "dual eligibles," are a particular challenge inasmuch as they consume disproportionate resources in both programs. According to most estimates, these individuals account for approximately 25 percent of Medicare and 45 percent of Medicaid dollars, even though they only represent 16-18 percent of the eligible persons in these programs. These individuals are more likely to be in poor health, be chronically ill and have functional limitations, all of which lead to reliance on LTC services. Among the challenges in serving dual eligibles are conflicting Medicare and Medicaid conditions of participation, regulatory requirements, payment incentives and eligibility standards. The state has not taken full advantage of existing opportunities to integrate the financing and programmatic aspects of the two programs on behalf of many of its estimated 650,000 dual eligible recipients.

State Policy Options

There are various initiatives that the state, in partnership with senior living and services organizations, could undertake to improve coordination of senior services and supports:

- **Recommendation 8.1:** The state should develop a single, standardized, automated assessment, service plan and authorization process that would be required for existing and prospective nursing home and congregate care facility (i.e., assisted living) residents and HCBS recipients. The tool should readily accommodate initial assessment/screening activities as well as periodic reassessments and avoid creating any new information-gathering mandates or otherwise duplicate or conflict with existing federal assessment requirements. While the information would be standardized, the tool would be flexible enough so that a provider is not gathering information that is not relevant to the episode of care. The data can be transmitted to other providers to avoid duplicative processes, promote quality and achieve greater efficiencies.

- **Recommendation 8.2:** The state should develop a system of individualized care coordination, particularly for elderly/disabled who live in the community or in a non-medical facility, do not receive case management and are "at risk" of needing medical care. Supported by technology, care coordinators would address consumers' needs as they evolve, negotiate service barriers and educate families. Consumers would choose their own coordinator, which would be a provider or independent practitioner. Examples of current care coordination approaches that could be made more efficient are the NHTD and traumatic brain injury waiver programs. Another model that could be piloted in LTC is the Medicaid Service Coordination program administered by the NYS Office for People with Developmental Disabilities. The state could also explore the Patient Navigator demonstration grant authorized under ACA that would utilize providers to coordinate care for chronically ill Medicare beneficiaries.

- **Recommendation 8.3:** The various models of care coordination that have emerged beg the question – should this role be better defined and credentialed? The complexity of this role is the need for both nursing and psychosocial intervention. DOH and NYSOFA commissioned the Social Work Leadership Institute of the New York Academy of Medicine to research this issue, and a report came out last year, entitled "Who is Qualified to Coordinate Care?" which provides recommendations that should be explored.

- **Recommendation 8.4:** The state should identify high-cost dual eligibles who could benefit from intensive case management programs such as PACE and MLTC. The state should mine data from the Medicaid Data Warehouse to flag and intensively case-manage vulnerable people based on known research. As shown in recent studies, it is not all dual eligibles that skyrocket the cost; it is a relatively small subset of them with specific clinical, functional and cognitive/behavioral characteristics.

- **Recommendation 8.5:** The state should expand enrollment in MLTC plans, PACE programs and Medicaid Advantage plans. The state has recognized savings from these programs, which have improved case management, reduced inpatient hospitalizations and enhanced adherence to medication management protocols. Yet those currently enrolled in these programs are only a fraction of those whose care could be delivered better and more inexpensively under these models. The state could act to expand enrollment in these programs by eliminating authorization and capitalization barriers to the development of new plans, utilizing an "opt-out" approach to enrollment of targeted individuals,

streamlining and coordinating regulatory oversight and further reforming the Medicaid rate-setting process. These plans could also be permitted to negotiate "sub-capitations" from commercial managed care plans.

- **Recommendation 8.6:** The state should assist senior living and services organizations to partner with other health care providers and plans to offer case management, care coordination, disease management and other value-added services that assist consumers in navigating, organizing and managing their care in the community. Among other things, demonstrations should be conducted to build an organized "gateway" to LTC services for individuals who are enrolled in ACOs, managed care plans and other coordinated care arrangements. LTC providers could also explore providing caregiver support services such as chronic disease education, emotional support, respite care, home-delivered meals, financial advice and legal information.

- **Recommendation 8.7:** The state should facilitate collaboration between senior living and services organizations, hospitals and other health care facilities through participation in the Medicare Hospice Concurrent Care, a three-year demonstration program created through the ACA. This demonstration will allow patients who are eligible for hospice care to also receive all other Medicare-covered services during the same period of time. The demonstration will be conducted in up to 15 hospice programs nationally in both rural and urban areas with an evaluation of the impacts of the demonstration on patient care, quality of life and Medicare spending.

- **Recommendation 8.8:** The state should work with senior living and services organizations, hospitals, health systems and other provider networks to participate in the Independence at Home demonstration program, created through the ACA, for chronically ill Medicare beneficiaries. The objective of this demonstration is to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes, while preserving the beneficiary's ability to live at home.

- **Recommendation 8.9:** The state, along with senior living and services organizations, should conduct demonstrations or other research to test whether expanding access to primary care in nursing homes reduces unnecessary hospitalizations, which increases both Medicare and Medicaid spending.

Revisiting Government Oversight and Consumer Satisfaction

Government efforts to ensure quality of LTC services have met with mixed results at best. As a regulator and primary payor/financier, government bears a responsibility for ensuring that senior living services are delivered in conformity with reasonable requirements. Perhaps the ultimate measure of quality – consumer satisfaction – is not measured consistently nor systematically taken into account as part of oversight efforts or other determinations of quality.

"Existing survey processes are poor proxies for measuring quality of services and can in fact compromise quality. These processes are often replete with subjectivity and inconsistencies, largely fail to focus on outcomes and are largely devoid of positive reinforcement or sharing of best practices."

A properly structured and administered regulatory, surveillance and enforcement system is necessary to protect vulnerable seniors and ensure high quality services. Part of ensuring quality is dealing forcefully with providers that seriously or repeatedly fail to correct problems. The state and federal governments should take strong actions against providers that fail to ensure compliance with minimum standards. However, existing survey processes are poor proxies for measuring quality of services and can in fact compromise quality. These processes are often replete with subjectivity and inconsistencies, largely fail to focus on outcomes and are largely devoid of positive reinforcement or sharing of best practices.

A growing aspect of government enforcement and oversight stems from state and federal efforts to combat fraud and abuse in the Medicaid and Medicare programs. Unfortunately, these efforts have resulted in millions of dollars of recoveries from providers not for fraud, but for technicalities and paperwork errors. In these cases, the issue is not whether services were actually provided or needed, but whether bookkeeping errors or other technicalities justify denying otherwise legitimate claims. In other cases, agencies such as the NYS Office of the Medicaid Inspector General (OMIG) have reinterpreted state agency regulations and policies or worse yet, audited providers that were already audited by state agencies on the very same issues. These activities often divert direct care staff from their most important duty, which is to care for patients/residents.

Information on quality is available to consumers now, consisting of staffing levels, complaints, and inspection/enforcement reports posted on both state and federal Web sites. However, this information is confusing, difficult to navigate and reported separately for each level of care, making informed choices among providers virtually impossible. In the case of nursing homes, the ACA requires changes to the Nursing Home Compare Web site and Five Star Nursing Home Quality Rating System. The law further requires that states maintain consumer-oriented Web sites that include information on both complaint and enforcement data. The law also requires nursing homes to electronically submit staffing information based on payroll data including category of work, employee turnover, tenure and separate data on agency and contract staff.

State Policy Options

There are various initiatives that the state, in partnership with senior living and services organizations, could undertake to revisit government oversight and consumer satisfaction:

- **Recommendation 9.1:** The state should work with providers and consumers to revisit regulations and enforcement to address the increased risk of adverse events in an era of consumer choice. Individuals who are served in their homes or have more freedom of choice in a facility value the independence, convenience, control and familiarity that result. At the same time, individual homes or more home-like facilities offer less structured settings for care delivery. As such, there is a potentially greater likelihood of accidents, gaps in services and other adverse events. Regulatory requirements, survey processes and quality measurements applicable in these situations should reflect an appropriate sharing of risk between providers, patients, regulators and other stakeholders.

- **Recommendation 9.2:** The state should promote reasonable and consistent survey/enforcement processes and address barriers to person-centered approaches for ACF/assisted living, nursing home and subsidized housing services.

- **Recommendation 9.3:** The state and providers should work together to promote collaborative efforts including joint training of regulators and providers to share person-centered initiatives and create a broader understanding of how to move person-centered care and related best practices forward. This type of training approach has been utilized in at least one other state.

- **Recommendation 9.4:** As part of the transition to the new Quality Indicators Survey (QIS), the state should implement training for nursing homes providers on the new process. Early experience with QIS has shown that additional surveyor education is necessary before the completed survey can be considered the survey-of-record.

- **Recommendation 9.5:** For providers with multiple service lines, the state should undertake concurrent surveys of the various programs to reduce costly, inefficient and duplicative individual inspections. Under the current system, a single CCRC has multiple levels of surveys often looking at the same issues as recently completed surveys. This inefficient use of resources could be compounded as new business models emerge through health care reform unless there is a coordinated approach to oversight.

- **Recommendation 9.6:** The state should develop a performance measurement system – perhaps based on a uniform assessment tool – that would provide comment data elements related to patient characteristics and outcomes allowing comparisons of quality and performance across service providers at various levels of care. Existing systems are not based on similar measures/data and the data are not properly risk-adjusted, so comparisons of quality and outcomes are not possible across different types of providers.

- **Recommendation 9.7:** The state should take advantage of the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) satisfaction tools developed by the Agency for Healthcare Research and Quality and designed to assess the person-centeredness of care, compare and report on performance, and improve quality of care.

Person-centered care focuses on the consumers' definition of "quality," therefore it is essential that consumer and family satisfaction surveys become part of health care rating systems at the federal and state levels.

- **Recommendation 9.8:** The state should develop a process to access and utilize civil monetary penalty funds for the intended purpose of improving quality of care and/or quality of life, either through making regular grant awards based on competitive proposals addressing key quality issues or through demonstration pilot projects to address specific high-cost priority quality areas, such as preventable falls or complications from prevalent chronic conditions such as diabetes or heart disease.

- **Recommendation 9.9:** State law should be revised to allow nursing homes and other providers to include binding arbitration provisions in their admission agreements. This would help to reduce litigation and liability insurance costs, which are ultimately reflected in Medicaid rates of payment.

- **Recommendation 9.10:** The state should pass legislation to clarify the role of the OMIG, reaffirm the commitment to combat true fraud and abuse and ensure reasonable due process and fair treatment of well-intentioned providers. If, as it has been conjectured, there is widespread actual fraud in the Medicaid program, a focus on combating that fraud could actually lead to millions of dollars of additional recoveries for the state.

- **Recommendation 9.11:** Following the lead of the federal government, which is required to develop plans to implement value-based purchasing programs in Medicare for skilled nursing facilities and home health agencies by fiscal year 2012, the state should develop plans to implement value-based purchasing programs in Medicaid for LTC services based on appropriate indicators of quality and funding mechanisms.

PROMOTING THE USE OF TECHNOLOGY

As hospitals, other providers and practitioners become more "wired," clinicians will be able to exchange information across clinical settings, which will allow coordination and integration of services across the full continuum of care. Telehealth and monitoring technologies will facilitate preventative, diagnostic and treatment interventions in real time across distances, expanding service access and enhancing labor efficiency.

Over the next 5 to 10 years, senior living and services organizations will need to implement and effectively utilize technology to successfully manage the services they provide and stay current with the rest of the health care system with which they are interacting.

Both facility-based and HCBS senior services providers must be a major focus of this effort, especially since these programs specialize in serving individuals who are high-cost drivers in the system and move between care settings as their needs change. Payers, patients, providers and the general public will be well served to include senior living and services providers in the planning and development of health technology systems and networks.

This chapter will focus on policy options and sustainable solutions that promote the use of technology by:

- Increasing access to health information technology; and
- Supporting senior living and services with assistive technologies.

Real-Life Case Study

"It's like I'm another person starting all over again. All of a sudden I have this power to follow up on things I never thought I could think about anymore…My computer is just an extension of me."

Milton, 86, is a lifelong New Yorker who is homebound, but says his life has been transformed by computer technology. Through a new "virtual" senior center, he now participates in interactive discussion groups, classes and activities. And he orders groceries online, exchanges e-mail and hosts video chats with friends. Milton conducts e–case management visits with his social worker and participates in a regular e-friendly visiting session.

Increasing Access to Health Information Technology

The American Recovery and Reinvestment Act (ARRA) has encouraged and incentivized hospitals and eligible practitioners to invest in and transition to health information technology (HIT) platforms. The ARRA requires that hospitals and eligible practitioners become "meaningful" users of electronic health records (EHRs) in order to receive Medicare and Medicaid bonus payments. Some providers will be penalized under the Medicare program beginning in 2015 if they have not met the meaningful use criteria. Many hospitals and eligible practitioners are in the process of evaluating vendors, purchasing technologies or implementing EHRs.

"The transition to HIT will increase the quality of health care, reduce medical errors, improve health outcomes and redefine the delivery of health services."

As hospitals and eligible practitioners increase HIT deployment, providers will be able to exchange information across the full continuum of care. In addition, clinical decisions will be more informed through increased access to medical histories, diagnoses, prescriptions, allergies and treatment plans. The transition to HIT will increase the quality of health care, reduce medical errors, improve health outcomes and redefine the delivery of health services. Senior living and services providers are a critical component of the health care delivery system, and as this overall transition takes place, they will need to stay current and upgrade their current technology infrastructures in order to meaningfully exchange information and coordinate care.

State Policy Options

There are various initiatives that the state, in partnership with senior living and services organizations, could undertake to increase access to HIT:

- **Recommendation 10.1:** The state should work with the federal government and senior services providers to improve information access across providers through interoperable HIT. The nexus of care in the future will be the EHR, which will gather data from multiple sources and facilitate participation of doctors, nurses, allied health professionals, family members and patients in care management. EHR data can be organized in a way that provides decision support for evidence-based care, empowers patients to participate more meaningfully in care planning and promotes realignment of care delivery from hospitals/clinics to LTC facilities to the patient's home.

- **Recommendation 10.2:** The state should create incentives for LTC providers that comply with meaningful use standards and upgrade to certified platforms, consistent with the Medicare and Medicaid incentive payments for hospitals and eligible professionals that are meaningful HIT users.

- **Recommendation 10.3:** The state should provide technical assistance to senior living and services organizations as they purchase and implement HIT modules. The state could explore expanding the regional HIT extension centers that have been established to

provide technical assistance and share best practices with health care professionals that are eligible for Medicare and Medicaid bonus payments.

- **Recommendation 10.4:** Senior living and services organizations, along with the state, should work together to access grants created by the ACA to implement EHRs. The law authorizes the Secretary of Health and Human Services to make grants to LTC facilities to help offset the cost of implementing certified EHR technology designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. Supporting and advancing the timeframe within which LTC providers can participate in meaningful health information exchange is essential to successful implementation of the new models of care envisioned by ACA. Senior living and services organizations will become the critical missing link unless they are integrated into health information exchange efforts to support true care coordination and delivery of the right care at the right time in the right place.

- **Recommendation 10.5:** Senior living and services organizations, in concert with the state, should approach commercial insurers and large HIT vendors as a consortium to develop direct leasing and lending programs that leverage economies of scale.

Supporting Senior Living and Services with Assistive Technologies

The senior living service "system" is comprised of a patchwork of programs and supports that play a critical role in keeping the aging population in the community. If these services are fragmented or disjointed, this often leads to unnecessary utilization of services, adverse health outcomes or premature access to higher levels of care. Monitoring and other assistive technologies should be integrated with senior services and supports, such as housing and home care, to enhance care coordination and redirect care to outpatient settings. Promoting the use of technology that monitors the health of individuals and relays vital information to clinicians will improve consumer-provider relationships, enhance timeliness and appropriateness of service interventions and allow services to be provided in the least restrictive setting.

"Promoting the use of technology that monitors the health of individuals and relays vital information to clinicians will improve consumer-provider relationships, enhance timeliness and appropriateness of service interventions and allow services to be provided in the least restrictive setting."

State Policy Options

There are various initiatives that the state, in partnership with senior living and services organizations, could undertake to support senior living and services with assistive technologies:

- **Recommendation 11.1:** The state should explore opportunities to expand telehealth services in LTC settings. Telehealth services can help ensure access to home health care to individuals throughout the state, including rural areas. Telehealth can also be used in congregate care facilities to expand access to physicians and other care practitioners. In addition, these services can help address work force shortages through more effective use of clinicians.

- **Recommendation 11.2:** The state should incentivize the use of monitoring technologies in housing and HCBS programs as a means to enhance care coordination and redirect care to outpatient settings. Future funding opportunities could build upon the state's success in the expansion of telehealth for acute and primary care services.

- **Recommendation 11.3:** The state should provide added funding for technology and education in using computers in senior centers and other congregate day programs. Personal e-mail, Skype and other similar applications that can be introduced in these settings can go a long way toward addressing the needs of seniors to remain connected to the program even as they become homebound and frail. These programs can help prepare these individuals to use technologies to maintain their connections with doctors, friends and family.

GLOSSARY OF TERMS

Accountable Care Organization (ACO) - A network of health care providers that band together to provide the full continuum of health care services for patients. In exchange for receiving payment for all care provided to a patient, an ACO would be held accountable for the quality and cost of care. The ACO would also be eligible to share in any savings achieved as a result of these efforts.

Adult Care Facility (ACF) - Encompasses various types of residential facilities including adult homes and enriched housing programs. ACFs are established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. Such facilities may be operated by a natural person, a partnership, a not-for-profit corporation, a public corporation, a non-publicly traded business corporation or a limited liability company. Assisted living models in the state require adult home or enriched housing program licensure as a foundation.

Adult Day Health Care (ADHC) Program - Offers medically supervised services for individuals with physical or mental impairments (e.g., frail elders, children, people with dementia, AIDS patients, etc.) including: nursing, transportation, physical, occupational and speech therapies, nutrition assessment, medical social services, psychosocial assessment and rehabilitation, and coordination of referrals for outpatient health and dental services.

Assisted Living Program (ALP) - Available in some adult homes and enriched housing programs, the ALP combines residential and home care services. It is designed as an alternative to nursing home placement for individuals who historically have been admitted to nursing facilities for reasons that are primarily social, rather than medical in nature. The ALP operator is responsible for providing or arranging for resident services that must include room, board, housekeeping, supervision, personal care, case management and home health services. This is the only Medicaid-funded assisted living model in the state.

Assisted Living Residence (ALR) - Similar to an ALP, ALRs provide residential services as well as housekeeping, supervision, personal care and case management. Operators can choose to obtain an Enhanced certification (EALR) to enable residents to age in place and/or a Special Needs (SNALR) designation, which means the facility has a specialized unit for people with dementia, cognitive impairment or other special needs. SNALRs must meet specific programmatic, environmental and staff training requirements designed to meet the special needs of the population. The ALR, EALR and SNALR cannot access Medicaid funds.

Capitation - A method of paying for health care services under which providers receive a set payment for each person or "covered life" instead of receiving fee-for-service payment (i.e., based on the number of services provided or the costs of the services). Capitation can be adjusted based on demographic characteristics, such as age and gender, or expected costs of the members.

Certificate of Need (CON) - A review process, mandated under state law, governing the establishment, ownership, construction and renovation of health care facilities and services. Health care providers are required to submit a CON application and obtain approval: 1) before

new facilities are built or existing facilities are renovated; 2) before facilities acquire major medical equipment, or add or delete services; or 3) when ownership of a facility is changed or transferred. Providers subject to CON include ACFs, hospitals, clinics, nursing homes, home care agencies, hospices and adult day health care programs.

Certified Home Health Agency (CHHA) - Provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care in a home setting. CHHAs can also provide long-term nursing and home health aide services, can help patients determine the level of services they need, and can either provide or arrange for other services including physical, occupational, and speech therapy, medical supplies and equipment, and social worker and nutrition services.

Community Living Assistance Services and Supports (CLASS) Program - The CLASS program establishes a national voluntary insurance program for purchasing non-medical services and supports necessary for individuals with functional limitations to maintain community residence. Enrollment will begin January 1, 2011 and will target working adults who will be able to make voluntary premium contributions either through payroll deductions or directly. The first benefits will be paid out to eligible beneficiaries in 2016.

Community Services for the Elderly (CSE) Program - A state aging services block grant that enables localities to determine specific unmet needs and to shape the way the delivery system is organized to respond. Through the initial and ongoing annual planning and coordination process, a wide range of service needs and gaps have been identified including case management, personal care, home delivered meals, information and assistance, referral, social adult day care, transportation, respite, telephone reassurance and friendly visiting, health promotion and wellness activities, senior centers and other congregate programs, personal emergency response systems, minor residential repairs, escort and other important services.

Continuing Care Retirement Community (CCRC) - Residential alternatives for adults that offer, by contract, access to a continuum of long term care services as residents' health and social needs change over time. Residential and health care services include: 1) independent housing including meals, social activities, transportation, housekeeping and maintenance; 2) access to physician, prescription drug and rehabilitation services; 3) supportive housing and services provided in an adult home, an enriched housing setting, or an assisted living residence; and 4) skilled nursing facility care for residents who become temporarily ill or require long term care. Skilled nursing care may be provided on-site or off-site. Different models of CCRCs provide/guarantee varying levels of service.

Dual Eligible - An individual who is eligible for both Medicare and some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other dual eligibles, often those with slightly higher incomes (up to 120% of poverty), Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.

Electronic Health Records (EHR) - Computerized records of a patient's health information including medical, demographic, and administrative data. EHRs can be created and stored within one health care organization or shared across health care organizations and delivery sites.

Expanded In-Home Services for the Elderly Program (EISEP) - Assists elders who need help with activities of daily living (e.g., dressing, bathing, personal care) and instrumental activities of daily living (e.g., shopping, cooking) who want to remain at home and are not eligible for Medicaid. The program's case managers help elders and their families decide what assistance is needed and arrange for non-medical in-home services, non-institutional respite, ancillary services and other services available in the community. EISEP supplements and sustains informal care, and requires cost-sharing according to a sliding scale based on participants' income.

Federal Medical Assistance Percentage (FMAP) - The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. For New York state, the standard FMAP rate is 50%. States are currently receiving a temporary FMAP increase that was included in the American Recovery and Reinvestment Act of 2009 and later extended by H.R. 1586. The increase is effective from October 2008 through June 2011, subject to certain requirements. The Patient Protection and Affordable Care Act also contains a number of provisions that affect FMAPs, such as up to 100% for certain newly eligible individuals.

Federal-State Health Reform Partnership (F-SHRP) - A Medicaid Section 1115 waiver that became effective October 1, 2006 that created a partnership between the federal government and New York to reform and restructure the state's health care delivery system. In exchange for up to $1.5 billion in federal assistance, the state agreed to: (1) shift emphasis for LTC from institutional to community-based settings; (2) consolidate and rightsize excess acute care capacity; (3) invest in health information technology; and (4) combat fraud and abuse. Authority for F-SHRP ends on September 30, 2011.

Fee-For-Service (FFS) - A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement. Contrast FFS with capitation.

Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) - A program authorized in state law that provides funding to support the development of health information technology projects and restructuring initiatives designed to improve the stability, efficiency and quality of health care services. HEAL NY started in state fiscal year 2005-06, and has provided up to $1 billion in grants for various projects.

Health Information Technology (HIT) - Systems and technologies that enable health care organizations and providers to gather, store and share information electronically.

Home and Community Based Services (HCBS) - Under Medicaid, services available through waiver programs to groups of individuals who would be eligible for Medicaid if institutionalized and, but for the services, would be institutionalized in a hospital or nursing home. Under section 1915(c) of the Social Security Act, the federal government grants waivers of requirements that are otherwise applicable to Medicaid "state plan" services. These HCBS waivers include the LTHHCP, the nursing home transition and diversion waiver, and the traumatic brain injury waiver. Also included in HCBS are state plan services such as ADHC, CHHA and LHCSA.

Hospice - A program that provides care to terminally ill individuals that focuses on easing symptoms rather than treating disease. Provided both on an inpatient and outpatient basis, an emphasis of hospice is to help individuals remain at home or in a home-like environment for as long as possible. Hospices provide physical, psychological, social, and spiritual support and care for the patient and their family. Among the specific services offered are nursing and physician services, medical social services, nutritional and bereavement counseling, therapies, home health aide and homemaker services, medical supplies and appliances and short-term inpatient care.

Industrial Development Agency (IDA) - An independent public benefit corporation authorized under the state's General Municipal Law by a special act of the Legislature at the request of a sponsoring municipality. The purpose of an IDA is to promote, develop, encourage and assist in acquiring, constructing, improving, maintaining or equipping certain facilities, thereby advancing job opportunities and economic welfare. Among the powers of an IDA are to issue bonds to finance projects and enter into agreements for payments in lieu of property taxes.

Licensed Home Care Services Agency (LHCSA) - Offers 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 case.

Long Term Care (LTC) - Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in congregate care settings such as assisted living and nursing homes. Medicaid is the primary payer for LTC. Many of these services are not covered by Medicare or private insurance. This term is used interchangeably with "senior living and services" in this report, although the latter is in reality a more encompassing term.

Long Term Home Health Care Program (LTHHCP) - A Medicaid Section 1915 (c) waiver program that coordinates medical, nursing, and rehabilitative care for people living at home who are medically eligible for nursing home placement. A wide range of services is provided and limited by a monthly budget of up to 75% of the average nursing home cost in the county. Local departments of social services determine eligibility and authorize services for the program.

Managed Long Term Care (MLTC) - Plans which provide long term care services (like home health and nursing home care) and ancillary and ambulatory services (including dentistry, and medical equipment), and receive capitated Medicaid payments. Members get services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare cards. Members must be eligible for nursing home admission. While several plans in the state enroll younger members, most plan enrollees must be at least age 65.

Medicaid Advantage Plus (MAP) - A full-risk, managed long term care plan for individuals 18+ years of age with Medicare and Medicaid coverage who have a chronic illness or disability. Enrollees require health and long term care services and may be in need of nursing home level of care. Enrollment is voluntary. Enrollees receive flexible care planning to promote independence and help them live in their own homes and communities for as long as possible.

Medical Home - A health care setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Naturally Occurring Retirement Community (NORC) - An apartment building or housing complex that was not specifically built for the elderly, in which many of the residents have aged in place. These older residents now need support services to enable them to continue living in their homes. To qualify for state funding, a NORC must have at least 50 percent of its households headed by a person aged 60+ or at least 2,500 residents meeting this age requirement. "Neighborhood NORCs" are geographically defined areas in a municipality containing certain numbers of elderly people in low-rise buildings and single/multi-family homes.

Nursing Home Transition and Diversion (NHTD) Waiver - A Medicaid Section 1915 (c) waiver program available to New Yorkers with disabilities and seniors, designed to allow for the delivery of services in the community rather than in a nursing home. While offering services similar to a LTHHCP, this waiver is administered through a network of Regional Resource Development Centers, each covering specific counties throughout the state.

Nursing Home - Also known as a skilled nursing facility, provides 24-hour medical, nursing and other services. These facilities are licensed by the New York state Department of Health. A nursing home offers a protective, therapeutic environment for those who need rehabilitative care or can no longer live independently and require around-the-clock care and supervision.

Olmstead Decision - A 1999 Supreme Court ruling in the case *Olmstead v. L.C and E.W*, which affirmed the rights of individuals with disabilities to live in their community. The integration mandate of the Americans with Disabilities Act requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." This decision has broad implications for all states.

Palliative Care - Often provided in conjunction with hospice care, palliative care seeks to address not only physical pain, but also emotional, social and spiritual pain to achieve the best possible quality of life for patients. Palliative care extends the principles of hospice care to a broader population that could benefit from receiving this type of care earlier in their illness or disease process.

Patient Protection and Affordable Care Act (ACA) - Enacted into law in March 2010, the ACA puts into place many health care reforms including the development of state health insurance exchanges, individual and employer health insurance mandates, insurance subsidies for individuals and businesses, and Medicare and Medicaid changes. The ACA also includes the CLASS plan to reform financing of LTC services and supports, various demonstration programs to experiment with new models of care delivery and risk-sharing and the establishment of a Medicare Advisory Board, among many other provisions.

Payment Bundling - A form of reimbursement wherein providers receive a single payment for all of the care provided for an episode of illness, rather than per service rendered or by provider. A bundled payment may include both acute and post-acute care.

Program of All-Inclusive Care for the Elderly (PACE) - An organization that provides a comprehensive system of health care services for members age 55+ who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services on a capitated basis. Enrollees use PACE physicians and an interdisciplinary team develops care plans and provides on-going care management. The PACE is responsible for directly providing or arranging all primary, inpatient hospital and long term care services required by enrollees.

Senior Center - A congregate program that provides socialization, nutritious meals, case management, other supportive services, health screenings, informational seminars and activities.

Senior Living and Services - Encompasses the entire range of care and service settings, from housing for independent seniors, to home care in individuals' residences, to congregate care facilities like assisted living and more intensive settings such as skilled nursing facilities. The term includes a broad range of services from non-medical supports like housekeeping and shopping, to intensive acute and post-acute medical services. Seniors accessing such services may include individuals who are healthy and seek to age in place; who require post-acute medical care and rehabilitation and who are in the last stages of life seeking hospice care. The term is used interchangeably with "long term care" in this report.

Value Based Purchasing - A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures.