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Introduction

Long term care organizations are – to an arguably greater extent than any other part of the healthcare system – providers whose capacity to successfully accomplish their missions is closely connected to what happens in the rapidly changing policy environment at the Federal, State, and local levels. Given the tremendous pace of new policy developments that will directly impact the long term care field, CCLC developed this Sourcebook as a resource that will provide CEOs, managers, and other interested parties with ready access to clear, up-to-date, and accurate information about critical and emerging long term care programs and policies in Washington and in New York. The CCLC Sourcebook is comprised of sections covering the following areas: Key State Programs and Policy Initiatives; Key Federal Programs and Policy Initiatives; Regulation and Oversight of Long Term Care; Additional Topics (including Emergency Preparedness, Health Information Technology, Pay-for-Performance, and Person-Centered Care); and Grant Programs and Other Funding Opportunities. The Sourcebook also includes as a contact list of CCLC staff and a list of key State and Federal contacts. We hope that the Sourcebook will be a useful tool for your organizations, and, as always, we encourage our members to contact the CCLC staff at 212.258.5330 or refer to our Web site, www.cclcny.org, for further information and support in connection with new and developing policy matters affecting the long term care community.

About CCLC

The Continuing Care Leadership Coalition (CCLC) is a membership and advocacy organization representing more than 100 of the nation’s most innovative and comprehensive not-for-profit and public long term care organizations in the New York metropolitan area and beyond. CCLC’s establishment in 2003 as an affiliate of the Greater New York Hospital Association (GNYHA) highlights the growing importance of continuing care services in today’s health care marketplace.

CCLC’s purpose is to shape, through advocacy, research, and education, an environment that supports the delivery of, and access to, continuing care services of the highest quality and to provide state and national leadership in advancing effective continuing care policies and practices through the collective experience, vision, and effort of our members.
Key
State
Programs
and
Policy
Initiatives
The Commission on Health Care Facilities in the 21st Century
In 2005, Governor Pataki and the New York State Legislature created the Commission on Health Care Facilities in the 21st Century, a panel to undertake a rational, independent review of health care capacity and resources in New York State. The goal of the Commission is “to ensure that the regional and local supply of hospital and nursing home facilities is best configured to appropriately respond to community needs for high-quality, affordable and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability.” Specifically, the Commission is considering possible consolidation, closure, conversion, and restructuring of institutions, and reallocation of local and statewide resources. To consider the particular needs of each region, the Commission comprises 18 statewide members, 36 regional members, and six Regional Advisory Committees (RACs) providing recommendations for rightsizing in their respective regions. The Commission’s schedule calls for the release of a report to the public in September 2006 and the issuance of final recommendations on rightsizing in December 2006. If the recommendations are approved by the Governor and the Legislature, they become New York State law and must be implemented by the Commissioner of Health. Additional information can be obtained from the Commission’s Web site at http://www.nyhealthcarecommission.org.

Criminal History Record Check (CHRC) Program
New York’s Criminal History Record Check (CHRC) program, which went into effect on April 1, 2005, requires operators of health care facilities, licensed home care agencies, certified home health agencies, long term home health care programs, personal care services agencies, and AIDS home care programs to obtain a criminal history record report for all prospective employees prior to their employment. On September 1, 2006, new changes to the CHRC went into effect, amending the record check process by establishing an electronic mechanism for providers to use in completing the CHRCs. In addition, the changes called for the creation of a database of CHRC results in order to streamline the CHRC process and avoid duplication of requests, and clarified the State’s role in determining whether the criminal record of specific prospective employees disqualifies such individuals from employment in a long term care organization. Further information about the CHRC program is available through a Web-based training on the New York State Health Provider Network Web site at the following link: http://commerce.health.state.ny.us/hpn.

HEAL NY: The Health Care Efficiency and Affordability Law for New Yorkers Capital Grant Program
In January 2005, the Healthcare Education Project, a joint advocacy effort of GNYHA, CCLC, and 1199 SEIU United Healthcare Workers East, successfully advocated for the adoption of the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) Capital Grant Program. The program authorizes $1 billion in capital grants over four years to strengthen the health care system through both capital restructuring projects and health information technology (HIT) projects. Under Phase 1 of HEAL NY, the Department of Health awarded $53 million for multi-stakeholder HIT projects in May 2006. Under Phase 2 of HEAL NY, $269 million is available for capital restructuring initiatives. Over the next few years, the Department of Health plans to release the remainder of the $1 billion in HEAL NY funds for both HIT and capital restructuring initiatives. More information about HEAL and related grant funding opportunities can be found at http://www.health.state.ny.us/funding/index.htm.

Long Term Care Restructuring Initiative
New York State is undertaking a long term care restructuring initiative comprising several concurrent and related efforts that support the goal, set forth in the January 2004 Interim Report of the Governor’s Workgroup on Health Care Reform, of achieving a long term care (LTC) system that supports self-determination, provides services that meet consumer needs, provides high-quality care, and ensures efficiency and affordability. This initiative has its roots in the 1999 U.S. Supreme Court Olmstead decision, which requires that states make efforts to ensure that individuals can receive care in settings that are most appropriate to their needs and is also a reflection of evolving consumer preferences. The New York State Department of Health serves as the lead agency responsible for the State’s LTC restructuring initiative. The Department of Health has contracted with a Project Director to organize the initiative and is working with the New York State Office for the Aging (NYSOFA). The following elements are included in the State’s initiative:

Point of Entry (POE) System
A proposed system for providing information, initial screening, and assistance to all those interested in long term care services in New York State or who are already receiving medical or other supportive services through NYSOFA programs, Medicaid, or private-pay providers. NYSOFA plans to implement Phase 1 of the State’s POE plan, which includes voluntary information, screening, and referral services, in late 2006. NYSOFA plans to begin development of Phase 2 of the State’s POE plan, which would include mandatory assessment, care plan development, and service authorization for Medicaid recipients, in approximately two to three years following implementation of Phase 1. As part of Phase 1, in June 2006, the Department of Health and NYSOFA invited county departments of social services to respond to a Request for Applications (RFP) to be the POE contractor for their county. In cases where county departments of social services do not choose to be the POE contractor, the State will send another RFP to identify a non-provider, not-for-profit entity to serve in the role of POE contractor for the county.
The Nursing Home Transition and Diversion (NHTD) Medicaid Waiver

A proposed 1115 Medicaid waiver, which allows states to test new programs and access federal Medicaid funds, to promote community-based care for individuals 18 years of age or older through the coordination of Regional Resource Development Centers (RRDCs). The State’s goal is to transfer or divert 5,000 eligible individuals from nursing home care to community-based care over three years. The program is modeled on the existing Traumatic Brain Injury waiver program and would rely upon the RRDCs to coordinate health care services and other services for individuals enrolled in the program. The State accepted applications for RRDCs and Quality Management Specialists to assist with case management for the program in April 2006.

Comprehensive Medicaid Waiver

A planned 1115 Medicaid waiver to coordinate existing long term care programs and enhance community based services (also known as the “Mega Waiver”). With this initiative, the Department of Health plans to incorporate all existing Department of Health 1915(c) waiver programs, including the Long Term Home Health Care Program, the Care at Home waiver, the Traumatic Brain Injury waiver, and the Nursing Home Transition and Diversion waiver under a single 1115 waiver. With the additional flexibility that this waiver provides, the State plans to allow Medicaid-eligible persons of all ages and disabilities to access long term care services, whether or not they are eligible for nursing home care.

Nursing Home Rightsizing Demonstration Program

Authorized by statute in 2004 (New York State Public Health Law, Section 2801-e), the Rightsizing Demonstration Program permits the Department of Health to administer a program to reduce the number of nursing home beds in New York State by 2,500. The program allows facilities to apply to the Department of Health to temporarily decertify residential health care facility beds or to apply to permanently decertify such beds and convert them to “less restrictive long term care beds, units, or slots, including but not necessarily limited to assisted living program beds, adult day health care program slots, and/or long term home health care program slots.” In the first round of applications, the Department of Health approved 13 facilities to convert 831 beds, most of which are in the New York metropolitan area. The second round of applications was due to the Department of Health in August 2006.

LTC Medicaid Eligibility Changes

As part of its long term care restructuring efforts, the State is also implementing long term care Medicaid eligibility changes that increase the level of scrutiny of individuals applying for Medicaid to receive LTC services. (see page 17). Closely related to the State’s LTC Restructuring Initiative are the restructuring activities of the Commission on Health Care Facilities in the 21st Century (see page 6), which is proposing restructuring changes for hospitals and nursing facilities in New York State in 2006. In addition, State funding for restructuring initiatives has been authorized and is available through the Healthcare Efficiency and Affordability Law for New Yorkers (HEAL-NY) program (see page 6).

Managed Long Term Care (MLTC)

The Managed Long Term Care (MLTC) demonstration program was created by the New York State Legislature in 1997 through the enactment of the Managed Long Term Care Integration and Financing Act (Chapter 659 of the Laws of 1997). The program was developed to address the needs of disabled and chronically ill individuals and was designed specifically to improve access to home and community-based care, enhance the coordination of long term care services and financing, and test a variety of alternative service delivery and financing models. As of August 2006, a total of 16 MLTC plans were operating in New York State. Two MLTC models are operating currently in the State: Programs of All-inclusive Care for the Elderly (PACE) and partially capitated MLTC plans.

- PACE programs provide a comprehensive system of health care services for members age 55 and older who are otherwise eligible for nursing home admission. Both Medicare and Medicaid pay for PACE services on a capitated basis. PACE members are required to use PACE physicians, and an interdisciplinary team develops care plans and provides ongoing care management. PACE programs are responsible for directly providing or arranging all primary, inpatient hospital, and long term care services required by a PACE member.

- Partially capitated MLTC Plans provide long term care services (like home health and nursing home care) and ancillary and ambulatory services (including dentistry and medical equipment), and receive Medicaid payment. Members get services from their primary care physicians and inpatient hospital services using their Medicaid and/or Medicare benefits. Members must be eligible for nursing home admission. While several plans in New York State enroll younger members, MLTC plan enrollees must be at least age 65.
Of the 16 plans in existence, 12 are partially capitated MLTC Plans and 4 are PACE plans. In addition, as a result of provisions of the 1997 Managed Long Term Care Integration and Financing Act and subsequent amendments to the Act, there are an additional 24 potential slots for new MLTC programs, ten of which have been designated for specific organizations and 14 of which remain to be designated or to be assigned through a competitive RFP process.

In March of 2006, the New York State Department of Health issued a statutorily mandated report reviewing the status of MLTC Plan development, implementation, and operation in New York. The following are several of the key findings:

- 15,000 individuals were enrolled in MLTC plans as of March 2006;
- Enrollment in MLTC has grown at a rate of 20% per year during the last three years;
- 85% of all enrollees are members of the eight plans that, as of March 2006, served all or part of New York City.
- MLTC plans receive very positive satisfaction scores from consumers, with 90% of enrollees rating plan performance as good to excellent.

A full copy of the report is available on the New York State Department of Health Web site at the following link:

**Medicaid: Basic Eligibility**

Medicaid is a joint Federal-State health insurance program providing benefits for people with limited incomes and resources who can’t afford to pay for all medical expenses. In order to qualify for Medicaid, individuals must meet certain requirements, including one or more of the following: they have high medical bills; they receive Supplemental Security Income (SSI); and they meet certain specific age, income, resource, or disability requirements. The financial eligibility requirement can differ for each of those categories.

The Medicaid program in New York is administered by the New York State Department of Health, Office of Medicaid Management. Eligibility is determined by the departments of Social Services at the county/local level. In New York City, the Human Resources Administration determines eligibility.

Medicaid covers three separate categories of services for eligible providers. These categories include community medical services, home care services, and institutional care services, and have their own rules, regulations, and eligibility requirements. Community services include services of physicians “furnished in other than a hospital room or hospital-based clinic except for ambulatory surgery services,” dentists, nurses, optometrists, podiatrists, and other related professional personnel; outpatient or clinic services; sickroom supplies, eyeglasses, and prosthetic appliances; rehabilitation services, including physical therapy, speech therapy, and occupational therapy; laboratory and x-ray services; transportation when essential to obtain medical care; and prescription drugs, durable medical equipment, and sick-room supplies. Home care services include nursing; home health aide services; physical, speech, and occupational therapy; personal care services; and care provided through the long term home health care program (LTHHCP). Institutional care services include care in hospitals, nursing homes, and other medical facilities.

For more information regarding the Medicaid program, please contact an agency listed below:

- New York State Department of Health at 1-800-541-2831 or http://www.health.state.ny.us/health_care/medicaid/index.htm.
- NYC Human Resources Administration at 1-877-472-8411.

**Medicaid: Rebasing and Reform of the Medicaid Rate Setting System**

The final State Fiscal Year (SFY) 2006–07 Budget Agreement in New York State included a provision to “rebase” the operating component of Medicaid rates for residential health care facilities in the State from the current 1983 base year to a new 2002 base year. Implementation of the provision, which will be phased in over four years, begins on January 1, 2007. During the first three years of the four-year phase-in (2007–09), facilities will receive a rate comprising their current rate, trended to the applicable calendar year, and an add-on reflecting each facility’s proportionate benefit from the application of the new base year. The amount of the add-on will be subject to statewide spending caps of $137.5 million for 2007, $167.5 million for 2008, and an estimated cap of $182 million in 2009. Beginning in 2010, each facility’s Medicaid rate will be calculated fully based upon the use of each facility’s 2002 base-year costs. A hold-harmless protection provision will ensure that no facility receives a lower rate than it would have received had the rebasing proposal not been implemented.

With respect to case-mix adjustment of rates, the new rebasing provision will result in a transition, over three years, from a case-mix adjustment based upon the use of the Patient Review Instrument (PRI) to one based upon the use of the Resource Utilization Group (RUG-III) Minimum Data Set (MDS) clinical assessments. In 2007 and 2008, Medicaid rates will be adjusted by a PRI-derived case-mix index (CMI), which will reflect each facility’s CMI effective
as of the end of 2006, while in 2009, rates will be adjusted by a CMI based upon MDS data specific to each facility. PRI submissions after December 2006 will only be required to support a rate adjustment when a facility’s CMI increases by 0.05 or greater. For such facilities, PRI submissions will be required until the end of 2008. The RUG-III case-mix adjustment system will be modified under the rebasing provision to reflect New York State wages, benefits, and weights; certain New York State-specific therapy minutes; and adjustments for special populations. The rebasing proposal also makes the following changes to the existing reimbursement methodology:

• Modifying the classification of certain costs:
  • Direct therapy costs and associated overhead costs will be included in the direct component of the rate.
  • Administrative overhead costs related to pharmacy services and the costs of non-prescription drugs and supplies will be considered as non-comparable costs and excluded from direct costs.
• Creating peer groups for both the direct and indirect component of the rate.
• Providing public facilities and facilities with less than 80 beds with relief from the payment constraints imposed by ceilings that apply to the direct and indirect components of the rate by allowing such facilities to receive “ceiling relief” of 50% of the difference between the facility’s direct and indirect costs per day and the ceiling price per day.
• No longer requiring not-for-profit nursing facilities to deposit reimbursement received from the State for depreciation expenses into a segregated “depreciation fund account.”
• Treating property taxes and payment in lieu of taxes as a capital cost.
• Phasing-out the current caps on administrative and fiscal costs and productivity and efficiency cuts, and providing per diem add-ons to rates for specific categories of patients.

MOLST Initiative and Other Forms of Advance Directives

An advance directive tells the health care provider what kind of care a person would like to have in the event that he or she is unable to make medical decisions. The staff from long term care organizations, will likely talk about advance directives to residents when they are admitted. Advance directives can come in several forms including a health care proxy, a living will, or a “Do Not Resuscitate” (DNR) order.

• In New York, a health care proxy form is used to authorize a third party (e.g., a family member or close friend) to make health care decisions in the event that the person receiving health care becomes incapacitated. For more resources on New York’s Health Care Proxy, please see the Department of Health Web site at http://www.health.state.ny.us and click “Health Care Proxy” under “Current Issues.”
• A living will is a document that provides specific instructions about an individual’s wishes with regard to specific health care decisions should the individual become incapacitated. It is separate and distinct from the health care proxy form, although instructions related to an individual’s advance wishes can be noted on a health care proxy form.
• In January 2006, the Department of Health approved the use of a physician order form, the “Medical Orders for Life-Sustaining Treatment” (MOLST) form, which provides the framework for health care providers to discuss and to document the patient’s wishes regarding cardiopulmonary resuscitation and any other life-sustaining treatment. The Department of Health’s approval allows health care providers and facilities to use the MOLST form as the legal equivalent of the inpatient DNR order with a non-hospital DNR form attached (except in Monroe and Onondaga counties, where a MOLST pilot program does not require the separate document). For more information, please visit the Department of Health Web site at http://www.health.state.ny.us/professionals/patients/patient_rights/molst/index.htm.
Key Federal Programs and Policy Initiatives
**Deficit Reduction Act of 2005 (DRA)**

On February 8, 2006, President George W. Bush signed the Deficit Reduction Act of 2005 (DRA), which contained several key provisions relevant to long term care. The provisions most significant to long term care providers are described below.

**Medicaid Eligibility: Changes to the Asset Transfer Look-back and Penalty Periods** The DRA lengthened the look-back period (the span of time during which a transfer of assets may result in a period of Medicaid ineligibility) from three to five years and changed the start date for the period of ineligibility. The full implementation of the new look-back period will take until February 8, 2011. Implementation of the new look-back period is to begin on February 8, 2009, at which point the current three-year look-back period will gradually be extended until February 8, 2011, when the new five-year look-back period will be fully in place. Also, the DRA changed the start date for the penalty period from the date an individual transfers funds to the point at which an individual begins to receive services in a facility. The DRA provides for a hardship waiver, but this term remains to be defined. (See also Medicaid eligibility on page 10.)

**Medicaid Eligibility: Excluded Coverage for Substantial Home Equity** The DRA establishes that an individual will not be eligible for Medicaid long term care services if the equity interest in the individual’s home exceeds $500,000, or up to $750,000 if the individual lives in a state that elects to establish a higher upper limit as allowed under the DRA.

**Expansion of State LTC Partnership Program** The DRA allows all states to develop programs similar to New York’s LTC Partnership Program, which allows individuals who have exhausted the benefits of approved private long term care insurance policies to access Medicaid without the same means-testing requirements as other applicants.

**Medicaid Fraud and Abuse Provisions** The DRA requires that any entity that receives or makes annual Medicaid payments of at least $5 million must establish written policies and an education program for all employees that includes information about the False Claims Act. Also, the DRA established a Medicaid Integrity Program under the U.S. Department of Health and Human Services and provides incentives to encourage states to establish False Claims Act laws.
Support for Home and Community-Based Programs

The DRA establishes new opportunities for states to offer, through the regular state plan process, home and community-based services (HCBS) that previously could have been offered only by applying under the HCBS waiver process. It also established a grant program, the “Money Follows the Person Rebalancing Demonstration,” to provide incentives for states to move people from institutions to community settings. In addition, the DRA established a new state option for self-directed personal assistance services, also known as “cash and counseling.” This provision requires that self-directed personal assistance services be provided based on a written plan of care and budget for people who would otherwise be eligible for personal care services under the state’s Medicaid plan or HCBS waiver.

Medicare: Overview

Medicare is the nation’s largest health insurance program, covering nearly 40 million Americans. It is administered by the Centers for Medicare & Medicaid Services. Medicare is available primarily to people who have worked for at least 10 years in Medicare-covered employment and are 65 years of age or older. It is also available to certain disabled individuals under 65 years of age and to people with end-stage renal disease. Other beneficiaries include:

- Individuals entitled to Railroad Retirement benefits or Railroad Retirement disability benefits (specialty funds for former railroad workers that are separate from Social Security);
- Certain Federal, state, and local government employees who are not eligible for Social Security retirement or disability benefits and who may be eligible for Medicare benefits if they worked and paid the hospital insurance portion of their Federal Insurance Contributions Act (FICA) taxes for a sufficient period of time; and
- Individuals who are not otherwise eligible for Medicare but who are over age 65 and who may purchase coverage by paying a monthly premium.

Medicare includes Part A Hospital Insurance, Part B Medical Insurance, Medicare Advantage (Part C) and Prescription Drug Coverage (Part D). Part A is the primary source of Medicare funding for nursing facilities and home health agencies.

Medicare Part D

Medicare Part D is a voluntary prescription drug program that was created by the Medicare Prescription Drug Improvement and Modernization Act of 2003. The program, which began on January 1, 2006, is available to all persons eligible for Medicare Part A or Part B. The Part D benefit is offered through insurance companies as a free-standing prescription drug plan (PDP), or through Medicare managed care, or Medicare Advantage, plans.

Part D covers prescription drugs, biologicals, insulin, and certain medical supplies associated with the injection of insulin. Each prescription drug plan has its own formulary, which is a specific list of generic and brand-name drugs that it will cover.

The standard Part D plan requires a monthly premium, and its design calls for deductibles, co-payments, and co-insurance. However, prescription drug plans may modify the plan design as long as the benefit plan they offer is at least equal in value to the standard benefit.

Special Rules for Dual Eligibles

Special rules apply to those who are eligible for both Medicare and Medicaid (“dual-eligibles”). Although participation in Part D is voluntary, New York State law requires dually-eligible Medicaid recipients to enroll in Medicare Part D as a condition of Medicaid eligibility. Therefore, if a dual eligible refuses to enroll in Part D, or disenrolls from the program, that person will not be eligible for Medicaid and will lose all Medicaid benefits.

Full benefit dual eligibles are auto-enrolled in a Part D plan and receive substantial help in paying for some or all of the costs associated with Part D. Further, in New York State, institutionalized full benefit dual eligibles receive Medicaid’s Part D Wrap-around coverage, under which Medicaid will pay for the costs of certain drugs ordinarily excluded under Part D, such as barbiturates and benzodiazepines. Full-benefit dual-eligibles are also allowed to change Part D plans as often as every month, if needed.

To learn more about the Medicare prescription drug program, visit http://www.medicare.gov or call 1-800-MEDICARE.

Medicare: PPS Payment Systems for Nursing Homes and Home Health Agencies

For nursing homes, the Part A program pays for up to 100 days of inpatient care for patients who have previously been hospitalized for a minimum of three days. The Balanced Budget Act (BBA) of 1997, modified the way in
which payment is made for Medicare skilled nursing facility (SNF) services. The BBA called for the phase-out of the old system of paying SNFs on a reasonable cost basis and established a new SNF prospective payment system (PPS), which went into effect starting on July 1, 1998. The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). Comprehensive information regarding the SNF PPS can be found on the Skilled Nursing Facilities PPS page of the CMS Web site at the following link: http://www.cms.hhs.gov/SNFPPS.

For home health agencies, the Part A program pays for the care of eligible beneficiaries in 60-day episodes, which can be renewed for clients who require longer spans of care. As with nursing homes, home health agencies are now paid under Medicare pursuant to a prospective payment system. Under this system, Medicare pays home health agencies (HHAs) a predetermined base payment that is then adjusted to reflect the health condition and care needs of the beneficiary. The payment is also adjusted for the geographic differences in wages for HHAs across the country. Comprehensive information regarding the home health PPS can be found on the Home Health PPS page of the CMS Web site at the following link: http://www.cms.hhs.gov/HomeHealthPPS.
Regulation and Oversight of Long Term Care

There are a number of rules and regulations, at the Federal, state, and local levels of government that govern New York State nursing facilities and home health agencies. The rules and regulations are linked to the receipt by providers of public funds through the Medicare and Medicaid programs. The following is a list of key regulations applicable to long term care providers at the Federal, state, and local levels.

**Federal Regulations** Under Title 42 of the United States Public Health Law, there are two key sections of the U.S. Code of Federal Regulations (CFR) applicable to long term care organizations, both established following the passage of Omnibus Budget Reconciliation Act of 1987 (OBRA'87). Nursing facilities are regulated under 42 CFR 483, a section of the CFR that includes nursing home standards, or conditions of participation, in the areas of quality of care, resident rights, resident assessment, and quality of life. Home health agencies are regulated under 42 CFR 484, which sets forth requirements for the uniform collection of assessment information by home health agencies. Consistent with these Federal laws, the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid policy, publishes additional regulations and guidance documents.

**Key CMS Regulations and Guidance**
- Nursing home surveys – CMS State Operations Manual
  - Survey and enforcement process, Chapter 7
  - Survey procedures, Appendix P
  - Guidance to surveyors, Appendix PP
  - Guidance to surveyors, Appendix B
- Medicare payment – Updates and notices for the skilled nursing facility and home health prospective payment systems are published each year in the Federal Register.
- Program Transmittals – CMS releases program transmittals, named after the cover page, or transmittal page, to communicate new or changed policies or procedures that are being incorporated into a specific program manual, such as the State Operations Manual.

The above regulations and guidance are available on the CMS Web site at http://www.cms.hhs.gov/home/regsguidance.asp.

**State Regulations** The two key sections of the New York State Public Health Law regulating long term care are Article 28-A for nursing homes and Article 36 for home health agencies. Consistent with these State laws, the Department of Health, the State agency that administers Medicaid policy, promulgates regulations and guidance documents.

**Regulations and Guidance from the Department of Health**
- New York State nursing home standards are found in Title 10 of the New York Code of Rules and Regulations, Part 415 (10 NYCRR 415). Home Health Laws and Regulations can be found under Title 10, Article 7. Guidance concerning these standards is issued periodically by the Department of Health in the form of “Dear Administrator” Letters (DALs). A selection of current DALs is available on the CCLC Web site (http://www.cclcny.org), the Department of Health Web site (http://www.health.state.ny.us), and the Health Provider Network (https://commerce.health.state.ny.us). Sections of the New York State nursing home and home care regulations that relate to specific issues of interest to providers are identified below:
  - Nursing home minimum standards – 10 NYCRR 415
  - Nursing home environmental standards
    - Nursing home physical environment, 10 NYCRR 415.29
    - Construction standards, 10 NYCRR 713
    - Environmental health, 10 NYCRR 702
    - Fire safety, 10 NYCRR 702.3 and 10 NYCRR 711.2
    - See also NFPA 101 1997 Life Safety Code (incorporated by reference)
  - Nursing home payment – 10 NYCRR, Subpart 86-2
  - Medicaid eligibility – 18 NYCRR, Part 360
  - Home health agencies – 10 NYCRR, Article 7
    - Standards, 10 NYCRR 763
  - Home health payment – 10 NYCRR
    - Certified Home Health Care Agencies, Subpart 86-1.46
    - Long Term Home Health Care programs, Subpart 86-5
Local Laws. While Federal and State standards are the primary means by which long term care activities are regulated, some localities have passed local laws and implemented local regulations that impose additional requirements on long term care providers. Information about New York City local laws that apply to providers can be found on the City Council’s Web site at http://www.nyccouncil.info/index.cfm. Likewise, many surrounding counties in the New York metropolitan area post their local laws on their Web sites. For example, Suffolk County’s laws are accessible at (http://www.co.suffolk.ny.us/) by clicking Suffolk County Links, then by clicking Laws of Suffolk County.
Emergency Preparedness

Nursing homes are expected to take steps to ensure their readiness to respond to a variety of emergency situations, including natural disasters, power disruptions, and chemical, biological, radiological, nuclear, and explosive (CBRNE) events.

In this regard, the Department of Health requires that nursing facilities have in place comprehensive emergency preparedness plans. The Department of Health has recently emphasized that it is essential that these plans include surge and evacuation plan components, which should be developed and submitted to each facility’s New York State Department of Health Regional Office and local Emergency Management Office.

For further information regarding the comprehensive emergency preparedness plan, facilities may refer to the nursing home page on the New York State Department of Health, Health Provider Network (HPN) at https://commerce.health.state.ny.us/hpn/ (password protected).

Several brochures have been produced by New York State to help individuals and organizations enhance their level of readiness. These include:

- New York State “Emergency Tips;”
- New York State Department of Health’s “Plan to be Prepared;” and
- New York State Emergency Management Office’s “Be Prepared!”

These brochures can be downloaded by going to the following sites:

- http://www.health.state.ny.us/environmental/emergency/emergency_tips-plan_to_be_prepared.htm
- http://www.health.state.ny.us/publications/doh-7070.htm

Members can also find a host of additional preparedness resources on the “Emergency Preparedness Resource Center” pages of the GNYHA Web site, which can be accessed at the following link:

http://www.gnyha.org/eprc/community

Key telephone numbers to keep on hand in case you need them in the event of an emergency are as follows:

- CCLC and GNYHA personnel can be reached 24/7 in the event of an emergency by calling GNYHA’s main telephone number at 212-246-7100. If you need assistance after normal business hours, a recording will provide information for reaching a GNYHA staff member on call.
Health Information Technology
Businesses have been using information technology for many years to improve the efficiency of their operations. In health care, interest in and adoption of health information technology (HIT) has been growing significantly in recent years. On the Federal level, the President recently signed an Executive Order to encourage the development of HIT and establish a National Health Information Technology Coordinator under the U.S. Department of Health and Human Services. In New York State, HIT investment is being encouraged under the HEAL NY law (see page 6), which provides funding for multi-stakeholder HIT projects.

In 2006, CCLC conducted the first comprehensive assessment of the status of HIT initiatives in long term care organizations. The survey found that, at present, the greatest level of investment in HIT in long term care organizations has been in the area of billing applications, while the top HIT priority for LTC organizations going forward is to invest in and implement electronic health record systems. The survey found that the greatest barrier to the implementation of HIT systems in LTC organizations is the initial cost of such systems. One of the best sources for information on HIT specific to the long term care sector is the Center for Aging Services Technologies (CAST), whose Web site (http://www.agingtech.org) contains a number of important resources, including a clearinghouse of products and technologies, discussion boards regarding new technologies, and information about grants and funding opportunities.

Pay for Performance (P4P)
At both the Federal and State levels, policy makers are moving forward with plans to make “pay for performance,” otherwise known as “P4P,” a part of the methodology for calculating Medicare and Medicaid payments for long term care providers and other health care providers. The P4P concept links incentive payments to the achievement of specific performance outcomes by health care providers. Under Medicare, the movement toward adoption of a P4P system for home health agencies was given impetus by a provision of the Deficit Reduction Act of 2005 (Section 5201), which specified that rate adjustments to the home health prospective payment system for annual inflation increases would be reduced by two percentage points beginning in 2007 for any home health agency that does not provide CMS with the data needed for measuring quality performance. Section 5201 also directed the Medicare Payment Advisory Commission to submit a report to Congress by no later than June 1, 2007, making recommendations regarding the structure for adding “value-based payment,” or P4P, adjustments to the home health PPS. For nursing homes, CMS is conducting a multi-state P4P demonstration program to gain experience and collect data needed for the eventual implementation of a nursing home P4P system under Medicare. The demonstration, will provide additional payment for facilities that meet certain quality standards, in 8 states beginning in 2008. In the nursing home sector, there is also an initiative at the State level, pursuant to a provision in the final State Budget for State Fiscal Year 2006–2007, to begin demonstrating the feasibility of putting in place a P4P system under Medicaid.

Person-Centered Care
Person-centered care refers to the practice of basing key long term care decisions — in areas ranging from how meals are served and how bathing is offered to how work is structured in an organization — on individual resident needs, preferences, and expectations. Person-centered care, which is integral to the concept of culture change in long term care, is increasingly viewed as an essential aspect of delivering quality care to long term care patients and residents, and, as such, is included among the priority areas that CMS expects state Quality Improvement Organizations (QIOs) to focus on in working with organizations under the terms of CMS’s Eighth Scope of Work. The fostering of person-centered care is a central objective of the CCLC-1199 SEIU Quality Care Committee (QCC). The QCC was established by CCLC and 1199 SEIU in 2001 as part of the contract between the Association of Voluntary Nursing Homes and 1199 SEIU in New York City. It provides a framework for teams from 40 nursing homes (with equal representation from labor and management staff) to work together to improve the quality of care in some of the largest nursing facilities in the country. As part of its charge to identify common approaches to staffing and care practice issues that affect quality of care and the workplace environment, QCC continues to actively support the integration of person-centered care principles through training and a range of initiatives to support organization-wide collaboration. For more information, please see CCLC’s Web site at http://cclcny.org/20060906PersonCenteredCare.htm.
Grant Programs and Other Funding Opportunities
Dementia Grants
The New York State Dementia Grant Program was created in 1988 by the New York State Legislature and is coordinated by the Eddy Alzheimer’s Services of Northeast Health and the Department of Health. This bi-annual grant provides nursing homes with funding to support research and projects that are aimed at improving care for New York State nursing home residents with dementia. For more information on this grant, visit http://www.nehealth.com/html/neh_eddy_alzheimers_nysbg.asp.

Health Workforce Retraining Initiative Grants
The Health Workforce Retraining Initiative (HWRI), established under New York’s Health Care Reform Act (HCRA) of 1996, provides grants to support the training and retraining of health care workers. Under HWRI, the Departments of Health and Labor jointly solicit applications from home care providers, long term care facilities, health worker unions, labor-management committees, health care facility trade associations, educational institutions, and other health care facilities. Grants are provided to those facilities and organizations that increase the number of workers in occupations with documented shortages, foster new skills needed for a changing health care system, and support additional skills needed for new jobs due to changes in the marketplace.

Healthcare Workforce Recruitment and Retention Act
In January 2002, in the wake of a comprehensive campaign by the Healthcare Education Project, the New York State Legislature and Governor approved the Healthcare Workforce Recruitment and Retention Act, which amended the Health Care Reform Act to provide funding for nursing homes, hospitals, and, through a subsequent amendment, home health agencies, to help them recruit, retain, and retrain health care workers and improve overall levels of quality. There are three key programs that have their basis in the Act:

Nursing Home Workforce Recruitment and Retention Program
This program authorized the distribution of $288 million to nursing homes across New York State over the three-year period from 2002–2004 to assist facilities in their efforts to recruit and retain a qualified nursing home workforce. This program was reauthorized in 2005 at a funding level of $330 million to be distributed over the period from January 1, 2005, through June 30, 2007. These dollars are allocated based on a formula measuring the proportion that each nursing home’s salary and fringe benefit costs make up of the total of such costs statewide.
**Nursing Home Quality Improvement Demonstration (QID) Program**
The QID program provided for the distribution of $187.5 million to nursing facilities in New York during the 2002–2004 time period under a competitive application process for facilities undertaking projects to: 1) increase staff; 2) increase training of staff; 3) decrease staff turnover; and 4) improve the quality of care for residents. Members of the CCLC Quality Improvement Consortium were successful in securing funding for a multi-pronged initiative that included staff compensation enhancements, comprehensive training for thousands of direct care staff, and a variety of facility-specific workplace improvement initiatives. In 2005, the QID program was reauthorized for 2005, 2006, and the first six months of 2007 at a funding level of $93.75 million over the 30-month period. In 2006, the legislature approved the expenditure of an additional $62.5 million to supplement funding levels for existing QID grant awardees.

**Home Health Care Recruitment and Retention Program**
The final State Budget for State Fiscal Year 2006–2007 established a new Recruitment and Retention program designed specifically for home health care providers. Under this program, home health rates of payment under Medicaid will be adjusted with rate add-ons totaling, in the aggregate, $50 million for the period June 1, 2006, through December 31, 2006, and an additional $50 million for the period January 1, 2007, through June 30, 2007. Funding will be allocated proportionally based on each agency's total hours of direct care services provided to Medicaid patients. Providers eligible for the rate add-ons include certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs, managed long term care plans, and approved managed long term care operating demonstrations.

**Patient Safety Awards**
The New York State Patient Safety Award Program was established in October 2000 as part of the New York State Health Information and Quality Improvement Act. The New York State Patient Safety Award is a Department of Health initiative to reduce medical errors and improve the quality of care. Those eligible for the yearly grant program include New York State's licensed nursing homes, federally qualified health care centers (FQHCs), adult care facilities, and hospitals. Awards are given annually based on the demonstration of ongoing quality improvement systems and evidence that quality improvement efforts have resulted in the reduction of medical errors statewide.
Contacts
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212.258.5331 f

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## Key State Contacts

**New York State Department of Health**  
518.474.7354  
http://www.nyhealth.gov

- Bureau of Quality 518.408.1282
- Division of Quality and Surveillance for Nursing Homes & ICFs/MR 518.408.1267
- Division of Home and Community Based Care 518.408.1132
- Office of Finance and Reimbursement 518.474.1057
- Office of Managed Care 518.474.1590
- Office of Medicaid Management 518.474.3018

**New York State Office for the Aging**  
800.342.9871  
http://aging.state.ny.us/

**IPRO**  
http://www.ipro.org

- Provider Helpline 800.446.2447
- Nursing Home Issues 800.852.3685
- Home Health Quality Initiative 800.233.0360

## Key Federal Contacts

**Center for Medicaid and Medicare Services**  
http://www.cms.hhs.gov/

- Baltimore Headquarters 877.267.2323
- Region II 212.616.2205
- Center for Medicaid and State Operations (CMSO) 410.786.3870
- Region II CMSO 212.616.2400