PURPOSE

The purpose of this Informational Memorandum is to provide Area Agencies on Aging (AAAs) and the Aging Network with information regarding changes made in the New York State Medicaid program. These changes will be enacted as a result of the passage of budget legislation for State Fiscal Year (SFY) 1995-96. These changes affect home and community based care and Medicaid eligibility. This IM also notes follow-up activities that should be conducted by Area Agencies on Aging.

BACKGROUND

This legislation was passed by the New York State Senate and Assembly as bill number A.7984-A/S.5280-A. The bill amends the Public Health Law and the Social Services Law. The purpose of the bill is to ensure the appropriate and efficient provision of health care services through the Medicaid system. This legislation also reduces State and local expenditures through structural reform of the Income Maintenance program. However, this IM only provides information regarding the changes made to the Medicaid Program since these will directly affect the elderly.

Included among the major changes in Medicaid enacted as a result of this legislation are:
• changes in a wide range of Medicaid funded services including transportation, home care, and other home and community based services;

• allowing adult homes and enriched housing programs to apply to obtain "Limited Licensure for Home Care Services;"

• changes in Medicaid copayments and spousal resource levels; and

• creation of State income tax deductions to encourage the purchase of long term care insurance.

Changes in Medicaid required as a result of this legislation will be implemented by the State Department of Social Services and the State Department of Health during State Fiscal Year 1995-96. The State Office for the Aging will continue to monitor developments resulting from this legislation and provide relevant information to the Area Agencies on Aging.

SUMMARY OF KEY PROVISIONS

The following information summarizes several of the key provisions, and notes some anticipated or possible impacts.

- **Transportation** (Section 78)

Local social services districts are directed to manage the provision of transportation services in a coordinated and efficient manner beginning July 1, 1995. Transportation services must receive prior approval from the local social services official and must be essential, medically necessary, and appropriate.

The local social services official must make appropriate and economical use of transportation resources including "transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services" [emphases added].

The impacts of these requirements on the Aging Network are not clear and will depend on how they are implemented. If local districts can continue to use Medicaid funds cooperatively to purchase transportation services from the aging network, the change could produce positive efficiencies. If, however, districts attempt to use aging-funded transportation to replace Medicaid-funded transportation, then there might be negative impacts on the aging network. The State Office for the Aging will be discussing implementation questions with the Department of Social Services.

- **HARRI and Local District Delegation** (Section 96)

The requirements for home care assessment and the delegation of
responsibilities by social services districts are extended for two years until July 1, 1997. (The home care assessment instrument currently is referred to as HARRI which currently is being field tested.)

**Fiscal Assessments** (Section 97)

The requirements for home health services management and fiscal assessment, personal care management and fiscal assessment, and private duty nursing and fiscal assessment are extended for two years. These requirements now expire on July 1, 1997. As a result, home care providers must continue to conduct a "fiscal assessment" of the cost-effectiveness of services when compared to nursing home placement for persons who will require services for more than a continuous 60-day period.

**High Risk Home Care Cases** (Section 73)

Nursing homes, assisted living programs, adult homes, and enriched housing programs are required to admit high-cost Medicaid home care cases on a priority basis effective immediately.

Persons who cannot reasonably be maintained in a home setting for health or safety reasons must be appropriate for such residential care. The State Department of Social Services will set standards, and local social services districts will make determinations. How this priority system will work is not known at this time.

In addition, the Department must establish a method or formula for determining a fair and equitable distribution of priority admissions so that all residential long term care providers equitably share the responsibility for accepting high risk placements. This is likely to be difficult to implement, especially since the law requires that no provider be unduly burdened by this requirement or forced to jeopardize profitability or viability.

By March 1, 1996, the Commissioners of Health and Social Services must submit a report to the Governor and the Legislature on these requirements and any recommendations for their continuation or modification.

The State Office will follow the development of regulations and procedures related to this requirement and will keep Area Agencies on Aging informed.

**Local District Responsibilities for Personal Care, Home Care Services, and Private Duty Nursing** (Section 91)

Several new requirements are placed on social services districts.

- Districts with programs that place individuals solely into certified home health agencies upon hospital discharge must ensure
that these individuals are reviewed for possible placement into personal care within two weeks of discharge and, if possible, receive personal care within four weeks.

- Effective September 1, 1995, each social services district must review the plan of care using the fiscal assessment.

- Every district must ensure access to a consumer directed personal care program.

- Where appropriate and cost effective, districts cannot restrict, and are not restricted from approving, private duty nursing as an alternative to nursing services provided by a home health agency.

**Standards for PERS and Shared Aide Services** (Section 86-b)

Modifications and additions were made to existing requirements for the provision of personal emergency response services. In addition to PERS, shared aide services must be included in the provision of personal care services and home health services.

Requirements for State Department of Social Services standards are expanded to include:

- Assuring that the PERS or shared aide services are appropriate, can meet the needs of the client, ensure quality of care, and will not jeopardize the client's health or safety;

- Determining the geographic appropriateness of shared aide in terms of staffing and assuring that both the provider and the local district consider the impact of the site selected on staff who will be assigned to work there;

- Consulting with staff working at the sites and employee organizations representing such staff regarding the management and operation of the shared aide site; and

- Assuring that local districts have a plan for providing information to consumers and their representatives on PERS and shared aide services, including how to express concerns.

Standards must be issued by August 1, 1995 after seeking public comment. Please be advised that this process has begun. The State Department of Social Services has developed draft administrative directives incorporating information from previous transmittals, as well as adding new information required by this Chapter. By April 1, 1996, after consulting with local district representatives, providers, home care workers, and service recipients, the State Social Services Department must submit a report to the Governor and Legislature outlining any changes needed in the standards for PERS and shared aide.

**Personal Care Program Savings Targets for PERS and Shared Aide Services** (Section 92)
For the period from April 1, 1995 through March 31, 1996, for each local social services district the State Department of Social Services must establish State share Medicaid cost savings targets resulting from the development and implementation of PERS and shared aide in the personal care program. The aggregate target cannot exceed $53 million.

The Department must consult with each district in developing each district's target. Factors to be utilized include, but are not limited to:

- The size of the district's personal care program -- both the number of service recipients and amount of expenditures;
- The potential savings through the appropriate and efficient use of PERS and shared aide, taking into account the district's geographic size, the number of recipients already using PERS and shared aide, the density of the personal care recipient population, and the number of recipients that might benefit from PERS or shared aide; and
- The district's historical success in reducing personal care expenditures through the use of PERS and shared aide.

The Department may intercept other State payments made to any district which fails to achieve the savings target in the amount of the State's share of the savings that were not achieved. The Department also is required to do the following by the noted dates:

- By October 31, 1995, submit a progress report to the Governor and the Legislature on the implementation of this section and each district's target savings;
- By March 1, 1996, inform each district of its progress towards meeting its target; and
- By June 1, 1996, submit a report to the Governor and Legislature on the impact of the requirements of this section, including the targets for each district, an analysis of the reduction in expenditures due to implementation of the PERS and shared aide, funding recouped from local districts because of failure to meet the reduction, analysis of the impact of shared aide and PERS on the quality of care, and barriers to their further implementation. Local districts, service recipients, and service providers are to be consulted in the preparation of this report.

**Incentive Payments for Personal Care Savings** (Section 92-a)

The Department of Social Services is directed to develop and issue a methodology to give counties incentive payments, up to a total of $1 million, based on local savings in the personal care program.

**CHHA Savings Targets for PERS and Shared Aide Services** (Section
In consultation with the State Health Department, the Department of Social Services is required to establish a state share Medicaid cost savings target for each certified home health agency. This target is to be achieved as a result of each agency's development and implementation of PERS and shared aide efficiency initiatives. The statewide aggregate savings cannot exceed $15.5 million.

Agency specific targets are to be developed in consultation with representatives of the home care industry and are to include, but not be limited to, the following factors:

- The agency's current caseload and caseload profile;
- Historical expenditures to each agency for home health services; and
- The status of current agency implementation of PERS and shared aide programs.

By August 1, 1995, each agency must be notified of its target, and by January 1, 1996, they must be informed of their progress toward achieving their target savings.

The State Health Department is required to calculate an adjustment to the approved rate of payment for the July 1, 1995 through December 31, 1995 period for each agency by a sufficient amount so the agency can achieve its savings target prior to March 31, 1996.

As soon as practicable after March 31, 1996, the State Department of Social Services must review total payments made to each agency, the amount of offset from payments otherwise due to the agency, and the total savings achieved by the agency as a result of the development and implementation of PERS and shared aides efficiency initiatives.

**Consumer Directed Personal Assistance Program** (Section 77)

A "Consumer Directed Personal Assistance Program" replaces the "Patient Managed Home Care Program" (which expires on July 1, 1995). (The patient managed home care program was a demonstration program in up to 10 local districts which allowed certain Medicaid personal care clients greater flexibility and freedom of choice.)

The new Consumer Directed Personal Assistance Program also is designed to allow maximum flexibility and freedom of choice but is not a demonstration. In this program, the client takes on more control and responsibility. However, clients may be assisted with service coverage, supervision, advocacy, and management. Providers are not liable for the fulfillment of responsibilities agreed to be undertaken by the client. However, this does not diminish the provider's liability for failure to exercise reasonable care.
Eligible individuals must be informed of the availability of this program and have the opportunity to participate. These include persons who are:

- Eligible for long term care and services provided by a CHHA, LTHHCP, AIDS home care program, or personal care services;
- Eligible for Medicaid;
- Determined by the local district to be appropriate for the program (i.e., a person who is able and willing to make informed choices, or has a legal guardian able and willing to make informed choices, or has designated someone who is able and willing to assist in making informed choices as to the type and quality of services, including but not limited to such services as nursing care, personal care, transportation and respite services); and
- Covered by other criteria that may be established.

**Limited Licensure for Home Care Services** (Section 105-b to 105-f)

Until December 31, 1997, adult homes and enriched housing programs will be allowed to become "limited home care services agencies" and to provide personal care services, to administer medications, and to apply sterile dressings needed by their residents.

Medicaid reimbursement for these services will be at a rate that is "significantly less than the current costs of providing such services through a personal care provider or certified home health agency." In addition, the local social services district must determine that the services proposed to be provided will be cost effective compared to other available options.

Only adult homes and enriched housing programs that are determined by the Social Services Commissioner to be providing quality of care consistent with the needs of residents could be licensed.

The Department of Social Services must provide a detailed report to the Governor and the Legislature on or before June 26, 1997 on the resulting cost savings.

The short term impact of this new approach will be a shift away from services delivered in adult homes and enriched housing programs by home care agencies and toward residential care facility services which never have been delivered to their residents by facilities before. The larger impacts will be a subject of the required report.

**Adult Day Health Care** (Section 63)

The cap on the current daily rate for adult day health care provided by nursing homes is extended to March 31, 1996. As a
result, the maximum daily payment rate for adult day health care (excluding the allowable costs of transportation) will continue to be 65 percent of the sponsoring nursing home's daily Medicaid rate.

**Long Term Home Health Care Program** (Section 122)

The Long Term Home Health Care Program is extended for two years, through December 31, 1997.

**Foster Family Care Demonstration** (Section 123 to 125)

The foster family care demonstration program is extended until December 31, 1996. (The program was first authorized in 1983.) The purpose of this demonstration is to encourage the development of foster family care as a community-based alternative to long term care and to determine its viability and effectiveness at up to ten sites. Services to be provided by the foster family include room, board, personal care, supervision or assistance with daily living tasks, and other needed services.

**Spousal Resources** (Section 83)

The community spouse resource allowance is generally capped at $74,820 for the period of January 1, 1995 through June 30, 1997. This has been accomplished by amending one of the four factors [see pg. 8] used to determine the community spouse resource allowance pursuant to Social Services Law, § 366-c(d).

Section 366-c was enacted in 1989 to permit an institutionalized spouse to qualify for Medicaid while providing a resource allowance sufficient to prevent the impoverishment of the healthy, or community, spouse. Pursuant to § 366-c(d), as now amended, the community spouse resource allowance is the greatest of the following amounts:

(i) (A) prior to January first, nineteen hundred ninety-five, sixty thousand dollars, which shall be increased annually by the same percentage as the percentage increase in the federal consumer price index;

(B) on and after January first nineteen hundred ninety-five through June thirtieth, nineteen hundred ninety-seven, seventy-four thousand eight hundred twenty dollars or such greater amount as may be required under federal law;

(ii) the lesser of sixty thousand dollars which shall be increased annually by the same percentage as the percentage increase in the federal consumer price index or the spousal share; or
(iii) the amount established for support of the community spouse pursuant to a fair hearing under this section; or

(iv) the amount transferred pursuant to a court order for the support of the community spouse. (Social Services Law, § 366-c(d))

Since the $74,820 cap is in place only until June 30, 1997, the Legislature will have to take some action at that time to extend it and/or raise it. $74,820 is the maximum community spouse resource allowance currently permitted under Federal law.

**Co-payments** (Section 98)

Required co-payments for certain Medicaid services (including in-patient general hospital care, out-patient hospital and clinic services, home health services including long term home health care, medical supplies, and prescription drugs) are extended for two years until July 1, 1997. That is, Medicaid payments to providers will continue to be reduced by the co-payment amount, and providers may charge patients for those amounts. Providers may not deny services to individuals unable to pay the co-payment amount.

**Tax Deductions for Long Term Care Insurance** (Sections 99 to 101)

Commencing in 1996, purchasers of long-term care insurance who are 55 years of age or over may subtract a portion of their premiums paid during the taxable year from their Federal adjusted gross income in deriving their New York adjusted gross income. An identical adjustment is authorized for New York City taxpayers.

The amount that may be subtracted is limited as follows:

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<th>AGE</th>
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In order for a long-term care insurance policy to qualify for a tax break, it must first be approved by the Superintendent of the New York State Department of Insurance.

Long-term care insurance must meet minimum loss ratio standards and an appropriate definition of insured event as established by the Insurance Department pursuant to regulations to be issued.
Also, to be approved, all of the following benefits must be provided:

- a minimum of 3 years of long-term care benefits;
- a case management function designed to control inappropriate use of long-term care services;
- coverage for skilled, intermediate and long-term care and custodial home health care without requiring a prior stay in a nursing home, hospital or other institution or facility;
- coverage for care in a nursing home without requiring a prior stay in a hospital or other institution or facility;
- the right to convert group long-term care coverage to an individual policy; and,
- adjustments for inflation.

Any policy which is offered as or purports to be a long-term care insurance policy, but which has not been determined by the Superintendent of Insurance to qualify for a tax break must clearly state that it does not qualify.

### Long Term Care Financing Task Force  (Section 105-a)

An eleven-member Long Term Care Financing Task Force is established to look at long term care financing. The Task Force will:

- Study alternatives to the current public funding mechanisms for long-term care,
- Review demographic trends with regard to their impact on long-term care financing,
- Review the limitations of current long-term care financing mechanisms, and
- Review alternative models of financing and providing long-term care services through public, private, and public-private financing systems.

The task force must report its findings and recommendations to the Governor and the Legislature on or before April 1, 1996.

### FOR FURTHER INFORMATION

AAAs should become familiar with these changes in Medicaid, and related programs and services, in order to respond to inquiries from older persons and their families, subcontractors, and local officials. AAAs should contact their local social services districts to discuss how these requirements will be implemented locally.
The State Office for the Aging will review regulations and administrative directives issued by the Department of Social Services and the Health Department as a result of this legislation. We will transmit any relevant information to the Area Agencies on Aging.

- For general information related to this legislation you may contact Dave Murray of the Policy Analysis Unit at (518) 474-8147.

- For information related to changes in the Personal Care Program contact Andrea Hoffman at (518) 474-5444.

- For information related to spousal resources, co-payments or long term care insurance contact Bill Graham at (518) 474-0388.