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Proposals that reduce NYS spending and promote the independence and integration of seniors and people with disabilities

November 13, 2009

The state's Independent Living network and disability community have been advocating for policy changes in New York that would increase the independence of seniors and people with disabilities. Despite the fact that these proposals were cost-effective and save money, the administration has been slow to act on the advocate proposals. Even in the face of serious financial difficulties, New York State has an unprecedented opportunity to improve the lives of seniors and people with disabilities to support them living in the most integrated setting as mandated by the Supreme Court's Olmstead decision. Unfortunately, instead of developing state policy that promotes savings through people receiving services in the most integrated setting appropriate for their needs, the administration has simply proposed manipulating the Medicaid rates to generate savings. The administration's approach has the potential to backfire and reverse progressive state policy, ultimately costing the state more in institutional care.

Recommended Policy Changes and their Associated Savings

Proposed Policy Change	Non-Federal Share Savings
1. Increase utilization of the Nursing Facility Transition and Diversion Waiver to transition people from nursing facility placement to community living	\$85.7 million
2. Divert people from nursing facility placement using the Nursing Facility Transition and Diversion Waiver	\$84.2 million
3. Shift people currently receiving Certified Home Health Care to the less costly Consumer Directed Personal Assistance Program	\$43.4 million
4. Shift people currently receiving Traditional Personal Care to the less costly Consumer Directed Personal Assistance Program	\$26.6 million
5. Expand the pool of direct care workers to match the federal rules for family caregiving to promote the use of more cost-effective services	\$39.4 million
6. Utilize assistive technology to contain costs	\$7.7 million
Total Savings from the Proposals	\$287 million

Policies that promote community-based services save money!

National research has demonstrated that states which shift from using institutional care including nursing facilities to community-based models of care are leveling out their long term care costs. States that are not making this transition are continuing to see their long term care costs escalate.

New York has taken some steps in the direction of promoting more effective use of community-based alternatives, but overall New York's system is still institutionally-biased. According to the most recent spending data from Thomson Reuters (formerly Medstat), in 2007 60.71% of New York's Medicaid spending for long term care for seniors and persons with physical disabilities was for institutional nursing facility care. Other states are making the shift. The state of Washington has steadily reduced its spending for nursing facility care while investing in community based alternatives. Compared to New York during the same year, Washington State only spent 44.42% of its Medicaid long term care dollars serving seniors and physically disabled for nursing facility care. In terms of per capita spending, New York also spent dramatically more for nursing facility care at \$349.80 compared to less than one-third of that amount in Washington State (\$91.96). In fact, only one state spends more per capita on nursing facility placement - Connecticut which spends \$351.99, and only one other state spends more than \$300 - Pennsylvania which spends \$311.13.

New York State should implement the following recommendations.

- 1. Increase utilization of the Nursing Facility Transition and Diversion (NFTD) Waiver to transition people from nursing facility placement to community living for a potential annual savings of \$85.7 million in the non-federal share.**

According to the 2009 3rd quarter report of CMS' Minimum Data Set (Q1A), there are currently 22,027 New Yorkers living in nursing facilities that indicated they wish to return to the community. Institutionalizing these individuals despite the fact that they want to live in the community costs over \$2.5 billion. The Nursing Facility Transition and Diversion Waiver was expected to have 5,000 enrollees by the end of year three. As of September 25, 2009, more than half way through year two, the waiver enrollment was 231 individuals. NYS could achieve significant cost savings by increasing utilization of the NFTD Waiver and transitioning more individuals out of costly institutions and into community based settings.

While the Department of Health has clearly worked to implement the waiver, its bureaucracy has slowed progress and the waiver is only one of many confusing and sometimes contradictory DOH initiatives. Department staff - at times - have micro-managed implementation and tended to over-medicalize the program slowing implementation despite the fact that this model has the potential to create significant savings. Although the NFTD waiver is too new to get good cost-savings comparisons, the TBI waiver has demonstrated a cost savings of just over \$29,000 per individual, per year in the non-federal Medicaid share compared to the cost of institutionalizing these individuals.

Even if the state only realized 85% of the TBI waiver's savings and only transitioned 25% of the MA-eligible individuals who have expressed a desire for community-based living, we estimate NYS would \$85.7 million. If over four years, the state transitional all of these individuals, the cumulative savings in the non-federal share would be \$857 million.

2. NYS should immediately establish a facilitated enrollment process for the NFTD and TBI Waivers to divert people from nursing facility placement for a potential annual savings of \$84.2 million in the non-federal share.

Too often, people leave the hospital and go into a nursing facility immediately following a hospital stay and then are unable to leave that costly setting to return to the community. Because the enrollment process for waiver services is lengthy, people often are placed in nursing facilities. The New York State Health Department should create a facilitated enrollment process that allows seniors and people with disabilities to immediately return home from the hospital. This approach would promote the concept that the individual is expected to be independent and help them return home with more cost-effective services.

Based on the assumption that the state could divert 25% of 13,187 Medicaid nursing facility admissions and save 85% of the established savings under the TBI waiver, New York State could save \$84.2 million in the non-federal share and promote the independence of these individuals by avoiding long-term institutionalization.

3. NYS should implement a plan to shift some people currently receiving Certified Home Health Care to the less costly Consumer Directed Personal Assistance Program for a potential annual savings of \$43.3 million in the non-federal share.

Advocates have demonstrated that the Consumer Directed Personal Assistance Program (CDPAP) is the most cost-effective model for assistance in the home because the per-hour rate for CDPAP is cheaper than other home care services. When consumers self-direct their nursing tasks, the savings are significant. Compared to Certified Home Health Care, CDPAP reduces Medicaid spending by \$9.52 for every hour of service. Assuming an average of 5 hours of service a day, by shifting about 5,000 people from Certified Home Health Care to CDPAP, the state would reduce Medicaid spending by approximately \$86.8 million (a savings in the non-federal share of \$43.4 million).

In reviewing the national data, it seems that there is significant room for making such a shift. In New York State, Certified Home Health Care accounts for 14.75% of the state's Medicaid long term care spending for aged and physically disabled individuals. In comparison, Certified Home Health Care in Washington State is just 2.04%.

State law provides for expanded participation in CDPAP through contracts with peer based programs to provide education and outreach to eligible individuals and training for discharge planners, LDSS' and others. In addition, the CDPAP statute was amended to require county enrollment targets and annual implementation plans, to promote

consistency regarding approved service levels across the state. Unfortunately, the administration has not fully implemented these proposals and has therefore failed to generate the potential saving from this paradigm shift.

4. NYS should implement a plan to shift some people currently receiving Personal Care Services to the less costly Consumer Directed Personal Assistance Program for a potential annual savings of \$26.6 million in the non-federal share.

CDPAP is also cheaper than traditional Personal Care services. Although the savings are not as dramatic, they are significant. On average, CDPAP is 6.89% cheaper than traditional personal care with a per hour Medicaid savings of \$1.46. Assuming an average of 10 hours of service a day, by shifting about 10,000 people from Personal Care to CDPAP, the state would reduce Medicaid spending by about \$53.3 million (a savings in the non-federal share of \$26.6 million).

The state could take additional steps to realize increased savings by promoting the shift from medical model approaches to the more cost-effective consumer-directed model.

The state should set aggressive county enrollment targets for CDPAP. The state has begun to receive reports from individual counties about their usage of CDPAP and plans for how they intend to promote the use of that program. Under current law, the State is required to set county enrollment targets. By setting aggressive enrollment targets for counties and approving their plans, the State has control over assuring Medicaid savings are realized from this initiative.

The state should expand consumer direction into the Nursing Facility Transition and Diversion and Traumatic Brain Injury Waivers. Currently, counties are forcing people off of CDPAP because they are eligible for Home and Community Support Services (HCSS) under these waivers even though those services may, in fact, be more expensive. In Monroe County, a man receiving services on the TBI waiver is being told that he will be removed from CDPAP. Now he may not personally be able to manage his own services, but his wife – who is a nurse – can. And they like the idea of managing who comes in and out of their home.

Even when consumers are not being forced to drop their CDPAP services, the logistics of having both HCSS staff from an agency and consumer-directed attendants make the choice unworkable. Disability groups have urged the Department of Health to provide consumer direction as an option within these waivers, but they have not moved forward with these plans. This is particularly frustrating because attendants under the CDPAP model can do a variety of health related tasks that would otherwise require a nurse. HCSS provides safety monitoring which is a far less skilled task and could easily be done by a CDPAP attendant. Expanding CDPAP into the waivers will give consumers more control and reduce Medicaid spending.

The state could realize additional savings by relaxing the requirement that consumers physically visit their doctor within thirty days of the reauthorization. This is not to say that physician assessments are not important; it is simply a costly requirement that is burdensome for personal care consumers. The State should amend the regulation to require individuals to visit their physician once a year, which is common for an annual physical. Such a change is permissible by CMS. According to the State Medicaid Manual, Pub. No. 45, Chapter 4, Section 4480, "...nor does Federal law require that a physician prescribe the services in accordance with a plan of treatment. States are now permitted the option of allowing services to be otherwise authorized for the beneficiary in accordance with a service plan approved by the State" (Centers for Medicare and Medicaid's State Medicaid Manual). This allowance can be found in 42 CFR § 440.167 for Personal Care Services. The regulation states:

§ 440.167 Personal care services.

Unless defined differently by a State agency for purposes of a waiver granted under part 441, subpart G of this chapter –

(a) Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are –

(1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;

For example, in 2006, Idaho passed S. 1339 that amended the existing law to remove the standard which requires that personal care services be ordered by a physician or authorized provider. New York State can and should make this regulation amendment.

5. NYS should expand the pool of direct care workers in the Consumer Directed Personal Assistance Program to match the federal rules for paid family care givers, which would promote the use of this cost-effective service for a potential annual savings of \$39.4 million in the non-federal share.

The relationship between an attendant and the consumer is essential to the success of the any home care service, but the ability to select who comes into your home is a critical component to the success of the Consumer Directed Personal Assistance Program. To increase the savings generated by using CDPAP, the state needs to implement policies which would promote the use of that model. Because of the type of assistance that is being provided, individuals with disabilities, particularly seniors, often prefer having a family member serve in this role. Family members often make the choice to institutionalize a senior because they do not want to have strangers in their homes.

Federal regulations [42 C.F.R. § 440.167], state that personal attendants cannot be a family member who is "legally responsible" for the care of an individual. This is interpreted to include spouses and legal guardians (parents) of minors. However, New York State regulations [18 NYCRR § 504.14(h)(2)] are much more restrictive than federal regulations and expand the prohibitions on attendant employment to certain members of the consumer's

family to include spouse, parent, child, son-in-law, or daughter-in-law. If the NYS regulations were amended to expand the definition of personal attendant to match the federal regulation, we estimate that 3% of the Medicaid nursing facility population would transition into the community and New York State would save \$78.8 million annually in institutionalization costs (\$39.4 million in the non-federal share).

This approach also addresses a critical shortage of home care workers that stalls efforts by states to shift toward a community-based model of long term services and supports. Previous efforts in New York State to address the need for direct care workers have not focused on significantly expanding the pool of workers, but have focused on making the job more appealing to people interested in this work by providing improved benefits or a career ladder. While these efforts have had some impact, they have generally drawn from the same pool of workers, rather than expanding it.

By expanding the ability to pay family members to provide assistance, the State would be drawing in workers who would not generally want to be an attendant with the potential for significantly increasing the pool of workers and addressing a critical barrier to moving toward a cost-effective community-based model and reduce the state's Medicaid spending.

The state could require that the State Education Department work with the network of Independent Living Centers to develop and implement a model for training people with disabilities to become attendants to realize further savings both by promoting the shift from medical model approaches to the more cost-effective consumer-directed model and by providing employment to these individuals. Although generally not considered as potential workers, many people with certain types of disabilities (i.e. psychiatric or developmental disabilities) often already provide some level of personal assistance on an informal basis. Direct care employment may be a good fit for this population because they tend to be comfortable with basic tasks and are committed to the concept of supporting people who want to live in the most integrated setting. Ultimately, this approach creates opportunities for people with disabilities to be competitively employed and expands the pool of potential direct care workers. The disability community has been suggesting such an approach for about seven years. The difficulty in getting such an initiative started is that it is difficult to get one state agency to invest in a model that creates savings in another area. The Independent Living network – because it is a consumer controlled model that hires people with disabilities – is most likely to implement such a model successfully.

6. NYS should better utilize assistive technology to contain costs for a potential annual savings of \$7.7 million in the non-federal share.

While there are options for assistive technologies under the waivers and through vocational rehabilitation, generally this type of assistance has been overlooked by the NYS Department of Health which oversees much of New York's long term care system. Discussions about the use of technology and equipment have generally focused on tele-health as opposed to meeting more basic needs of individuals who want to live independently. Technology,

however, has the possibility of significantly reducing long term care costs. For example, people who require 24-hour or overnight home care because they are unable to get out of bed independently to open the door for the morning attendant could potentially reduce hours if they were provided with assistive technology which allows them to open the door. Assuming that the state only provided such assistive technology to 250 people and reduced their need for personal care by 8 hours a day, the state could reduce Medicaid spending by \$15.4 million.

To make technology more readily available, the Department of Health should use the next round of HEAL funding to expand the Technology Related Assistance for Individuals with Disabilities (TRAID) program. TRAID is a federally-funded project administered by the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. In New York, the TRAID dollars have been used to establish regional technology centers that are providing information, borrowing, and referral services for persons with disabilities. The TRAID Centers work to improve people's access to assistive technology equipment and services. Under the NYS Commission on Quality of Care and Advocacy for Persons with Disabilities, the TRAID program provides coordination of assistive technologies for assistance in education, employment, community living, and information technologies. There are twelve Regional TRAID Centers (RTCs) across the state. While this provides a strong foundation, the State needs to expand this program. The next round of HEAL funding provides a funding mechanism for expanding the TRAID program. The state could then coordinate the efforts of the TRAID project with the Regional Resource Development Centers for the waivers to enhance the use of technology in promoting the independence of people.

The state can address the deficit by promoting independence and consumer-direction!

Independent Living and disability rights advocates have identified specific barriers that push people into institutional settings who could otherwise benefit from community living and suggested ways New York State could address those barriers so individuals with disabilities and seniors can both live in the most integrated setting and help control New York's Medicaid spending. We have also demonstrated the potential savings of shifting to the consumer directed model for providing long term services and supports.

As the Legislature prepares to present proposals for the New York State Budget 2010-2011, it is imperative to remember that cutting services and supports that keep people out of costly institutions is not smart planning for New York State. New York's disability community is looking to our leaders in Albany to make the right choice.