

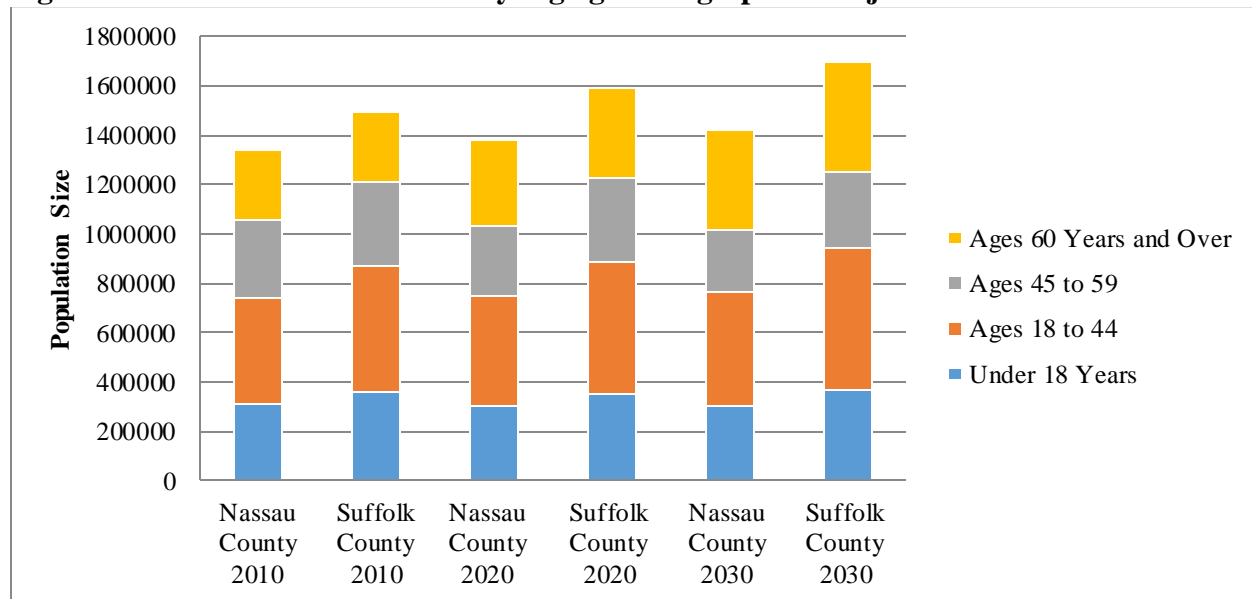


## A Snapshot of Long-Term Care Service Delivery Trends on Long Island and the Impact on the Aging Population Issue Brief

### EXECUTIVE SUMMARY

The age composition on Long Island, particularly across Nassau and Suffolk Counties, has changed dramatically over the last several years.<sup>1</sup> Across both counties, 20-year projections show an upward trend, particularly among residents 60 years of age and older, as illustrated in the following graph.<sup>2,3</sup>

**Figure 1: Nassau and Suffolk County Aging Demographics Projections: 2010-2030<sup>4,5</sup>**



Nassau and Suffolk Counties were ranked among the top 25 counties nationwide with a population of aged individuals 65 years and older.<sup>6</sup> Other counties in this ranking include Kings, Queens, and New York Counties.

Growth projections along with changes across the healthcare landscape, place new demands on Long Island's long-term health care infrastructure.<sup>7,8</sup> These new demands create a need for medical, social,

<sup>1</sup> Long Island also encompasses two New York City boroughs (Brooklyn and Queens). However, the term "Long Island" commonly refers only to Nassau and Suffolk counties, and that is the terminology used in this issue brief.

<sup>2</sup> New York State Office for the Aging. "County Data Book: Nassau County," <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/29Nassau.pdf> (accessed July 9, 2016)

<sup>3</sup> New York State Office for the Aging. "County Data Book: Suffolk County," <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/49Suffolk.pdf> (accessed July 9, 2016)

<sup>4</sup> New York State Office for the Aging. "County Data Book: Nassau County."

<sup>5</sup> New York State Office for the Aging. "County Data Book: Suffolk County."

<sup>6</sup> Loraine West et al., "65+ in the United States: 2010," United States Census Bureau, June 2014, <http://census.gov/content/dam/Census/library/publications/2014/demo/p23-212.pdf> (accessed September 9, 2016).

behavioral health, and long-term services while delivering quality, coordinated, patient-centered, and cost-effective care. A literature review and discussions with local long-term care industry leaders reveal the following emerging trends across the long-term care sector on Long Island:

- Major federal, state, and private insurer investments are necessary to expand access to long-term care program offerings;
- Avoidable hospital inpatient and emergency department readmissions present an opportunity for operational synergy, continuity of care and cost savings;
- New delivery models are changing the scope of traditional long-term care; and
- Increased resources are being dedicated to home and community-based care programs.

This issue brief discusses the emerging trends across nursing homes, home health, and community-based programs. A complete examination of the full continuum of all long-term care options are beyond the scope of this investigation, but issues raised here could be the basis for a larger report that explore those issues in depth.

## **INTRODUCTION**

The definition of long-term care is multifaceted. Long-term care services generally include the following five distinct service types:

1. Medical/physical care
2. Mental health services
3. Social support
4. Residential amenities
5. Hospice services

At its core, long-term care encompasses a range of services and supports. It is generally defined as hands-on assistance provided for an extended period of time to patients of any age, (though older people are the primary users) who cannot take care of themselves due to a prolonged disability, illness or cognitive impairment such as Alzheimer's disease. Examples of programs may include joint replacement rehabilitation and therapy, medication management, advanced care planning, and assistance with activities of daily living (ADL).<sup>9</sup>

The boundaries among primary, acute, and long-term care have blurred due in large part to changes in patient mix, increased incidence of complex clinical diagnoses and the development of new and innovative delivery and payment models.<sup>10</sup> Depending on the change in condition and functioning, an individual's needs may fluctuate back and forth among the various levels and types of long-term care services. For example, after a hip surgery, a patient may require extensive rehabilitation therapy in a nursing facility for two or three weeks before returning home where the patient would then receive continuing care from a home health care agency. Later, this same patient may suffer a stroke and after hospitalization have to stay indefinitely in a long-term care facility.

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<sup>7</sup> Ibid.

<sup>8</sup> This paper does not discuss cover the full continuum of long-term care options such as hospice, residential care communities and others.

<sup>9</sup> Professional Research Consultants, Inc., "2014 PRC Community Health Needs Assessment Report: Suffolk County, New York. Total Population Findings with a Special Analysis of the Target Population of Medicaid Recipients and Uninsured Patients," <https://suffolkcare.org/pubfiles/2014%20Suffolk%20County%20Community%20Needs%20Assessment.pdf> (accessed September 9, 2016).

<sup>10</sup> Ibid.

There is no single funding source for long-term care. From a financing perspective, the long-term care system is supported by public funds, out-of-pocket expenditures, and private long term care insurance. Long-term care health insurance coverage affects overall access to long-term care services, quality and costs. But it does not come cheap. Contrary to common belief, Medicare, the federal insurance program for those 65 years and older, has not been considered a major payer for long-term care. Medicare focuses on medical acute care, such as doctor visits, drugs, and hospital stays.<sup>11</sup> To be eligible for Medicare post-acute nursing home and home health services, people must require skilled care or therapy services for short periods. Medicare also provides medical care and other services to people with chronic care or long-term care needs. However, home and other care services are limitedly covered.

After Medicare benefits are exhausted, some individuals need long-term care services that must be paid for out-of-pocket, by private insurance, or by the Medicaid program for those with low incomes and assets. Medicaid, the federal/state health insurance program for the poor, is the major public program covering long-term care for the elderly and for disabled people of all ages. Medicaid allows for long-term care coverage through several vehicles and over a continuum of settings. Additionally, state Medicaid programs, such as New York, are partnering with the Centers for Medicare and Medicaid Services (CMS) to pilot a number of grant, state, and federally funded demonstration projects.

Another option to cover long-term care services is private long-term care insurance. However, the rate of adoption and coverage of long-term care services by private insurance entities continues to pose a challenge. To help bridge the coverage gap, New York State developed the NYS Partnership for Long-Term Care (NYSPLTC); a unique Department of Health program combining private long-term care insurance and Medicaid Extended Coverage (MEC).<sup>12</sup> However, across all New York State counties, an average of 2 percent of patients 65 years and over has an active Partnership policy. Although Nassau County performs slightly above the state average with 2.2 percent of individuals 65 years and older with an active Partnership policy, Suffolk County falls behind the state average with 1.9 percent, according to 2014 data.<sup>13</sup>

## **NURSING HOME SNAPSHOT**

Traditionally, nursing homes provide three types of services:

1. Skilled nursing or medical care and related services;
2. Short-term rehabilitation needed due to injury, disability or illness; and
3. Long-term care, which is health-related care and services not available in the community, needed regularly due to a mental or physical condition.<sup>14</sup>

The majority of nursing homes on Long Island are either non-profit or proprietary owned.<sup>15</sup> Nursing homes have transformed from functioning primarily as residential communities for the aging to providers

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<sup>11</sup> United States Department of Health and Human Services, "The Basics," Department of Long-Term Care. <http://longtermcare.gov/medicare-medicare-more/medicare/> (accessed September 10, 2016).

<sup>12</sup> New York State Partnership for Long Term Care, "About the NYS Partnership," <http://www.nyspltc.org/> (accessed September 10, 2016).

<sup>13</sup> New York State Partnership for Long Term Care, "2014 Quarterly Update," [http://www.nyspltc.org/docs/update\\_4th\\_quarter\\_2014.pdf](http://www.nyspltc.org/docs/update_4th_quarter_2014.pdf) (accessed September 10, 2016).

<sup>14</sup> The New York State Department of Health, "Selecting a Nursing Home in New York State: A Guide for Consumers," September 2015, [http://www.health.ny.gov/facilities/nursing/select\\_nh/docs/select\\_nh.pdf](http://www.health.ny.gov/facilities/nursing/select_nh/docs/select_nh.pdf) (accessed July 12, 2016).

<sup>15</sup> Newsday Long Island. Map of Nursing Homes, [http://data.newsday.com/long-island/maps/nursing\\_homes](http://data.newsday.com/long-island/maps/nursing_homes), (accessed August 2, 2016).

of short and long-term social, physical, and mental health services.<sup>16</sup> Nursing homes are primarily designed to provide sub-acute or skilled nursing care for those recovering from an illness or to provide long-term nursing or supervision which is not appropriate for a hospital or available through home care programs. Short term placement in a nursing home may be necessary for a person immediately after an acute illness for a period of rehabilitation. Long term nursing home care may be necessary for the person with multiple health problems which cannot be treated at home or which place too heavy a burden on family and friends.

In 2006, the New York Commission on Health Care Facilities in the 21<sup>st</sup> Century published a report with a plan to stabilize and strengthen New York's health care delivery system.<sup>17</sup> Several recommendations targeted Long Island-based acute and long-term care facilities requesting to downsize nursing home beds, add specialty units and transfer sub-acute services to larger health care systems. The decision to move forward with this approach came in part from an assessment of community health needs and long-term care quality improvement metrics.

The evolution of nursing home service offerings from providing primarily custodial care to rehabilitative care has made way for home and community-based programs. Across Long Island, nursing home facilities are taking cases that were formerly only for hospitals; but they are losing custodial care days to home and community-based programs. In response to the movement towards home-based care, nursing home administrators like Ken Knutsen of Huntington Hills Center for Health and Rehabilitation believe that nursing home facilities that do not currently offer housing or other long-term care services will either expand their service models to meet those needs or downsize into smaller entities tailoring to the short-term rehabilitation population.<sup>18</sup> In Eastern Suffolk County, Peconic Bay Skilled Nursing and Rehabilitation Center, a 60-bed acute and home care facility anchored by the Peconic Bay Medical Center, has evolved their delivery model since the 1980s to accommodate the shift in demand for short-term rehab and home care services.<sup>19</sup> Peconic Bay's skilled nursing facility (SNF) line of business is now almost exclusively tailored to short-term rehabilitation patients, offering services including joint replacement surgery.

Nursing homes, when compared to other long-term care options such as home care and assisted living facilities, are costly. However, costs can vary depending on a number of factors including labor, real estate, type of facility, vacancies, and the type of admission (i.e., short-term vs. long-term).<sup>21</sup> Although the cost of long-term care is high, it varies greatly depending on whether it is accessed at home—from family or paid caregivers—or takes place in a nursing home or assisted living facility. The cost of certain nursing home and other long-term care services and accommodations on Long Island are projected to exceed the New York State average in year 2022, as depicted in the figure below:

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<sup>16</sup> Thomas H. Dennison, "New York's Nursing Homes: Shifting Roles and New Challenges," Medicaid Institute at United Hospital Fund, August 2013, <http://www.uhfny.org/assets/1349> (accessed August 2, 2016).

<sup>17</sup> Commission on Health Care Facilities in the 21<sup>st</sup> Century, "A Plan to Stabilize and Strengthen New York's Health Care System," December 2006, <http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf> (accessed August 7, 2016).

<sup>18</sup> Interview with Ken Knutsen, Huntington Hills Center for Health and Rehabilitation, Adelphi University Center for Health Innovation, August 10, 2016

<sup>19</sup> Interview with Ron McManus, Peconic Bay Skilled Nursing and Rehabilitation Center, Adelphi University Center for Health Innovation, September 12, 2016.

<sup>21</sup> Skilled Nursing Facilities, "Nursing Home Costs," <http://www.skillednursingfacilities.org/resources/nursing-home-costs/> (accessed August 3, 2016).

**Table 1: Side-by-Side Comparison of Annual Long-Term Care Projected Costs in 2022 on Long Island vs. New York State Average<sup>22</sup>**

		2012 Costs		Projected Costs in 2022	
	Service/ Accommodation	Long Island	Long Island		New York State Average
<b>Home Care</b>	Homemaker services	\$45,760	N/A		\$56,496
	Home health aide	\$51,022	\$61,891		\$61,661
<b>Assisted Living Facility</b>	Private one bedroom	\$62,280	\$119,346		\$72,214
<b>Nursing Home</b>	Semi-private room	\$147,205	\$169,329		\$126,554
	Private room	\$156,950	\$190,759		\$197,322

### HOME HEALTH AND COMMUNITY-BASED CARE SNAPSHOT

Home and community based care refers to formal services provided in home or community-based settings and paid for from either private or public funds.<sup>23</sup> Across Long Island, home and community-based services have become increasingly integral to supporting the aged, chronically ill, and those with functional limitations. State and federal officials have been searching for ways to shift care from nursing homes to home or community services in the hopes that this would reduce costs. The focus has been on expanding services, supports and assisted living facilities, thereby reducing the number of older adults who reside in nursing homes.

Like nursing homes, home health care can be expensive. The average cost of home health care in New York State in 2011 was \$20 per hour, according to an industry survey.<sup>24</sup> Assuming 20 hours of care per week, this represents average home health care costs throughout New York State can reach approximately \$21,000 per year.<sup>25</sup>

The home health industry has faced difficulty under Medicare which has capped admitting new agencies into the program and recently offered a negative payment update for home health services.<sup>26</sup> Across New York, the Medicaid program serves as the major financier of home and community-based services. Coverage under the Expanded In-Home Services for the Elderly (EISEP), a state program which provides non-medical care services to the elderly in their homes as well as support services such as case management, is determined by the type of tasks or level of assistance with activities of daily living along with the frequency of services required.<sup>27</sup> Costs are also shared on a sliding scale based on income. For

<sup>22</sup> United States Department of Health and Human Services, “Cost of Care in Your State,” Department of Long-Term Care, <http://longtermcare.gov/cost-of-care-results/?state=US-NY#> (accessed August 6, 2016).

<sup>23</sup> Robert F. Clark, “Home and Community-Based Care in the USA,” Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services, October 1991, <https://aspe.hhs.gov/basic-report/home-and-community-based-care-usa#home> (accessed September 13, 2016).

<sup>24</sup> New York State Department of Financial Services, “The Cost of Long Term Care in New York,” [http://www.dfs.ny.gov/consumer/ltc/ltc\\_about\\_cost.htm](http://www.dfs.ny.gov/consumer/ltc/ltc_about_cost.htm) (accessed September 12, 2016).

<sup>25</sup> Ibid.

<sup>26</sup> Centers for Medicare and Medicaid Services, “CY 2017 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model; and Home Health Quality Reporting Requirements,” <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices-Items/CMS-1648-F.html> (accessed November 5, 2016).

<sup>27</sup> New York State Department of Health, “Expanded In-Home Services for the Elderly,” [https://www.health.ny.gov/health\\_care/medicaid/program/longterm/expand.htm](https://www.health.ny.gov/health_care/medicaid/program/longterm/expand.htm) (accessed September 13, 2016).

example, a patient who only needs help dressing and bathing may receive minimal coverage during fixed times of the day. Contrast that with a patient who requires assistance with ambulating and toileting which would likely equate to a maximum coverage allotment.

Over the last several years, New York State has developed a series of initiatives to expand home and community-based resources for the long-term care, aging population. In 2010, the New York State Commissioner of Health issued a solicitation for five counties to participate in the County Long-Term Care Financing Demonstration Program.<sup>28</sup> Participating counties were permitted to reduce its county nursing bed capacity and, in some instances controversially, close nursing homes in an effort to invest any resulting demonstrated savings into programs or services that encouraged the use of community-based long-term care alternatives to institutional care.

Recognizing the need to accommodate more individuals opting for home care services, other New York State programs such as the Access to Home Program were created to provide assistance with the cost of adapting homes to meet the needs of those with disabilities or functional limitations.<sup>29</sup> The State believes this form of financial assistance enables individuals to safely and comfortably continue to live in their residences and avoid institutional care. Counties on Long Island soon followed suit. In 2008, Suffolk County amended its code, mandating that affordable housing built with county funds must incorporate accessible design.<sup>30</sup> Among the features that can be approved include enlarged doorways and passageways, no-step entrances and blocking between wall studs around the toilet and shower areas for grab bars.

In August 2016, New York State Governor Andrew Cuomo announced a \$50 million dollar funding opportunity to assist counties across New York further develop home care services for the aging.<sup>31</sup> The funding, which is made available through the Expanded In-Home Services for the Elderly Program, will help maximize independence and prevent advanced and more expensive levels of care for seniors; the cost of which is often assumed by Medicaid.<sup>32</sup> This is a case-managed community-based long-term care initiative designed to serve functionally impaired elderly individuals who are lower income but not yet Medicaid eligible. The table below shows the expected county-based allocation and local share in Nassau and Suffolk Counties, respectively:

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<sup>28</sup> New York State Department of Health, "Section 367-v of the New York State Public Health Law - County Long-Term Care Financing Demonstration Program," [https://www.health.ny.gov/regulations/public\\_health\\_law/section/367v/index.htm](https://www.health.ny.gov/regulations/public_health_law/section/367v/index.htm) (accessed August 10, 2016).

<sup>29</sup> New York State Department of Health, "About the Access to Home Program," <http://www.nyshcr.org/Programs/AccessToHome/> (accessed September 13, 2016).

<sup>30</sup> Marcelle S. Fischler, "Aging in Place by Design," *The New York Times*, July 17, 2009, [http://www.nytimes.com/2009/07/19/realestate/19lizo.html?\\_r=0](http://www.nytimes.com/2009/07/19/realestate/19lizo.html?_r=0) (accessed September 15, 2016).

<sup>31</sup> New York State Department of Health, "Governor Cuomo Announces More Than \$50 Million to provide In-Home Services for Seniors," Office for the Aging, <http://www.aging.ny.gov/News/2016/2016News41.cfm> (accessed August 11, 2016).

<sup>32</sup> New York State Office of the Governor, "Governor Cuomo Announces Over \$50 Million to Provide In-Home Services for Seniors," Press Release, August 16, 2016, <https://www.governor.ny.gov/news/governor-cuomo-announces-over-50-million-provide-home-services-seniors> (accessed August 23, 2016).

**Table 2: New York State Expanded In-Home Services for the Elderly, Long Island Allocation, Fiscal Year 2016-2017<sup>33</sup>**

County	State Based Allocation	Local Share	Total
Nassau County	\$3,676,818	\$1,200,606	\$4,877,424
Suffolk County	\$3,695,373	\$1,206,791	\$4,902,164

The program provides non-medical services and supports for seniors who need help with basic daily activities, or require assistance with shopping, cooking, or paying bills. All enrollees are expected to receive care coordination, and when appropriate, could also receive additional supports, including support for caregivers.

## **POLICY DISCUSSION**

**Major federal, state and private insurer investments are necessary to expand access to long-term care program offerings.**

### ***Integration of acute and long-term care services financing***

A primary barrier to the integration of acute and long-term care is the fragmentation of funding sources, particularly between Medicare and Medicaid. While a single source of financing is not essential, integration is impeded when providers lack financial incentives to develop a package of services in various settings that meets the needs of the aging population. Fear of financial risk on the part of health plans may also hinder efforts to integrate across lines of business. Long-term care users need a variety of services across numerous settings (e.g., home, doctor's office, hospital, day center, nursing home), but in the Medicaid and Medicare fee-for-service systems, no single person or organization is responsible for or can impact all needed care, resulting in services that are often characterized as fragmented, uncoordinated and prevalent with unintended financial incentives.

Many mistakenly believe that general health insurance will pay for long-term care or that Medicare will cover it when they get older. In reality, Medicare and most private insurance options does not cover traditional custodial care. Medicare will cover care in a skilled nursing facility or pay for skilled home health care services only when medically necessary, such as following an inpatient hospital stay. Much of the variation in access to Medicare home health services is associated with social and personal conditions and therefore CMS' ability to improve access for certain vulnerable patient populations through payment policy may be limited.

Medicaid is likely to continue to play a major role in financing long-term care at the state level, with increasing flexibility from the federal government for expanded home and community-based options. The role of private long-term care insurance, however, remains the subject of much debate. Private long-term care insurance plays a very limited role in financing care. Many elderly and aging individuals lack the personal savings to pay for care for a significant length of time and generally cannot afford premiums for private long-term care insurance.<sup>34</sup> Regardless of finances, not everyone qualifies for long-term care

<sup>33</sup> New York State Department of Health, "Expanded In Home Services for the Elderly Program," Office for the Aging, [http://www.aging.ny.gov/NYSOFA/Programs/CommunityBased/EISEP\\_FinalAllocations\\_2016-17.pdf](http://www.aging.ny.gov/NYSOFA/Programs/CommunityBased/EISEP_FinalAllocations_2016-17.pdf) (accessed August 15, 2016).

<sup>34</sup> United States Department of Health and Human Services, "The Economic Impact of Long-Term Care on Individuals," Office for the Assistant Secretary for Planning and Evaluation, October 1994, <https://aspe.hhs.gov/basic-report/economic-impact-long-term-care-individuals> (accessed November 1, 2016).



insurance, and insurers might refuse to cover people with certain pre-existing conditions or a mental illness other than Alzheimer's disease or dementia.

Despite ongoing efforts to promote private long-term care insurance, widespread coverage faces a number of significant hurdles, including the affordability of coverage, uncertainty about future premium increases, and disincentives created by the availability of Medicaid coverage.<sup>35</sup> Financing strategies that offer flexibility in how dollars are used will likely appeal to more elderly patients and their families. Policymakers in the public and private sectors should be exploring the advantages of disability-based financing rather than financing that limits consumer choices to a defined set of benefits.

### ***The shift to managed care***

New and innovative statewide efforts attempt to shift patients in need of short-term and long-term care services into managed long-term care programs (MLTC). New York has embarked on a historic reform effort to overhaul the Medicaid program by requiring that all long-term care patients be enrolled in a managed care program. In 2012, New York received approval from CMS to begin the mandatory enrollment of dual eligibles into MLTC plans.<sup>36</sup> The rollout of mandatory enrollment began in September of 2012 in Manhattan, and was then phased in through the remainder of New York City. In January 2013, mandatory enrollment was initiated in Nassau, Suffolk and Westchester counties. Further expansion across the state was implemented as plan capacity grew. By the end of 2014, mandatory MLTC enrollment had been implemented in the majority of counties in New York. Statewide capacity was approved by CMS in mid-June 2015 and achieved by July 2015. Today, MLTC mandatory enrollment is active in all counties in New York, giving any eligible resident the ability to join a long-term care plan in order to better manage their individual care needs.

The manner in which New York is implementing Medicaid redesign is by shifting the program from “fee-for-service” to mandatory MLTC. Under fee-for-service, Medicaid pays for covered services when costs for those services are incurred. Under MLTC, the state will pay insurance companies at specific overall rates to cover the expenses for their plan's beneficiaries. The goal is to hold a single organization responsible for managing the acute, preventive and long term care needs, including home and community needs, of the individual. Managed care entities create incentives for participating network providers to deliver long-term care at the appropriate level of quality while maintaining or reducing costs. For example, in 2012, Aetna Better Health of New York, an Aetna Medicaid company, announced their participation in the program. Serving both Nassau and Suffolk Counties, Aetna manages services that include in-home personal care, care management, adult day care, home-delivered meals and medical supplies, non-emergency transportation, dental, social and environmental support and vision services.

When states delegate functions to managed care organizations, it is difficult to yield full responsibility for management and guidance, especially for the very vulnerable populations that require long-term care services. Significant components of effective oversight include explicit contract language about plans' responsibilities, early attention on the part of states to determining how performance will be measured, and ongoing feedback from consumers and providers to help monitor program operations. Efforts to improve the quality of services and deliver them in a more efficient manner are worthy goals, but if managed long-term care programs are to succeed, careful design based on a thorough understanding of the strengths and needs of the various populations that use them will be important.

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<sup>35</sup> Richard W. Johnson and Cori E. Uccello, “Is Private Long-Term Care Insurance the Answer,” Urban Institute, March 1, 2005, <http://www.urban.org/research/publication/private-long-term-care-insurance-answer> (accessed October 26, 2016).

<sup>36</sup> New York State Department of Health, “Building for the Future Managed Long Term Care Programs in New York,” [https://www.health.ny.gov/health\\_care/medicaid/redesign/ltc\\_forum\\_white\\_paper.htm](https://www.health.ny.gov/health_care/medicaid/redesign/ltc_forum_white_paper.htm) (accessed November 1, 2016).



**Avoidable hospital inpatient and emergency department readmissions present an opportunity for operational synergy, continuity of care, and cost savings.<sup>37</sup>**

Nursing homes across both Nassau and Suffolk Counties have cited avoidable hospital readmissions within 30 days of discharge as a shared concern. Avoidable hospital readmissions of nursing home residents can be traced to a variety of causes including inadequate communication between facilities, lack of advance directives spelling out patients' wishes for end-of-life care, and failure to execute treatment plans in the nursing home.<sup>38</sup> Poor communication, as noted by Peconic Bay Skilled Nursing and Rehabilitation Center, pervades the SNF setting often occurring between emergency room admitting providers and SNF designated nursing staff.<sup>39</sup> Even in instances where nursing facilities are affiliated with a hospital entity, as with Peconic Bay, these issues may still pose a challenge.

As a solution, Long Island-based hospitals including Long Island Jewish Medical Center, a Northwell Health owned hospital, have partnered with think tanks and local stakeholders to help bridge communication gaps by enhancing the ways critical patient information is shared by institutions and with patients and family caregivers. The Interventions to Reduce Acute Care Transfer Program (INTERACT), is a quality and process improvement program, supported by CMS to improve the identification, evaluation, and communication about changes in resident status and develop advanced care planning prior to hospital discharge.<sup>40</sup> Nineteen hospitals, mainly covering the downstate New York region are partnering with 28 nursing homes (1 to 4 nursing homes per hospital) in the program.

Despite the lack of financial incentives to integrate a continuum of care for elders with chronic disabilities, a number of providers are attempting to create integrated service systems with the goal of addressing avoidable readmissions. There are also strong market incentives to develop such systems. Hospitals trying to fill beds, and skilled nursing facilities looking to expand beyond traditional long-term care, see integration as a way to develop business. Hospitals are integrating vertically; buying nursing homes, rehabilitation centers, and home health agencies, in an effort to become an all-purpose provider in the community. Skilled nursing facilities and, to a lesser extent, home health agencies, are more likely to be integrating horizontally; building alliances with hospitals, physicians' groups, assisted living developers, and other community-based providers.

Federal and state value-based demonstration projects such as the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACO), and the Medicaid Delivery System Incentive Payment Program (DSRIP) rely on integrated service systems and are actively assessed on their ability to reduce avoidable hospital readmissions for the aged and disabled populations. Stakeholder forums conducted by the Nassau-Queens Performing Provider System (NQ-PPS), as part of the DSRIP noted that readmissions

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<sup>37</sup> Kenneth S. Boockvar and Orah R. Burack, "Organizational Relationships Between Nursing Homes and Hospitals and Quality of Care During Hospital-Nursing Home Patient Transfers," *Journal of the American Geriatrics Society*, [http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2007.01235.x/epdf?r3\\_referer=wol&tracking\\_action=preview\\_click&show\\_checkout=1&purchase\\_referrer=www.bing.com&purchase\\_site\\_license=LICENSE\\_DENIED\\_NO\\_CUSTOMER](http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2007.01235.x/epdf?r3_referer=wol&tracking_action=preview_click&show_checkout=1&purchase_referrer=www.bing.com&purchase_site_license=LICENSE_DENIED_NO_CUSTOMER) (accessed November 1, 2016).

<sup>38</sup> United Hospital Fund., "IMPACT to Reduce Readmissions Collaborative," [https://www.uhfnyc.org/initiatives/quality\\_improvement/IMPACT](https://www.uhfnyc.org/initiatives/quality_improvement/IMPACT) (accessed September 12, 2016).

<sup>39</sup> Interview with Ron McManus, Peconic Bay Skilled Nursing and Rehabilitation Center, Adelphi University Center for Health Innovation, September 12, 2016.

<sup>40</sup> Suffolk Care Collaborative, "Interventions to Reduce Acute Care Transfer Program," <https://suffolkcare.org/aboutDSRIP/projects/2bvii> (accessed September 7, 2016).

could be avoided with improved responsiveness, more timely discharge reports from hospitals, improved patient and family education, and standardized evidence-based protocols.<sup>41</sup>

Integrated health systems such as Northwell Health developed a continuing care network of non-owned, post-acute providers as a strategy to pull together providers to work together on a number of objectives, such as reduced readmissions, decreased post-acute care costs, and improved quality of care.<sup>42</sup> Starting in 2008, Northwell Health assessed potential post-acute partners using several quality metrics, including nurse staffing ratios and star ratings on Medicare's Nursing Home Compare. From a list of 266 potential facilities, the health system initially selected 19 for its SNF affiliate network after reviewing geographic proximity to system hospitals, referral patterns and quality data. By instituting frequent monitoring, patient assessments on every shift and other components, early successes included a reduction in heart failure rehospitalization rates within the SNF affiliate network from approximately 6 percent in 2010 to 2 percent in 2012.

### **New delivery models are changing the scope of traditional long-term care.**

#### ***Bundled and episodic models***

Nursing home facilities and home health agencies are among the cohort of providers that have entered into agreements to take part in federal and state demonstration programs such as the Bundled Payments for Care Improvement (BPCI) Initiative, administered by the Centers for Medicare and Medicaid Services. The BPCI initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care, such as a hip replacement.<sup>43</sup> These models may lead to higher quality and more coordinated care at a lower cost to Medicare. The BPCI includes physicians, physician group practices, post-acute providers, and hospitals as "episode initiators." Given the variety of care providers involved in an episode of care, strategic partnerships across Long Island have been fostered between skilled nursing facilities and hospitals. Hospitals including Huntington Hospital, Winthrop University Hospital, and South Nassau Communities Hospital are all active participants in BPCI.<sup>44</sup>

Among the small handful of Long Island based nursing home providers participating in BPCI, Huntington Hills Center for Health and Rehabilitation believes these types of models are the way of the future.<sup>45</sup> Huntington Hills accounted 29 percent of all total Medicare days were attributed to BPCI or related value-based program in July 2016 with that number expected to rise in future years.

Despite successes, some industry leaders argue that bundled payments may hinder the ability for a patient to choose the most appropriate and preferred setting to receive care services. The impact of bundled payments on the patient experience is not widely researched. Arguably, "unbundling" certain services may better support the move towards consumer-directed and family-centered care.

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<sup>41</sup> Nassau-Queens PPS, "Community Needs Assessment," [http://www.nq-pps.org/application/files/2614/3395/4403/FINAL - Nassau\\_Queens\\_PPS\\_Community\\_Needs\\_Assessment\\_Report.pdf](http://www.nq-pps.org/application/files/2614/3395/4403/FINAL_-_Nassau_Queens_PPS_Community_Needs_Assessment_Report.pdf) December 2014. (accessed July 12, 2016).

<sup>42</sup> Healthcare Financial Management Association, "Bridging Acute and Post-Acute Care," November 2013. <http://www.hfma.org/acutepostacute/> (accessed August 30, 2016).

<sup>43</sup> Centers for Medicare and Medicaid Services, "Bundled Payments for Care Improvement (BPCI) Initiative: General Information," <https://innovation.cms.gov/initiatives/bundled-payments/> (accessed August 10, 2016).

<sup>44</sup> Centers for Medicare and Medicaid Services, "BPCI Initiative Episodes: Details on the Participating Health Care Facilities," <https://innovation.cms.gov/initiatives/Bundled-Payments/Participating-Health-Care-Facilities/index.html> (accessed August 10, 2016).

<sup>45</sup> Interview with Huntington Hills Center for Health and Rehabilitation

### ***Targeting medically complex, dually-eligible seniors***

Given the complexity of the Medicare and Medicaid dually-eligible population across Long Island, demonstration programs such as the Fully Integrated Duals Advantage (FIDA) Demonstration were developed to help provide synergy between the two public insurance programs. FIDA builds off the existing MLTC program. It is a joint Medicare and Medicaid demonstration designed to integrate care for New York eligible individuals who have both Medicare and Medicaid and who reside in a targeted geographic area. Individuals who choose to participate receive both Medicare and Medicaid coverage, including Part D prescription drugs, from a single, integrated FIDA managed care plan.

FIDA was designed to enhance what is offered under existing models by providing more services (such as behavioral health services and home and community-based waiver services), along with a more intensive participant- centered care coordination model. The model assumes that this enhanced approach will result in better health outcomes as well as result in cost savings.

### **Increased resources are being dedicated to home and community-based care programs.**

#### ***Shift in demand for short-term vs. long-term care services***

As a result of demographic trends and increased interest in non-institutional long-term care options, there will be an increased demand for home health and community-based services. Advisory bodies like the Long Island Regional Advisory Committee (RAC), a consortium of regional hospital and health care leaders, recognized the importance of service expansion and restructuring early on. In 2006, they issued recommendations to the New York Health Care Commission which included recommendations for service expansion and care coordination strategies across the home health market.<sup>46</sup>

Increased patient interest in home health and community based options has proven to be controversial. While data trends show that short-term nursing home stays increased throughout New York State, particularly across Long Island, some nursing home administrators believe short-term rehabilitation will eventually shrink as more patients opt for home health care or community-based services.<sup>47,48</sup> Moreover, administrators note that hospitals largely responsible for driving patients to either a skilled nursing facility (SNF) or home care setting recognize the cost benefits and growing patient preference for home care.

#### ***Interplay with assisted living***

The growth of the assisted living industry, which unlike community supportive housing is considered an option primarily for those that can afford higher out-of-pocket expenses, is also expected to grow. Assisted living programs often charge “a la cart” and still engage in mainly fee-for-service reimbursement models. However, one of the challenges is once a patient hits their out-of-pocket maximum, often they return back to a nursing home setting, as noted by Ken Knutsen, Administrator at Huntington Hills Center for Health and Rehabilitation.<sup>49</sup> In response to the increased need for assisted living and housing, a number of historically traditional nursing facilities across Long Island have expanded their service offerings to meet the growing needs of this population. For example, in August 2016, Gurwin Jewish

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<sup>46</sup> Commission on Health Care Facilities in the 21 Century, “Findings of the Long Island Regional Advisory Committee,” October 2006. <http://www.nyhealthcarecommission.org/docs/final/appendix2-longislandrac.pdf> (accessed August 28, 2016).

<sup>47</sup> Interview with Stuart Almer, Gurwin Jewish Nursing and Rehabilitation Center, Adelphi University Center for Health Innovation, August 3, 2016.

<sup>48</sup> Gurwin Jewish Nursing and Rehabilitation Center is a 460-bed sub-acute and long-term care full-service nursing facility which caters to Nassau, Suffolk and Queens county residents.

<sup>49</sup> Interview with Huntington Hills Center for Health and Rehabilitation

Nursing and Rehabilitation built a 230-bed residential complex for patients interested in assisted living options.<sup>50</sup>

As such, the availability of a variety of affordable residential options are key considerations for policymakers. Local policy makers will need to continue to assess the relative availability of non-institutional long-term care alternatives, such as adult day health care, long-term home care, and supportive housing. Assisted living is largely available only to those that can afford to pay often exorbitant out-of-pocket costs. Policy and local decision makers will need to address the question of how to make assisted living affordable for the modest and low-income aging population. In addition, these long-term residential options should also be responsible for providing certain service provisions and disease-specific programs.

## **CONCLUSION**

The long-term care infrastructure on Long Island will continue to undergo reforms. The growth in the number, proportion, and diversity of the aging population calls for the development of a range of delivery options to meet patient's needs. Most people will need some form of long-term services and supports in their lifetime, including assistance with daily activities such as bathing and dressing, because of a physical impairment or a cognitive impairment like Alzheimer's disease.

Additionally, policymakers will need to address the patchwork of public and private financing options that lack a uniform public policy or care framework. Medicare and Medicaid continue to suffer from gaps in coverage and poor coordination. While the majority of long-term services have been provided by Medicare and Medicaid, funding deficiencies at the state and federal level have placed a focus on the importance of private long-term care insurance. However, the market for these insurance products has been rocky and remains small. Caregivers are covering a sizable percentage of long-term care costs through out-of-pocket spending, which can deplete personal savings, retirement accounts, and other assets.<sup>51</sup> Not surprisingly, heavy long-term care costs and depleted personal savings have pushed more and more of the financing burden onto Medicaid, which in turn strains New York State's finances. With a growing aging population, future long-term care costs threaten to cripple the State budget. This may prove to be unsustainable.

The nursing home will remain an option for those with disabilities, acute, short-term conditions or those with insufficient or inadequate living arrangements. However, concerns about nursing home costs have spurred current efforts to make it possible for greater numbers of elderly individuals to receive services at home rather than in an institution. For that strategy to be successful, states and the federal government will need to reexamine Medicare payment regulations so that in-home Medicare beneficiaries can receive customized services and the appropriate personnel are adequately paid.

Given many individuals wrongly believe their potential long-term nursing home costs will be covered by Medicare or private insurance, there needs to be improved information about the need for savings and insurance dedicated to long-term care. State and local educational campaigns should address the lack of affordable long-term care financing options and encourage both young and older populations to set aside private savings and insurance in preparation for later needs. Of course, this is easier said than done as it requires a cultural shift as much as an increase in household financial capacity.

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<sup>50</sup> Interview with Gurwin Jewish Nursing and Rehabilitation Center

<sup>51</sup> The SCAN Foundation, "Financing Options for Long-Term Care: Who Benefits and at What Cost? Policy Brief," November 2015, [http://www.thescanfoundation.org/sites/default/files/lc\\_financing\\_summary\\_of\\_policy\\_modeling\\_november\\_2015.pdf](http://www.thescanfoundation.org/sites/default/files/lc_financing_summary_of_policy_modeling_november_2015.pdf) (accessed September 12, 2016).

The future long-term care system should also recognize all the options that can meet the residential and care needs of the individual and recognize that these needs do not necessarily increase in neat, predictable steps. The system must be flexible enough to address the acute, chronic, and non-medical social needs—such as housekeeping and transportation—of the long-term care patient, which may fluctuate over time.

More research is needed to illustrate the financial viability of the Long Island long-term care market and the possible impact of shifts in patient preference to home and community based services on the nursing home industry.

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