



New York Association of Homes & Services for the Aging

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Public Hearing Testimony

# **Long Term Care Compact A.10634-A**

**Submitted to:**

**Committees on Aging, Health and Insurance**

**Presented by:**

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New York Association of Homes and Services for the Aging

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Assembly Hearing Room, Room 1923  
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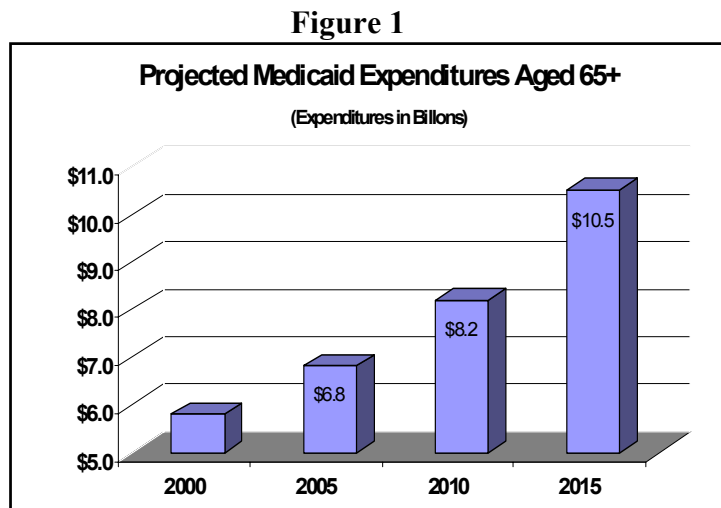
## Introduction

On behalf of the New York Association for Homes and Services for the Aging (NYAHSAs), I thank you for the opportunity to provide testimony regarding the Long Term Care “Compact” (A.10634-A), which would create a new approach to finance long term care services. My name is Wendy Saunders, and I am NYAHSAs’s Director of Government Relations.

NYAHSAs is a statewide organization of socially responsible, community-benefit organizations dedicated to providing high quality health care, housing, and community services to the elderly and people with special needs. NYAHSAs’s 630 members serve an estimated 500,000 New Yorkers annually. NYAHSAs’s mission is to represent its members and promote the association’s vision through ethical leadership, advocacy, education, research, information, and other services. NYAHSAs’s members include nursing homes, adult care facilities, assisted living providers, continuing care retirement communities, senior housing facilities, home care agencies, adult day care providers, and community services serving people of all ages.

NYAHSAs has long advocated for increasing private financing options for long term care services. We commend the sponsors of this legislation and committee members for seeking to address this critical need.

New York is facing a “demographic imperative” to address financing of long term care (LTC) services. By 2025 when most of the “baby boomers” have reached retirement age, the numbers of New Yorkers in the 65+ and 85+ age cohorts will have increased by 42 percent and 39 percent, respectively. When combined with the overall aging of the population, and in the absence of financing reforms, this explosive growth will undoubtedly place an unsustainable burden on Medicaid financing of LTC services. Figure 1 below shows how Medicaid expenditures for elderly New Yorkers are projected to grow over the next decade.



*Source: NYS Office for the Aging*

In 2003 NYAHSAs formed a Medicaid Reform Task Force, which issued a comprehensive report, *Preserving Long-term Care for the Long-Term Future* (excerpts attached). The overarching purpose of the NYAHSAs task force was to provide input on ways to make New York's Medicaid program more efficient while providing quality health care, particularly in the area of LTC services and supports. Two areas the task force examined and developed recommendations for reform on are very relevant to today's topic: (1) Medicaid eligibility and (2) private financing options. As indicated in our report, individuals' perceptions and behaviors about accessing LTC services do not square with reality and often result in delayed, poor decision-making. The widespread reluctance to plan for future LTC needs is rooted in a number of complex factors, including: (1) misperceptions about the likelihood of needing such services; (2) lack of understanding of how LTC is financed and what services are available; and (3) limited options to finance LTC costs.

Others view the program as a government entitlement that can and should be used to pay for care and services, without spending all of one's assets. Complex eligibility rules and the high cost of LTC have stimulated the development of a growing "elder law" establishment that assists individuals with financial means to shield or divest assets and qualify for Medicaid benefits.

We believe that the federal, state and local governments are thoroughly unprepared for the challenge of funding LTC services for the huge baby boom generation. While Medicaid has served an essential role in providing catastrophic coverage for LTC costs, it has created a dangerous disconnect between the individuals receiving covered services, the taxpayers supporting the costs, and the governments that administer the program. Over-reliance on Medicaid has de-sensitized the public to the risk of needing LTC services, reinforced an entitlement mentality towards the program, led to greater confusion about who pays the LTC bills and why they are seemingly high, and adversely affected the marketability of private LTC insurance.

As a means-tested program, Medicaid requires applicants to demonstrate that they are impoverished. This does not present an issue for individuals and families that are truly poor on the basis of income and assets even before they apply for benefits. However, it becomes a very real issue for people who do have assets and/or income above the Medicaid thresholds. Many of these individuals are literally forced in one of two directions to qualify for Medicaid—to exhaust their assets and contribute income to pay out-of-pocket for their care; or to divest or shield assets/income. Both paths inevitably lead to dependence, reliance, loss of control and limited service options.

Understandably, people who have worked or saved all of their lives may wish to give or bequeath money to their relatives or friends, in lieu of impoverishing themselves paying for often expensive LTC services. Medicaid rules offer many completely legal strategies to obtain eligibility without actual impoverishment through what is known as "asset divestiture" or "estate planning." Under Medicaid law, assets can be divested by transferring ownership to others; converting countable assets (e.g., cash, investments, etc.) to non-countable assets (e.g., automobiles, burial arrangements, etc.); or appealing

for an increase in the amount of assets the well spouse is allowed to keep. In effect, this results in taxpayer-supported private inheritances as individuals with financial resources transfer those resources to others and access Medicaid. We do not believe that this is what society intended when Medicaid program was established as a safety net program for the genuinely poor.

While most agree the practice of shielding ones' assets occurs, there is ongoing debate about the extent of the asset divestiture phenomenon. Rather than walking through various findings on this subject, I will refer you to the attached excerpts from our report, in which we explored the literature in some detail.

We are pleased that the Compact legislation seeks to add a new option to finance LTC costs. In our report, we recommended the creation of a mechanism like the Compact to counteract the incentive to shield or divest assets and increase the level of private financing of LTC services. At the same time, the Compact has the potential to increase consumer choice and to expand the availability of services that are not currently covered under Medicaid (e.g., home modifications, informal supports), but have the potential to keep individuals in their homes or in less-restrictive levels of care than would be possible if they were receiving services under the Medicaid program.

For these reasons, we believe that introduction of this legislation and today's hearing are important steps forward in elevating this critical discussion to the forefront of public debate. However, we have a number of questions and concerns around the legislation, which are discussed in the balance of my testimony.

### **Eligibility Issues**

The federal Deficit Reduction Act of 2005 (DRA) and corresponding changes made in this year's state budget include several measures designed to limit asset divestiture. It is unclear what impact these changes will have over both the short-term and long-term. However, we must take this opportunity to express our continued concern that the changes could have the unintended consequence of dramatically increasing the volume of uncompensated care being provided by nursing homes and other continuing care providers. We believe the state should create a funding stream to address this important issue.

The Compact legislation, as currently drafted, appears to be in conflict with some of the changes made under the DRA. Under the Compact, only three years of financial records will be examined, including those relating to asset transfers, rather than the five-year rule imposed under DRA.

It also appears that, in some ways, the Compact differs from current state law with respect to countable assets and income, as well as treatment of couples. It is unclear to NYAHS why this would be the case. We recommend refining the legislation to include direct references to Medicaid rules in these respects, which would also have the benefit of automatically adjusting as future changes are made.

In addition, we would be remiss if we did not take this opportunity to recommend further changes with regard to Medicaid eligibility as follows: (1) grant spousal impoverishment protections to community spouses of home and community based services recipients and then severely limit the use of spousal refusal or eliminate it with a tightly defined hardship exception; (2) strengthen estate recovery activities; and (3) review Medicaid eligibility rules and documentation requirements to identify opportunities to streamline determinations and promote uniformity. These recommendations and surrounding issues are spelled out in detail in the attached sections of our report.

## **Long Term Care Insurance**

There have been a number of recent changes designed to increase the number of individuals purchasing LTC insurance. These include new options under the New York State Partnership Program, state income tax incentives and a consumer education program. As with the recent Medicaid eligibility changes, it is too early to tell what impact these changes will have. However, more can be done in this area. You will find a series of comprehensive recommendations in this area in the attached excerpts of our report.

We are pleased that representatives from the insurance industry have indicated that new insurance options would likely be developed around the Compact. We encourage the sponsors of the legislation to take any steps necessary to encourage this development in connection with enactment of the Compact.

## **Quality Issues**

While NYAHSA is pleased that the Compact would allow payment for a greater array of services, we are concerned that it could create a situation where unlicensed providers/staffing agencies could provide publicly funded care free from the rules that govern licensed providers. The laws and regulations governing licensed providers are carefully crafted to ensure that quality care is provided.

In addition, under the Compact the assessment and care management process would vary significantly from that required of licensed providers, in that licensed social workers would be allowed to independently perform both of these functions. In addition, no mechanism would exist to determine the appropriateness of the care plan or the services provided. It is also unclear what would happen with respect to the assessment and care plan when a participant enters the subsidy period.

Further, while the legislation would require an annual assessment and an additional assessment when there is a significant change in the participant's condition, there is no requirement for care management. NYAHSA is concerned that, without on-going care management by licensed health care providers, unlicensed providers with no formal training may not be able to appropriately identify when such changes occur.

## **Payment Issues**

NYAHSA has a number of concerns related to payment issues under the Compact. To begin with, the pledge would be based on the cost of three years' worth of nursing home care. However, this number is no longer an accurate reflection of the average length of nursing home stay. For example, on a statewide basis less than 20 percent of all residents discharged in 2004 had stayed six months or more. Accordingly, the sponsors may want to consider adjusting the legislation to reflect this.

NYAHSA is pleased that the legislation has the potential to both increase the number of individuals paying the "private pay" rates for LTC services, and that payment during the subsidy period would be 10 percent greater than the Medicaid rate the provider would otherwise receive. However, we are very concerned about the current mechanism in the legislation that would require the provider to collect the additional 10 percent. This would create an administrative burden for providers. We would respectfully request that the legislation be amended to require the participant to submit the 10 percent to the program management entity (PME) when they submit their required income contribution. The PME should then remit the full payment to providers.

We are also concerned that, with the exception of a 30-day time frame on initial determinations of eligibility for the Compact, the legislation contains no time frames related to payment for services. Additionally, we are concerned about the period of time during which a participant transitions from the pledge period to the subsidy. We would like the legislation to clearly reflect time frames for PME determinations of appropriateness of services, including any appeals, to ensure no significant gaps in payment to providers. Further, the legislation allows for the subsidy to be paid either to the provider or participant. We strongly recommend that the payment be made directly to the provider to ensure full and timely reimbursement.

NYAHSA also seeks to have the legislation refined around the PME's process for determining "usual and customary" charges for services rendered during the pledge period, and to specifically include appeals to the PME's decisions related to the adequacy of payment in the appeals section of the legislation.

Because the Compact would allow for a broader array of services than are currently provided under Medicaid, the Department of Health (DOH) will need to set rates for these services. In addition, the legislation would allow DOH to reduce payments for services in some instances. The legislation should better reflect these processes and ensure provider input into any rate-setting mechanisms.

While both of these endeavors require the consultation the advisory committee, we are concerned that a nine-member panel with only two provider representatives will be ill-equipped to make recommendations. We propose either increasing the size and provider representation of the advisory panel, or creating a provider issues and integrity committee to mirror the consumer committee created under the current legislation. This committee could address quality issues in addition to those related to payment for services.

In discussions about the Compact, it has been indicated that the PME would be paid through some form of participant “user fee.” This fee and any others that could be applied to participants or providers should be clearly spelled out in the legislation.

The legislation also does not clearly address instances where a participant reaches the subsidy limit or is unable or unwilling to make required payments during the subsidy period. If the participant is receiving institutional care, providers could be stuck providing uncompensated care due to the practical inability to discharge such an individual for non-payment.

NYAHSAs also questions how the Compact would work for individuals with less than the \$20,000 in assets that appears to trigger the pledge, and why individuals must be denied LTC insurance to establish qualified LTC savings accounts.

### **Other Issues**

NYAHSAs questions why the legislation includes its own definitions (e.g., activities of daily living, severe cognitive impairment, health care practitioner) rather than referencing existing definitions. Conflicting or duplicative definitions will be difficult to administer, and make the Compact and any complementary insurance products harder to understand for consumers.

The state is currently undertaking a series of initiatives to reform the LTC system (e.g., LTC Point of Entry, nursing home transition and diversion waiver, “Mega Waiver”). It is unclear to us how the Compact would intersect with these initiatives. For example, the LTC Point of Entry may require all public pay clients and anyone using nursing home care to go through a screening and assessment process. Such a process could conflict with the standards that would be established for the Compact.

NYAHSAs strongly believes that, if the Compact is enacted, a much more comprehensive consumer education campaign than is currently contemplated under the legislation will be necessary to ensure success of the initiative. We also believe that providers should be specifically included as an education target.

In addition, NYAHSAs is concerned that issues raised in research on current consumer directed programs may equally apply to the Compact. The concerns are regarding: (1) the capacity of older people to manage their own care, largely related to the prevalence of cognitive impairment, and the need to rely on surrogates who may not carry out the person’s preferences; (2) how to monitor the quality of care in these programs; (3) the effects of worker shortages on participant choice; and (4) the inherent conflicts and issues that arise when family workers are paid for their services.<sup>1</sup>

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<sup>1</sup> Jane Tilly, Joshua M. Wiener, Consumer-Directed Home and Community Services: Policy Issues, Published: January 01, 2001, The Urban Institute.

## **Conclusion**

NYAHSAs embraces the goals of the LTC Compact legislation. However, we believe that significant questions remain concerning program standards, implementation and administration. We are prepared to continue to work with the sponsors and committees to address these concerns.

On behalf of NYAHSAs, I thank you for the opportunity to testify for our members and the thousands of elderly and disabled individuals they serve each and every day. I would be pleased to answer any questions you may have on our testimony.

## **Attachment**

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