NEW YORK STATE OF OPPORTUNITY. Department of Health

Recommendations for Revision of the Residential Health Care Facility Bed Need Methodology

Health Planning Committee of the Public Health and Health Planning Council

March 30, 2016

Agenda

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Rationale for the RHCF Methodology

Methodology Background

- Public Health Law (PHL) §§ 2801-a and 2802 requires a finding of public need for establishment of a new Residential Health Care Facility (RHCF) or construction of an existing or new RHCF
- The RHCF need methodology is set forth in regulation (10 NYCRR § 709.3) and establishes criteria for determining whether such public need exists
- The methodology was initially implemented to determine the appropriate and efficient allocation of capacity within the long term care system, promoting access and financial sustainability

Impact of the Methodology

- Some stakeholders have suggested that due to changes in the health care system, the methodology no longer serves its intended objectives and should be discontinued in favor of market forces
- Other stakeholders have asserted that discontinuance of the methodology could jeopardize the stability of the long term care system
- Before determining to take such a step, it is critical to assess the impact of ongoing transformative initiatives and trends in the health care system and understand how they interface with the long term care system
- These include Care Management for All, the Delivery System Reform Incentive Payment (DSRIP) Program, Value-Based Purchasing (VBP) and the movement towards more community-based long term care settings

Transformative Initiatives

- Care Management for All, which will shift virtually all Medicaid enrollees into managed care by April 2018, will improve benefit coordination, quality of care, and patient outcomes and is underway for the nursing home population
- Under the five-year DSRIP Program, which began April 1, 2015, Performing Provider Systems (PPSs) are collaborating in projects to achieve system reform in order to reduce avoidable inpatient and emergency department admissions through improved discharge planning and decreased service fragmentation
- Innovations in payment, such as payment bundling and VBP (80 to 90 percent of Medicaid payments to providers will be value based by 2020), are likely to impact long term care service planning
- It is difficult to predict the impact on the post-acute care industry of the system-wide shifts that will arise from these initiatives

Goals of the RHCF Methodology

Statement of Goals

The RHCF need methodology should be revised to support the following principles:

- The methodology should seek to ensure access to appropriate long term care settings
- In estimating need, the supply of all provider types (institutional and community-based settings) should be considered
- Sufficient flexibility should be afforded to allow consideration of local factors and the changing health care system
- The methodology should be effective for a duration that is only as long as is needed to understand the impact on long term care of ongoing transformative changes in the health care system

Key Environmental and Policy Dynamics

Profile of New York State Population

TABLE I Profile of New York State Population			
	2006[1]	2014[2]	2020 (projected)[2]
Total Population	19,306,183	19,746,227	19,697,021
Population, 65 Years and Older	2,522,686	2,898,094	3,115,588
Population, 80 Years and Older	756,432	802,640	747,241

TABLE II Long Term Care Utilization		
	2006	2014
RHCF (resident days)	107,587	99,245
Adult Care Facilities (number of residents)	N/A	36,195
CHHAs (number of providers)	140	136
LHCSAs (number of providers)	995	1,249
LTHHCPs (number of providers)	96	80

[1, 2] Source: US Census Bureau
[3] Source: Cornell University

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Profile of RHCF System

TABLE III Profile of RHCF System		
	2006	2014
Number of Beds	116,383	109,138
Occupancy	93.7%	92.9%
Payer Mix		
Medicaid	75.2%	72.1%
Medicaid Managed Care	3.5%	6.6%
Medicare	10.9%	11.6%
Commercial	0.3%	0.7%
Self-Pay	10.0%	8.9%
VA	0.1%	0.2%
Length of Stay [1]		
Less than 30 Days	53.4%	55.3%
30 Days to 1 Year	34.6%	35.5%
One Year and Greater	12.0%	9.2%
Projected Bed Need	123,403	121,349
Ownership Status		
Number of Facilities		
Not-For-Profit	283	237
Municipal	53	37
For-Profit	322	350
Total	**658**	**624**
Number of Beds		
Not-For-Profit	51,811	41,501
Municipal	12,049	9,096
For-Profit	56,631	63,104
Total	**120,491**	**113,700**

[1] Length of Stay for all NYS RHCF patients discharged during 2006 and 2014

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Summary of Dynamics

- The population of New York State is aging, particularly with relation to the “baby boom” generation (Table I)
- Many individuals and their families prefer to utilize community-based alternatives to institutional settings where appropriate, consistent with Olmstead (Table II)
- Individuals who do need nursing home care and their loved ones generally prefer to remain close to home in their communities
- The implementation of Care Management for All in nursing homes is underway
- PPSs have commenced carrying out their DSRIP project plans, which will have an overall impact on hospital utilization
- VBP will address system fragmentation and promote more cost-effective modes of care, potentially impacting RHCF utilization

Summary of Dynamics (continued)

- Payer mix data demonstrates that Medicaid continues to be the predominant payer in the nursing home area (Table III)
- The use of short stays, which includes post-acute rehabilitation admissions reimbursable by Medicare, is increasing (Table III)
- In 2006, the statewide occupancy rate was 93.7 percent and there were 116,383 beds and in 2014, the rate was 92.9 percent, when there were 109,138 beds (Table III)
- Between 2006 and 2014, several replacement facilities were constructed and several nursing homes undertook major renovation projects, but no new facilities were established and constructed

Timeframe

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- As recommended herein, the methodology should be revised and should be effective for a five-year period
- This should allow sufficient time to assess the impact of initiatives such as care management and DSRIP, particularly the intersection of these reforms and the long term care system
- This should avoid the use of old data and projections that are too far into the future
- During the interval, there should be a continuing reevaluation as to whether a methodology will be necessary in future years
- Information should be collected and reviewed on an ongoing basis to assist in that consideration

Recommendations

Revise the RHCF Methodology and Collect Data

- The methodology should be revised and applied for a five year period (update the planning target year from 2016 to 2021)
- The need methodology should function as a guideline and is not meant to be an absolute predictor of the number of beds needed in each planning area
- Information should be continually collected during that time to help assess options at the end of the five year period, including data on the managed long term care population and the RHCF penetration rate, growth in community-based provider supply (e.g. home care and assisted living), and RHCF occupancy trends, payer mix, case mix index and length of stay
- Information should be presented to the Health Planning Committee at the end of the second, third and fourth years for purposes of such discussion

Revise the Base Year and Trend Use Data

- The base year should be updated to 2014, which is the most recent data available
- In addition, the methodology should employ trended “use rates” for the planning area
- Further, to give a better profile of each planning area, the methodology should be revised so that planning area bed estimates are no longer blended with statewide figures

Revise the Planning Areas

- While allowing consideration of adjacent areas, the methodology uses the county as the planning area except for New York City and Long Island, each of which is a separate planning area
- County boundaries are an appropriate starting point but do not reflect the full range of considerations relevant to bed need estimates, such as reflecting the sparsely populated nature of rural regions or recognizing the natural boundaries of a densely populated area with defined communities
- The methodology should be revised to treat counties (including each county within New York City and Long Island) as a starting point, but permit flexibility in redefining the planning area for a particular application based on factors such as population density and travel time (including mass transit availability, geography and typical weather patterns)

Revise the Use of Migration Data

- The current methodology considers migration of individuals from their home counties to RHCFs in other counties by applying a universal migration adjustment, which may not be optimal in all planning regions
- To take a more nuanced approach, an adjustment should be applied in regions where appropriate

Revise the Occupancy Rate Threshold

- Currently, if the overall occupancy rate in a planning area is less than 97 percent, the Department determines whether to decertify beds in connection with a renovation or ownership transfer application and considers “local factors” in this determination
- Concerns have been raised that the 97 percent threshold level is high relative to actual experience, particularly because it does not differentiate subacute (short stay rehabilitation) utilization
- Therefore, the threshold should be revised to 95 percent for major renovations and for ownership transfers, while retaining consideration of “local factors”
- Such local factors should include the size of the facility, its proximity/travel time to other facilities, configuration of the facility’s nursing units, percentage of Medicaid admissions and the quality of nursing homes in the planning area (using the Centers for Medicare and Medicaid Services quality measures)
- The 97 percent threshold should be retained for net new beds