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

Health Planning Committee Report to the Public Health and Health Planning Council

April 14, 2016

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

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Our Current Environment

- Changing demographics

- Increasing reliance on community-based services

- Delivery System Reform Incentive Payment (DSRIP) Program requirement to reduce avoidable hospital utilization

- Movement to value-based payments

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Recent Trends

- Declining utilization of RHCF beds

- Declining number of RHCF beds

- Conversion from municipal and non-profit ownership to for-profit status

- Continuation of Medicaid as the predominant payer for RHCF residents

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Statement of Goals for the Revised Methodology

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

- The methodology should seek to ensure access to appropriate and available 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, including the special needs of a facility's population and the quality of nursing homes in the planning area, and allow responsiveness to the changing environment

- 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

- 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 and trends in the health care system

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Revise the Methodology Effective for Five Years

- The methodology should be revised and should be effective for a five-year period (update the planning target year from 2016 to 2021)

- This will avoid the use of old data and projections that are too far into the future

- This also should allow sufficient time to assess the impact of ongoing initiatives and trends (including care management, DSRIP, value based purchasing, the movement towards community-based settings and the aging of the population), particularly the intersection of and alignment between these reforms and the long term care system

- During the interval, there should be a continuing reevaluation as to whether a methodology will be necessary in future years, and information should be collected and reviewed on an ongoing basis to assist in that consideration

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Collect Data and Reevaluate

- Information should be continually collected during the five year period to help assess options at the end of such interval, including data on:

  - the managed long term care population and the RHCF penetration rate, including the number of managed long term care plans in each planning area and enrollment

  - number and composition of long term care/post-acute provider networks across the State

  - growth in community-based provider supply (e.g. home care and assisted living)

  - RHCF occupancy trends, payer mix, case mix index and length of stay

  - source of referrals to RHCFs and utilization of RHCFs for non-custodial care, including care for individuals with short-term rehabilitative, ventilator, dementia and traumatic brain injury (TBI) needs

- Information should be presented to the Health Planning Committee at the end of the second, third and fourth years for purposes of such discussion

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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

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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)

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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

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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

- 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"

- Local factors should include the size of the facility, its proximity/travel time to other facilities, configuration of the facility's nursing units, special needs (including behavioral health) of the population served by the facility, 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

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