



Testimony

**NYS Assembly Committee on Health
Hearing on Rural Health Care Services**

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Introduction

On behalf of the membership of LeadingAge New York, thank you for your attention to the significant challenges facing rural health care providers and the New Yorkers they serve. We appreciate the opportunity to present testimony today on the issues confronting providers of long-term and post-acute care and senior services in rural communities.

LeadingAge New York represents over 400 not-for-profit and public providers of aging services long-term and post-acute care (LTPAC). Our members cover the entire continuum of LTPAC and senior services and include senior housing, home care agencies, medical-model adult day health care programs, social adult day care programs, assisted living facilities, nursing homes, managed long term care (MLTC) plans and PACE programs. Our members also cover the entire state from Jamestown in Chautauqua County to Ogdensburg in St. Lawrence County to Greenport on the tip of Long Island.

Our testimony today highlights just a few of the daunting challenges facing LTPAC providers and MLTC/PACE plans serving rural communities. As the Committee has noted, these challenges include: workforce shortages, insufficient payment rates, a lack of transportation to bring providers to consumers and vice versa, dispersion of consumers over large geographic regions, insufficient population density to achieve scale and efficiencies, and inadequate housing stock. Many of these challenges are also experienced by LTPAC providers and consumers in urban, suburban and exurban communities throughout the state, but they are more pronounced and more difficult to address in rural communities. Our testimony highlights some strategies that can ameliorate these issues, but they are not cheap or easy. They require sensible investments, a willingness to innovate, community engagement, and sustained attention. Given the rising portion of our population over the age of 65 and shrinking percentage of working age adults, especially in rural communities, it is imperative that we act now to ensure that we have the capacity to care for older adults with functional limitations and individuals with disabilities in rural areas.

I. Demographic Changes

New York is home to approximately 3.2 million residents age 65 and older, representing 16 percent of the population, and growing. Between 2007 and 2017, the population of New Yorkers statewide who are 65 and older grew 26 percent, or by 647,000. At the same time the state's overall population grew by just 3 percent, and the population under age 65 shrank by almost 100,000.¹ Statewide, between 2015 and 2040, the number of adults age 65 and over statewide will increase by 50%, and the number of adults over 85 will double.² Currently, fourteen percent of older adults in New York State live in poverty.³

Older adults disproportionately live in rural areas. While only one-fifth of all Americans live in rural communities, more than one-quarter of seniors live in rural and "small-town" areas.⁴ Additionally, the

¹Christian González-Rivera, Jonathan Bowles, and Eli Dvorkin, *New York's Older Adult Population is Booming Statewide*, Center for an Urban Future, Feb. 2019.

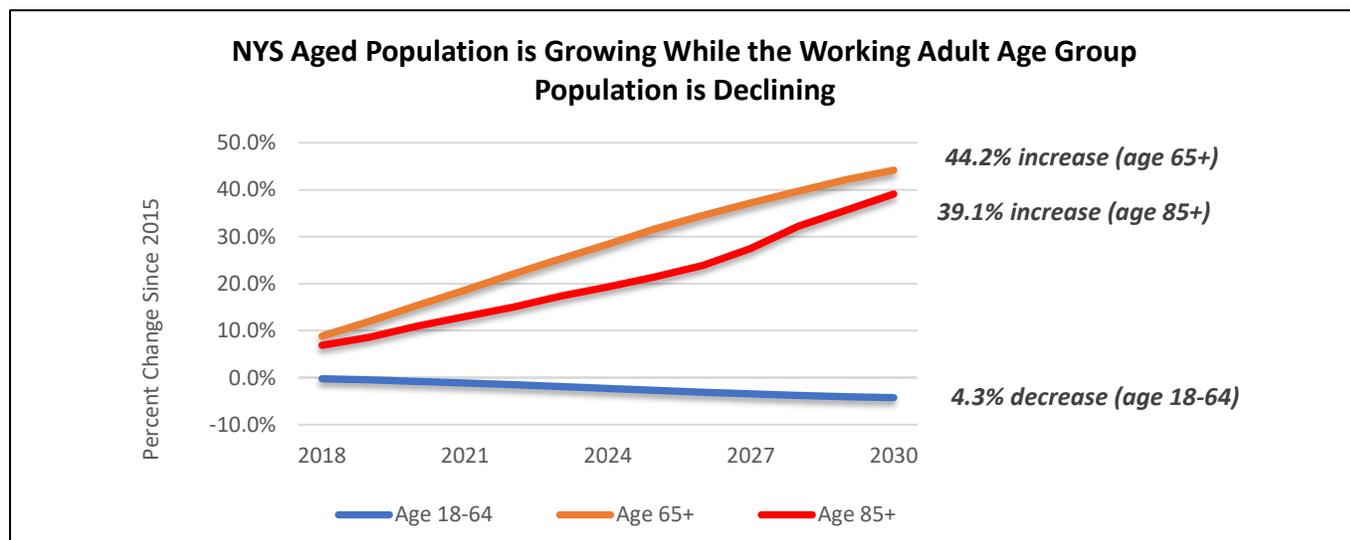
² LeadingAge NY analysis of Cornell University Program on Applied Demographics New York State Population Projections; <http://pad.human.cornell.edu/>; accessed Jan. 4, 2019.

³ Gonzales-Rivera.

⁴ Housing Assistance Council, *Taking Stock: Rural People, Poverty, and Housing in the 21st Century*, 2, 11, 12, 14 (2012), http://www.ruralhome.org/storage/documents/ts2010/ts_full_report.pdf.

median age of individuals in rural areas is 40 years – three years older than the national median.⁵ In New York, the population of older adults is growing at a faster rate in rural areas, than statewide. While the population of older adults statewide rose by 26 percent over the last decade, the growth in many rural counties far exceeded that level. For example, the growth of he population over age 65 exceeded 40 percent in the following counties and regions: Saratoga County; Livingston and Wyoming Counties; Oswego, Madison and Cortland Counties; Broome, Chenango, Delaware, and Tioga Counties; and Wayne and Seneca Counties.⁶

This growth in the older adult population will drive a corresponding increase in the number of New Yorkers with cognitive and functional limitations who need long-term care (LTC) services. However, by 2025, the availability of younger New Yorkers to care for seniors will be at its lowest point in a decade and declining. By 2040, the ratio of working-age adults to adults over age 85 will drop from 28 to 14. Both informal caregivers and workers in the formal care delivery system to support the growing population of seniors will be in short supply. Not only will providers and seniors in rural areas have difficulty finding working-age adults to serve as caregivers, many will be unable to pay for those services and will have to rely on Medicaid.



II. Workforce Challenges

These demographics are driving a workforce shortage in the LTPAC and senior services sectors. The workforce shortage is the top priority for all of our members statewide and is especially acute for our rural members. Workforce is not a problem looming in the distant future – it is a crisis today. Providers in rural areas face extraordinary challenges recruiting and retaining workers -- the pool of eligible candidates is small; access to required aide certification and nursing programs is limited; home care patients are dispersed over long distances, and aides must have reliable vehicles and spend hours each

⁵ *Id.*

⁶ González-Rivera, et al.

day driving between patients' homes; there is no access to public transportation; and the competition with other employers, such as hospitals and even fast food and retail establishments, is fierce.

Statewide data collected by the Center for Health Workforce Studies (CHWS), at the School of Public Health, University at Albany confirm the reports of our members. According to the CHWS, nursing homes and home care agencies report difficulty recruiting and retaining nurses, certified nurse aides (CNAs), home health aides (HHAs), personal care aides, and certain therapists.⁷ The shortage of workers is the most commonly cited reason for the difficulty.

These shortages are already having an impact on consumers and providers. They are preventing managed care plans and home care agencies from filling authorized home care hours, forcing consumers to forego or delay care, informal caregivers to abandon jobs and other family obligations to care for loved ones, and sometimes resulting in premature admissions to nursing homes. Nursing homes, assisted living facilities, and home care agencies are forced to ask workers to take on additional shifts, while others must use staffing agencies, incurring additional overtime and staffing expenses.

The Consumer Directed Personal Assistance Program (CDPAP), which enables older adults with functional limitations and individuals with disabilities to recruit, hire, train and supervise individuals that provide them with personal assistance, has played a critical role filling some of the home care workforce gaps in rural communities. However, this program has also been blamed for increases in the Medicaid personal care spending and managed long term care enrollment growth downstate. As a result of SFY 2019-20 budget actions, the state is moving to limit the number of fiscal intermediaries that support the CDPAP program and limit the payment to these intermediaries. We are working with the Department of Health to ensure that this budget initiative does not limit choice or access to CDPAP upstate.

III. Inadequate Rates

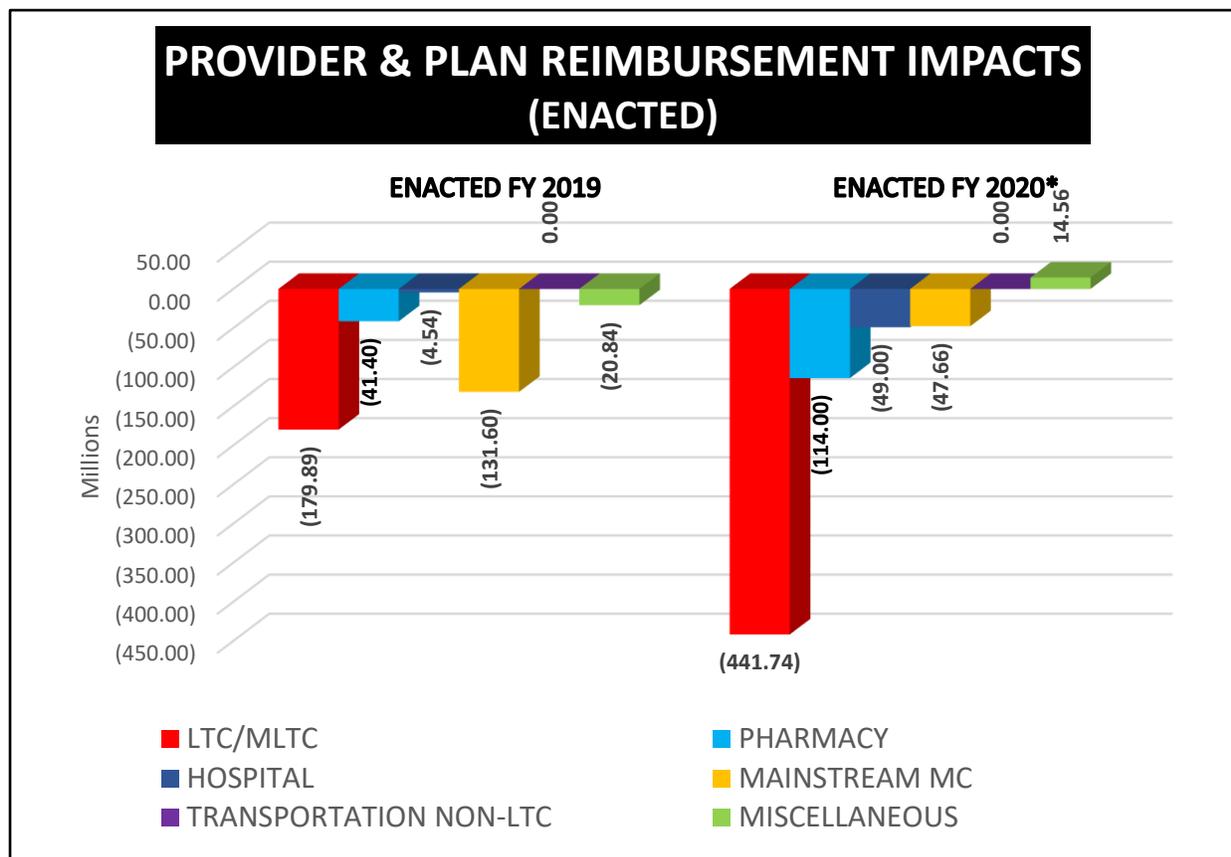
While demographic changes are a major factor contributing to the workforce shortage, a second impediment to recruitment and retention is the inability of LTPAC rates to support competitive wages and benefits. Our members value their staffs and want to pay them fairly for the important work they perform. The work of a nurse, or an aide, or a therapist, in LTPAC is demanding both physically and emotionally and requires extensive training, intensive documentation, and stringent accountability. Unfortunately, relying almost exclusively on public money, and against the backdrop of repeated cuts in funding, LTPAC providers have not had sufficient resources to offer wages competitive with the hospital sector.

Recent increases in the State's minimum wage, while well intentioned, have heightened the workforce and financial challenges of LTPAC providers. Providers that once paid higher wages than fast food and retail employers now struggle to compete for workers with those businesses, as well as with hospitals. While the State has appropriated funds to cover the increased wage expenses associated with the provision of Medicaid services, providers have not received increases to cover the added costs associated with services reimbursed by other payers, nor have they received funding to address the "compression effect" – the shrinking differential between minimum wage earners and those who were

⁷ Martiniano R, Krohmal R, Boyd L, Liu Y, Harun N, Harasta E, Wang S, Moore J. The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; March 2018.

earning slightly more when the law took effect. Unlike retail and fast food outlets, LTPAC providers cannot simply raise their prices to cover the added expense because the vast majority of their revenue comes from public payers (i.e., Medicare and Medicaid).

Deep Medicaid cuts over the past two years have exacerbated the wage challenges. The SFY 2019-20 budget cut Medicaid payments to long-term care providers and MLTC plans by **\$441.74 million** (all funds).⁸ These cuts are in addition to **\$179.89 million** cuts imposed in SFY 2018-19 and continued in the following two fiscal years. The cuts imposed on the long-term care sector far exceeded those imposed on any other sector, including pharmacy and hospitals. LTPAC providers have been forced to absorb these cuts while facing unprecedented demands for new investments in administration and infrastructure occasioned by managed care growth, value-based payment requirements, and health information exchange mandates.



*Each bar reflects budget cuts or investments that impact provider or plan rates or impose penalties. Budget initiatives that rely on maximization of federal funds, impact program eligibility, or shift payment sources are excluded.

Rural LTPAC providers tend to be harder hit by reimbursement cuts and cost increases than their urban and suburban peers. They cannot spread their costs and revenue reductions across large populations.

⁸ This figure is net of adds and includes only reductions in provider and plan payments. It does not include savings achieved through increased federal match or delays in implementation of new programs.

They generally lack the scale to leverage beneficial deals with managed care plans or to participate in risk-sharing arrangements. And, they have unique costs that are not accommodated in standard rates.

As a result, the financial condition of many rural nursing homes is precarious. Our analysis of nursing home operating margins for the most recent year available shows that 46 percent of homes in rural areas lose money on operations, compared to 39 percent in non-rural counties. The 2018 median Medicaid rate for a home in a rural county was \$13 lower per resident day than for a home in an upstate, non-rural county.

Rural nursing homes have been hard hit by the lack of any inflation adjustment in Medicaid rates since 2007. During this time, wages and benefit costs have increased by an average of 2 to 3 percent annually. Looked at another way, based on growth in the Consumer Price Index for Medical Services, one dollar in January 2008 is now worth \$0.73. While nursing homes were promised a 1.5 percent adjustment beginning in November 2018 to cover increased labor costs, it appears that the overall increase may be entirely offset by the case-mix cut enacted as part of the 2019-20 budget. With no real adjustment to Medicaid rates to reflect these increases in staffing costs that comprise the majority of nursing home expenses, homes must rely on other funding sources to make up for the \$50+ per day gap between the cost of care and Medicaid reimbursement the typical home endures.

However, their ability to offset this shortfall with Medicare post-acute revenue is faltering as a result of Medicare hospital reimbursement policies. Our members report that some rural hospitals are increasingly utilizing “swing beds” to provide rehabilitation in order to bolster occupancy, rather than discharging patients to the less costly model of rehabilitation in a nursing home. This practice increases costs to the Medicare program, while denying local nursing homes Medicare revenue. Other members have noted that some urban and suburban hospitals, by contrast, are referring patients from rural communities (including long-term residents of rural nursing homes) to post-acute care in facilities in close proximity to the hospital, rather than to the nursing homes in their hometowns. As a result, not only do the residents receive post-acute rehabilitation far from family and friends in a facility that is unfamiliar, the rural nursing homes experience a decline in Medicare revenue.

We have been seeing the effects of these financial pressures play out in closures, mergers, and sales of not-for-profit and public nursing homes in rural communities. Since 2014, 47 non-profit or public nursing homes have been sold to for-profit operators statewide; 15 of those homes were located in rural communities. At the same time, 4 non-profit rural nursing homes closed.

Home care agencies in rural areas are similarly operating with thin or negative margins, due to inadequate rates. In rural areas, this shortfall is exacerbated. Rural home care agencies’ patient census is typically smaller than urban and suburban agencies, and their fixed costs must be spread over fewer patients and fewer visits. While they have fewer patients, they must cover much larger geographic territories, and within their limited Medicaid and Medicare reimbursement, they must pay for the travel time and travel expenses of aides and nurses who spend hours each day driving between patients. Although they need to expand their patient base and visits, they too often find themselves turning away patients because they simply don’t have the staff to meet their needs.

IV. Assisted Living: Inadequate Rates and Lack of Capacity

Inadequate reimbursement and workforce challenges, together with low population density make the development and operation of assisted living facilities in rural communities very challenging. With an adult care facility SSI rate of approximately \$41.60 per day, it is difficult (if not impossible) to cover the cost of room, board, and services for low-income seniors. Many seniors in rural communities do not have enough wealth to support private pay assisted living. The financing of assisted living in rural areas is further challenged by low population density. A building of a cost-effective size may not be needed or feasible in a rural community. Although smaller buildings may be more appropriate to the size of the population, they are more expensive to operate on a per unit basis. This drives up the private pay rate—often beyond what the market can bear-- and makes serving the low-income population virtually impossible.

As a result of these challenges, many rural counties lack the full continuum of assisted living options. According to Department of Health data, some counties have no Assisted Living Programs (ALPs), which is the only Medicaid assisted living option in the state. Many rural counties lack have Special Needs Assisted Living Residences (SNALRs), commonly referred to as “memory care” for people with dementia or other cognitive impairment. And, many lack Enhanced Assisted Living Residences (EALRs), an aging in place model. Hamilton County has no adult care facility or assisted living of any kind. Moreover, rural adult care facilities in our membership are beginning to close their doors. The lack of options in these counties means that seniors are more likely to seek care in a nursing home when their needs cannot be addressed in their own homes—at a much greater cost to the individual and the state, if the person is Medicaid eligible. Last year, a not-for-profit adult home in St. Lawrence County ceased operations as a result of the inadequate SSI rate. Of its 27 residents, 22 went to a higher cost setting or higher level of care after the residence closed, thereby increasing the cost of their care.

Even where there are assisted living facilities, workforce shortages coupled with DOH regulations make it difficult for residents to access needed care. Under DOH regulations, nurses cannot practice nursing in assisted living facilities, except in the EALR. When residents of the other types of assisted living require nursing services (including services as simple as eye drops or changing a bandage), a visiting nurse from a certified home health agency (CHHA) must be summoned. However, in rural areas it is difficult to find a CHHA nurse who is available to visit to provide the needed services at the frequency required. Unfortunately, this can mean that residents with certain needs must go to a higher level of care, and other residents have to wait for services.

V. Substandard Housing and Isolation

Older adults in rural communities not only lack the assisted living options and access to home care that their peers in urban settings may enjoy, they often find themselves aging in place in substandard housing. Too often, these seniors are isolated by geography and lack of transportation. For example, in Sullivan County, there are only two bus routes, and they only operate on Thursdays and Fridays.⁹ This

⁹ State University of New York, Rockefeller Institute of Government, Stories from Sullivan: Rural Challenges (2018), <https://rockinst.org/blog/stories-sullivan-rural-challenges/>.

makes it nearly impossible for impoverished individuals to access healthy foods and basic medical services such as doctor visits or trips to the pharmacy.

Affordable senior housing developments, built with the support of state and federal grants, tax exempt bonds, and tax credit financing, have provided a welcome alternative to isolated and deteriorating homes for seniors in some rural communities. However, affordable senior housing is not available in most rural areas and additional capacity is needed as the population ages. Our members were delighted by the \$125 million in 2017-18 budget for the “Senior Housing Program.” We are hopeful that some of those funds will be dedicated to projects in rural communities.

The benefits of affordable senior housing can be enhanced through the work of resident assistants who provide “light-touch” services that may include: (1) establishing and maintaining networking relationships with community-based services and organizations; (2) providing residents with information and referral lists for community services, and assisting them with follow-ups; (3) arranging for educational, wellness, and socialization programs for residents; (4) helping residents arrange for housekeeping, shopping, transportation, meals-on-wheels, cooking, and laundry services; (5) establishing resident safety programs; and (6) advocating for residents.

A study conducted of residents of Selfhelp Community Services in Queens with resident assistant services and a control group found that the hospitalization rate for Selfhelp residents was approximately 43% lower than for the comparison group (after controlling for age, zip code and other factors). In addition, the study found that the rate of hospital discharges for ambulatory care sensitive conditions among the Selfhelp residents was 30 percent lower than that among the comparison group. An earlier study of Selfhelp residents demonstrated that the odds of visiting the emergency room were 53% lower for Selfhelp residents than for the comparison.

VI. Recommendations

There is no silver bullet that can solve all of these challenges and ensure that we can meet the growing demand for LTPAC workers. However, there are initiatives that the state can undertake to begin to tackle the issues:

Workforce

1. Allow for Advanced Certified Nurse Aides/Medication Technicians

The State should pass legislation to allow CNAs with additional training to administer medications in nursing homes under the supervision of a registered nurse. In New York, there is an exemption to the Nurse Practice Act for direct care staff employed in residences certified by the Department of Mental Hygiene. This exemption allows registered nurses to delegate nursing functions, including medication administration, to direct care staff provided there is adequate medical and nursing supervision.

The state is facing a significant nursing shortage, and many nurses express dissatisfaction with the repetitive task of routine medication administration consuming most of their time, leaving less time for more complex tasks. Meanwhile, aide-level workers are leaving health care to pursue other jobs due to wage restrictions and job satisfaction. Allowing these additional responsibilities can provide increased job satisfaction, allow for wage increases, a career ladder, and improved staff retention.

2. Expand the role of the nurse in the adult care facility (ACF) (S.1788)

Like nurses employed by nursing homes and hospitals, nurses employed by assisted living facilities (including Assisted Living Programs and other ACFs) should be permitted to practice their profession in those settings. By allowing nurses in ACFs to perform tasks within their scope of practice, Medicaid beneficiaries living in ACFs would receive more integrated, proactive, and preventive services that can reduce emergency department visits and hospital admissions. Nurses working in ACFs could also help to avert declines in health status that trigger nursing home placement, thereby saving money for the state, the federal government, and the consumer.

3. Facilitate cross-certification, streamline in-service training requirements, and promote the availability of competency exams of direct care workers.

The state should take steps to streamline the certification and re-certification of certified nurse aides (CNAs), home health aides (HHAs), and personal care aides. Currently, CNAs that seek to become HHAs must either take the 75-hour HHA training course or pursue a competency exam in lieu of training. However, only CNAs with one year or more of hospital experience are eligible for a competency evaluation in lieu of the course. Veterans who were trained in the United States military as medical technicians or medics are also eligible for competency evaluations in lieu of training. CNAs who work in nursing homes do not appear to be eligible for competency evaluations in lieu of the full course. Moreover, while competency evaluations appear to be a useful option to expand the pool of HHAs, we understand from our members that many HHA training programs will not administer competency evaluations, even though they are required to do so.

In-service training requirements for home health aides can also be a significant barrier to maintaining access to home care services. Home health aides are required to participate in 12 hours of in-service training annually to maintain their certification. Many home health aides work at more than one agency in order to achieve full-time work. Under the current structure, in-service training at one agency does not necessarily count toward the in-service training at another agency. This means that some aides receive 24 hours or more of in-service training and are diverted from caring for their patients during those hours.

Expanding access to competency evaluations and streamlining or aligning training and in-service requirements would expand the pool of aides and reduce duplicative in-service requirements.

4. Facilitate cross-training and lateral transfers across health and LTPAC settings.

Providers of health, LTPAC, behavioral health, and developmental disability services and unions should join together with regulators and educational institutions to explore cross-training and inter-disciplinary service opportunities in order to alleviate workforce shortages. The regulatory and practice barriers to transfers across settings should be identified and the impact of removing them evaluated.

5. Utilize Civil Money Penalty funds for CNA recruitment and retention.

The state has an account that currently holds \$8 million in funds derived from civil money penalties imposed on nursing homes. These funds are intended to be reinvested to support activities that benefit nursing home residents and improve quality of care or quality of life. However, New York State is not currently allocating the majority of the funds in this account. LeadingAge NY proposes using these funds to create a New York Careers in Aging program. The program would allocate \$7 million to the program,

for purposes including covering the expenses of up to 6,000 students to complete approved nurse aide training and testing programs, providing nurse aides with \$500 retention bonuses after 6 months of work, and providing up to \$250,000 for a contract to develop a marketing and recruitment plan, with an emphasis on social media, highlighting the career ladder to nursing and the benefits of working in a nursing home.

6. Promote accessible education and training for careers in LTPAC and aging services.

The State should provide incentives and funding to nursing schools, community colleges, other training programs, and students to broaden participation in formal courses of instruction for nurses and aides in rural areas. Techniques such as satellite broadcasts, web-based courses, training stipends, flexible scheduling of courses, student loan forgiveness programs, and on-the-job training opportunities should be pursued.

7. Support informal caregivers.

The state should offer expanded respite benefits, direct financial assistance, greater tax incentives, training programs, and education and community outreach programs for informal caregivers. This assistance would help consumers and their families to reduce their reliance on formal caregivers and delay the need to apply for Medicaid to cover long-term care costs.

8. Expand efforts to recruit young adults and “young” seniors for LTPAC careers.

The state should support programs like MercyCare in the Adirondacks which is successfully utilizing younger senior volunteers to provide supportive services to other seniors in need. In addition, it should help providers replicate career exploration programs in secondary schools and institutions of higher education, like the Geriatric Career Development (GCD) Program of The New Jewish Home which provides academic and career development assistance to at-risk New York City youth, through an in-depth, work-based learning program in a geriatric long-term care setting.

Payment Rates

1. Increase the Congregate Care Level 3 SSI rate

The state should increase the rate paid to adult care facilities to make it more feasible to provide the mandated services and enable ACFs that serve the SSI population to continue to operate.

2. Create a rural add-on to the Medicaid rate for rural ALPs and nursing homes

This add-on, like the Medicare critical access hospital rates, would enable the development and survival of smaller ALPs and nursing homes that have higher per-person costs.

3. Expand the scope of the personal care rural rate enhancement

We support the recent state plan amendment to provide a rate enhancement for personal care nursing supervision and nursing assessments in rural areas of the state. However, this enhancement should be expanded beyond personal care nursing to home health nursing and aide services. In addition, the geographic scope of the enhancement should be expanded beyond the seven counties that qualify as Frontier and Remote Areas. Instead, the enhancement should cover all of the counties defined as rural under section 2951 of the Public Health Law.

Other Innovations

1. Enact the Affordable Independent Senior Housing Assistance Program (A.4358/S.5269)

LeadingAge New York, along with a coalition of senior housing providers and associations, has called for the creation of the Affordable Independent Senior Housing Assistance Program to be administered by the Department of Health (DOH), and the investment of \$10 million over five years to fund Resident Assistants in 140 senior housing properties around the State. This modest investment would provide a cost-effective way to support healthy aging in place, while also generating Medicare and Medicaid savings.

2. Support Access to Telehealth, Safety, and Socialization Technologies

Telehealth and remote patient monitoring technologies can help older adults with chronic or post-acute conditions to manage more of their own care, while reducing home nursing visits, associated transportation expenses and avoidable hospital use. In addition, innovative safety technologies can assist older adults who live alone or are homebound to feel safer and less isolated. These technologies include motion detectors that identify changes in usual activity patterns and trigger calls from social workers to check on clients. Other technologies can create virtual senior centers where participants use a touch-screen device to attend interactive, video-based classes and connect with peers.

These modalities are especially useful in rural areas, where they can allow for more efficient use of a limited workforce and reduce social isolation. In addition, these technologies can improve access to specialized services in areas with physician shortages. The State should make funding available to expand access to telehealth, remote patient monitoring, safety technologies, and virtual senior center tools. LeadingAge NY also urges the state to continue its efforts to provide and improve the availability of telehealth by investing in broadband technology, so all areas of the state can benefit.

Conclusion

We appreciate the Chair's and the Committee's efforts to explore and address the challenges faced by providers and consumers in rural communities. Facing a rising population of seniors with high rates of chronic disease and rising rates of disability, the State must develop strategies, including regulatory reform and strategic investments, to ensure access to quality care and services for a growing senior population in rural communities. We look forward to working with policymakers and other stakeholders to address these challenges.

For questions or concerns, please feel free to contact Karen Lipson at klipson@leadingageny.org or 518-867-8383.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, hospice, assisted living programs and Managed Long Term Care/PACE plans. LeadingAge NY's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.