NYS ASSEMBLY STANDING COMMITTEE ON HEALTH

HEARING ON MEDICAID PROGRAM EFFICACY AND SUSTAINABILITY

Testimony

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INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on Medicaid program efficacy and sustainability. LeadingAge NY represents over 400 not-for-profit and public providers of long term and post-acute care (LTPAC), aging services, and senior housing, as well as provider-sponsored Managed Long Term Care (MLTC) plans collectively serving over 500,000 New Yorkers. Our membership spans the continuum of long-term care and aging services, from housing to home care and community service to assisted living and nursing home care.

The effectiveness and viability of the Medicaid program is exceedingly important to the hundreds of thousands of vulnerable New Yorkers who rely on long-term care (LTC) services daily. Medicaid has emerged as the *de facto* insurance program for LTC, leading to a high degree of reliance on Medicaid funding for these services. As the primary payer for LTC services in New York and nationwide, Medicaid bears significant responsibility for access to high-quality LTC services, the financial viability of the LTC sector, and its capacity to compensate staff appropriately for the difficult and essential services they deliver. Our testimony first addresses the ways in which the state's Medicaid funding decisions have depleted our long-term care system and led to the current workforce crisis. It next lays out a series of policy goals that would support a high-performing LTC system, and then addresses the questions posed in the hearing notice.

Inadequate Medicaid Funding for Long-Term Care

New York's Medicaid program offers much to be proud of – comprehensive coverage for over 7 million New Yorkers, comparatively generous benefits and eligibility thresholds, and the promise of a safety net for older adults and people with disabilities who require assistance with activities of daily living. However, that promise is increasingly proving to be an empty one. Our Medicaid program fails to pay rates to LTC providers that enable them to recruit and retain qualified staff in sufficient numbers, make investments that enable the delivery of the highest quality care, and upgrade facilities to support strong infection control measures and person-centered models. As a result of inadequate funding and pandemic-related stresses, LTC providers are facing the worst staffing shortages in memory. Home care agencies and nursing homes have been forced to delay and suspend admissions, consumers are facing barriers to care that lead to prolonged stays in hospitals, and not-for-profit providers are closing or selling to for-profit entities.

Despite the rapidly growing population of older adults in New York State, New York's principal focus for LTC policy for the past several years has been to reduce Medicaid spending on these services. Year after year, New York's LTC sector has borne deeper Medicaid cuts than any other

health care sector (Figure 1), while costs have risen and administrative requirements have grown exponentially. Although New York's LTC providers have taken more than their fair share of cuts, they have not gotten their fair share of capital investments or funding from the MRT waiver's DSRIP program. Only about 2 percent of DSRIP funds and 10 percent of Statewide Health Care Facility Transformation Program funds have been allocated to LTC providers. (Figures 2 and 3).

This policy of depleting the LTC system continued even when the pandemic struck, and public health experts projected that older adults and those living in congregate care facilities would be at gravest risk for severe disease and death. At the height of the pandemic, when most states poured resources into their LTC systems, offering Medicaid rate increases, staffing support, and other funding, New York State cut Medicaid reimbursement by 1.5 percent (a $168 million cut on nursing homes alone). By contrast, according to the Kaiser Family Foundation, during the pandemic, **more than two-thirds of states increased Medicaid payments for home and community-based services (HCBS) providers, and more than half increased Medicaid payments to nursing homes.** [1]

New York's depletion of resources from its long-term care providers and the losses and extraordinary costs arising from the pandemic have brought the State's system of LTC services and supports to the precipice. Even before the pandemic, New York had the largest shortfall in the nation between the cost of care and its Medicaid nursing home rates.[2] The inadequacy of the state's Medicaid rates is forcing providers that want to deliver high quality care to leave the market. Since 2014, approximately 20 nursing homes have consolidated or closed, and approximately 50 public and NFP nursing homes have been sold to for-profit entities. Moreover, since beginning of the pandemic, one non-profit nursing home in Westchester has closed, two upstate homes have announced fall closures, at least two are for sale in New York City, and several on Long Island have been sold or are in sale negotiations. We fully expect these numbers to grow.

Adult care facilities that serve Medicaid beneficiaries have also been struggling to survive on the Supplemental Security Income (SSI) congregate care rate of $42.02 per day that covers less than half of the cost of state-mandated services. And, a majority of the state's home care programs were incurring operating losses before the pandemic, including 67 percent of certified home health agencies that report negative or negligible operating margins, with a median margin of -14.78 percent.[3]

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[1] New York also enforced the closure of medical-model adult day health care programs long after other types of providers were permitted to resume services, rendering many unable to re-open and the loss of vital community-based resources.

2 Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care," November 2018. New York's $64 per day shortfall represents the largest shortfall of the 28 states the report analyzes.

3 "State of the Industry 2020," Home Care Association of NYS, February 2020, accessed at https://hca-nys.org/wp-content/uploads/2020/02/HCA-State-of-the-Industry-Report-2020.pdf.

Workforce Crisis

The state's Medicaid rates simply do not allow LTC providers to offer competitive compensation to their personnel, who perform skilled, sensitive, and demanding jobs. They do not allow LTC providers to recruit nurses and aides away from hospitals and physician practices in a highly competitive labor market. Even before the pandemic, 59 percent of home care agencies reported difficulty hiring full-time aides and nurses, and 69 percent of nursing homes reported difficulty hiring aides and nurses for evening, night, and weekend shifts.[4] The situation has gotten markedly worse over the course of the pandemic.

As a result of inadequate Medicaid rates, demographics, and COVID-related factors, longstanding LTC personnel shortages have reached crisis proportions. In an effort to cover shifts and recruit and retain staff, LTC providers are paying signing bonuses, retention bonuses, and shift differentials, but remain unable to fill vacancies. Many are, for the first time, seeking the services of staffing agencies at exorbitant rates, but the staffing agencies cannot meet their needs. Many have been forced to suspend admissions and/or close units, creating barriers to access for consumers and backlogs in hospitals. We are hopeful that federal eFMAP funding will provide some short-term support for the home and community-based workforce, but it is not a long-term solution and will not address workforce shortages in nursing homes and assisted living settings.

Outdated LTC Infrastructure

Public investment is needed in critical infrastructure improvements in LTC from technology and health information exchange to physical plant upgrades that support energy efficiency, infection prevention and homelike environments. Not only has the state failed to support these investments, it has also enacted direct care spending legislation that effectively prevents nursing homes from making capital investments that will curb transmission of COVID and improve the quality of life of residents. Without such investments, older adults and people with disabilities in New York will lack access to the highest quality care.

Additionally, providers need the support of regulators and resources to reconfigure services in a timely way, to meet the current needs and preferences of consumers, and establish new systems that are sustainable into the future. There is more demand for Vital Access Provider funding than funding available, and the Distressed Provider Assistance Pool funds are not being released to meet the needs of LTC providers. To date, the Statewide Health Care Facility Transformation Program has not proven to be a significant source of much-needed capital funding for long- term care providers. Lastly, the CON and related applications for construction and reconfiguration or changes in services can take years, and become increasingly complicated when involving different types of licensure.

[4] 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.

Ballooning Administrative Requirements Without Additional Reimbursement

The pandemic has led to an overwhelming array of new administrative requirements without any recognition of the additional personnel they require and costs they impose. For example, nursing homes and adult care facilities must submit daily reports, 365 days per year, to the Department of Health (DOH) with over 100 data elements. They must also submit weekly reports to DOH with other data, and nursing homes must submit weekly reports to CDC with similar, but not identical, data. Home care agencies must also submit reports regularly to DOH. Providers are required to screen and supervise visitors; stockpile personal protective equipment; conduct COVID testing and vaccination of staff, patients and residents; and document and report on those activities to various authorities. Nursing homes are also now required to summarize every contract for goods and services and post them on their websites. These new mandates are not only costly; they divert precious staff from the all-important responsibilities of caring for patients and residents.

We are facing a dismal near future in which there are only a handful of non-profit and public LTC providers, and inadequate Medicaid rates mean that high-quality care is available only for wealthy New Yorkers who can pay out of pocket. Health equity demands that New York's Medicaid program address these existential threats to the delivery of LTC services and supports that hundreds of thousands of beneficiaries rely on each and every day.

A New Approach to LTC Policy

In order to revitalize our long-term care system in the wake of this devastating pandemic, and ensure that older adults and people with disabilities receive the best possible care, we will need a multi-pronged, inter-governmental (e.g., Legislature, DOH, SOFA, SED, DOL, SUNY, DASNY) effort that includes a substantial investment of Medicaid dollars, regulatory reforms, and private and public sector engagement in workforce development. **Adequate Medicaid funding must be the foundation of this revitalized long-term care system.** We look forward to working with the Legislature to ensure that LTC is a top priority in the State Budget for State Fiscal Year 2022-23. We are also seeking changes to the state's 1115 Waiver Concept Paper to ensure that LTC is prioritized.

This inter-governmental effort **must prioritize health equity** across all dimensions and seek to implement policies and investments that achieve the following goals:

- ***Promote Access and Choice:*** New York's LTC system should provide Medicaid beneficiaries with access to an array of options suitable to varying levels of acuity and need, lifestyle preferences, and geographies. Those options should:
  - Make services available in the most integrated setting appropriate to the beneficiary's needs and preferences, including home care, adult day health care, and ACF/AL.
  - Include nursing homes that offer homelike environments, vibrant social lives, and personal privacy (e.g., Green House, Eden Alternative, etc.), recognizing that some individuals will be unable to live in community-based settings due to their medical complexity and lack of informal supports. These facilities must have the resources to

implement controls that mitigate the risks of airborne and other infectious diseases and to deliver advanced clinical care that reduces avoidable hospital use.

- ***Support a Well-Qualified, Appropriately Compensated, and Ample Workforce:*** Our LTC system should have sufficient resources to enable recruitment, retention, and career development of the LTC workforce. This can only be accomplished through Medicaid rates that support competitive wages and recognize the skills, sensitivity, and dedication that LTC work demands. Our laws and regulations must also optimize available personnel by allowing them to practice at the top of their scopes and by supporting cross-continuum certifications and occupational flexibility.
- ***Drive Quality and Value:*** New York's policies should incentivize the delivery of high-quality, person-centered care along the entire spectrum of LTC services and supports, through financial incentives that are reliable, timely, additive, and non-punitive.
- ***Strengthen Integration:*** The State's policies should support integration and coordination along the continuum of long-term services and supports and among the primary, acute, post-acute and LTC sectors, so that older adults can transition seamlessly from one setting to another.
- ***Target High Priority Social Determinants of Health for Older Adults:*** The state should address the social determinants of health for older adults through strategies tailored to their unique needs and preferences, including targeted investments to delay the need for higher levels of care; expanded support for unpaid, informal caregivers; and initiatives that forestall reliance on Medicaid coverage for higher cost services. Linking affordable senior housing with services is one example of a proven model that accomplishes these goals.[5]

LeadingAge NY's NFP and public members are committed to providing access to high-quality services and supports to the older adults and people with disabilities they serve. However, they are struggling to do so in the context of a shrinking workforce, increasing mandates, and Medicaid payment that simply is not keeping up with the reality of growing costs. We look forward to working with you to achieve these goals.

Hearing Topics

In addition to covering the issues discussed above, we are pleased to share our thoughts and recommendations with the Assembly Health Committee on some of the specific topics identified in the hearing notice.

1. **The effect and appropriateness of the Medicaid global cap on the Medicaid program and individuals' access to services.**

[5] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* October 2018. Li, G., Vartanian, K., Weller, M., & Wright, B. *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016. *Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.

The Medicaid global spending cap has alternatively been portrayed as a centerpiece of Medicaid redesign and as a budgetary device that is easily subverted by the State's ability to administratively change the timing of payments and to exclude certain services and payments from the cap. We would argue that the global cap construct has outlived its usefulness, is arbitrary, and ultimately jeopardizes the ability of the Medicaid program to support high quality care.

Year-to-year adjustments to the cap are based on the 10-year average growth rate in the medical component of the consumer price index (CPI), a measure of price inflation. Basing annual adjustments to the cap on an inflation factor fails to account for major factors that drive program expenditures – the timing of Medicaid payments (the cap is based on cash expenditures) and factors such as: (1) rising Medicaid enrollment; (2) unusual events such as a public health emergency; (3) changes in health care spending due to demographic trends such as an aging population; (4) changes in the composition of services; and (5) payment arrangements (i.e., fee for service vs. managed care).

Simply put, an annual adjustment based on a medical price inflation measure cannot provide sufficient resources to offset ongoing medical price inflation, increases in enrollment, and changes in benefits and service utilization. With Medicaid payments to providers that are already most often less than the cost of delivering services and payments to managed care plans that are at the "bottom" of the actuarial rate-setting range, continued failure to adjust the cap to reflect enrollment growth and other Medicaid cost drivers will further deprive providers and plans with the resources needed to ensure access to high quality of care and meet all program requirements.

2. Whether some Medicaid services or populations should be carved out of Medicaid managed care, and if so, which ones would benefit?

Existing statute delays the mandatory enrollment of the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) waiver participants into Medicaid managed long term care until January 2026. LeadingAge New York supports the continued carve out of the NHTD and TBI participants from managed long term care. NHTD and TBI participants are part of a well-defined and unique population that are well-served by the current waiver structure which also assures budget neutrality. Given ongoing concerns about the ability of MLTC premiums to accommodate the costs of high-need individuals, there seems little reason to disrupt these programs.

Legislation was enacted in 2020 to carve out the Medicaid non-emergency transportation benefit from MLTC benefit package and deliver the benefit through a statewide vendor. A transportation vendor RFP is pending, and the MLTC carve-out has not been implemented. MLTC plans have varying positions on this carve-out. Some MLTC sponsors have invested in their own vehicles, and others have longstanding contracts with high-quality vendors. By employing the drivers or controlling vendor contracts, these plans maintain that they are able

to deliver personally-tailored transportation and oversee customer service to their beneficiaries. According to these plans, this oversight enables them to prevent lengthy waits, stranded clients, and missed medical appointments. Ideally, transportation should be an optional benefit, allowing plans that would like to offer it the opportunity to do so.

3. Whether increased reliance on Medicaid managed care has created new access barriers for Medicaid members, and if so, suggestions for reducing these barriers.

The expansion of Medicaid MLTC has offered both advantages and disadvantages in terms of access to services. While the service authorization and utilization review processes of managed care have proven challenging for some beneficiaries, the fee-for-service system has presented its own barriers to enrollees. Prior to the introduction of MLTC, beneficiaries were forced to navigate a complex eligibility and authorization process through local departments of social services. Many MLTC beneficiaries have significant functional limitations and cannot navigate systems of care on their own. Many lack close family or friends who are able to oversee their care. The high-touch care management offered by our member MLTC plans identifies needs, arranges for and coordinates multiple services, connects beneficiaries with non-medical community services (e.g., home-delivered meals, transportation, environmental supports), and assists with eligibility recertifications. Absent this level of care management, many beneficiaries would be more isolated and face greater struggles to access care.

However, the centralized MLTC enrollment and assessment process through Maximus is resulting in delays in enrollment. We understand that some prospective MLTC enrollees are waiting 2 to 3 months for an assessment from Maximus, even though the Department of Health has reinstated telehealth assessments. We've been told that the state is working with Maximus to address these delays, but they are raising concerns for consumers. In addition, the centralized enrollment process tends to channel beneficiaries into MLTC plans without fully informing them of PACE and Assisted Living Program options. Some enrollees might, if given complete information, prefer a small, center-based program over a larger MLTC plan; others might prefer a congregate living environment with 24/7 support over living alone.

These barriers can and do negatively impact consumers by delaying access to, and coverage of, LTC services and supports. The state should ensure that Maximus staff are well-trained in all of the LTC options available to beneficiaries and impose clear performance and timeliness standards for all enrollment processes.

4. Whether New York could benefit from removing managed care organizations from Medicaid programs, like the model implemented in Connecticut and other states.

Management and provision of LTC services and supports has created a formidable challenge for all states, regardless of the model they implement. At issue is the reality that 9 out of 10 older adults on Medicaid who use LTC services are also Medicare beneficiaries, and the fundamental differences between these two programs lead to cost-shifting, inefficiencies, clinical fragmentation, and sub-optimal outcomes.

Integrated Medicare-Medicaid managed care plans and PACE programs offer an opportunity to bridge the divide between Medicare and Medicaid and a more comprehensive approach to health coverage that shows promise in improving outcomes and the consumer's experience of care. LeadingAge NY's plan members, which are all sponsored by not-for-profit long-term care providers, actively participate in integrated managed care models, including Medicaid Advantage Plus (MAP) and Programs of All-Inclusive Care for the Elderly (PACE).

However, the State's initiative to promote integrated care relies heavily on default enrollment in Medicare from Mainstream Medicaid managed care organizations and threatens to divert enrollment from integrated plans sponsored by providers specializing in LTC that do not operate mainstream Medicaid managed care plans. Concurrently, the State has indicated that it may scale back the partially capitated MLTC program, which accounts for 88 percent of current MLTC membership statewide. This would potentially shift those dually-eligible LTC beneficiaries who are unwilling to join a Medicare managed care plan from smaller plans focused on older adults and LTC to large mainstream Medicaid plans whose enrollment is primarily younger populations.

MLTC plans sponsored by non-profit LTC providers can and should play a key role in strengthening these initiatives given their unique expertise in the issues faced by older adults and the services they utilize. As the State pursues integration, it should leverage the expertise of plans that specialize in providing LTC services so as not to leave the responsibility for these vulnerable populations to organizations that primarily serve younger and healthier populations.

5. The effect of the changes to Medicaid coverage for various services enacted in 2011 and subsequent years, including the MRT II changes in 2020.

Elimination of Inflation Adjustments

The elimination of all inflation adjustments to Medicaid rates under the 2011 MRT 1 has likely had the most profound effect on the financial underpinnings of the LTC system of any of the MRT I initiatives. A dollar in 2008 is worth only about 70 cents now, based on the medical services component of the CPI. At the same time, the MRT's shift to mandatory enrollment in managed long term care led to an increase in administrative costs for providers that now must manage multiple Medicaid payers with diverse billing and reporting requirements. Providers cannot operate in 2021 with Medicaid payments stagnated at 2008 levels.

MLTC Premium Development and Spending Cuts

As discussed above, the shift to mandatory enrollment in MLTC plans under the first MRT has offered enhanced coordination and care management for beneficiaries. However, it has also strengthened the state's ability to reduce spending on LTC services without legislative oversight and diminished the transparency of rates paid for community-based LTC services. The state has decided to pay its MLTC plans at the bottom of the actuarially-sound rate range and calculates that range based on savings assumptions that are never clearly articulated and rarely

materialize. This allows the state to pull funding out of the LTC system without the same level of public scrutiny and predictability as rate changes enacted under fee-for-service financing.

Statewide Pricing System for Nursing Homes

Statewide pricing of nursing home care under Medicaid has been a driving factor in facility closures and facility sales, with primarily independently-operated facilities (mostly NFP and public) being purchased by multi-facility operators. Paying neighboring facilities essentially the same amount without regard to the level of investment in direct care or the level of quality provided has predictably led to failures of facilities that spent greater amounts on resident care than the prices allowed. As a result, Medicaid beneficiaries have less choice when it comes to accessing high-quality care options.

New Independent Assessor Process

The MRT II actions included the engagement of an Independent Assessor to conduct not only initial clinical eligibility assessments for personal care and consumer directed personal assistance services and MLTC enrollment, but also reassessments to determine continued eligibility and the need for changes in services. In addition, the MRT II directed the use of independent practitioners to examine beneficiaries, issue orders for services, and conduct clinical reviews of high-needs cases.

Our members are concerned that this expansion of Maximus responsibilities will add to the delays we are already seeing in initial assessments. They are also concerned that exclusive reliance on the Independent Assessor for assessments and reassessments will compromise the care planning process for beneficiaries and quality measurement. Maximus nurses will have little, if any, first-hand knowledge of the individual being assessed and will be unfamiliar with their informal supports and home environment. The impact of this lack of familiarity will be exacerbated by use of telehealth to conduct assessments.

In order to ensure the development of appropriate care plans, our member MLTC plans intend to continue to conduct their own assessments. However, it appears that the Department of Health is planning to eliminate the costs associate with assessments from MLTC plan premiums. The timing of the assessments, evaluation, and clinical review, and the integration of these steps into the processes for enrollment and care plan changes, must be structured to support timely access to needed care. In addition, plan-based assessments must be continued and should be appropriately reimbursed in plan rates.

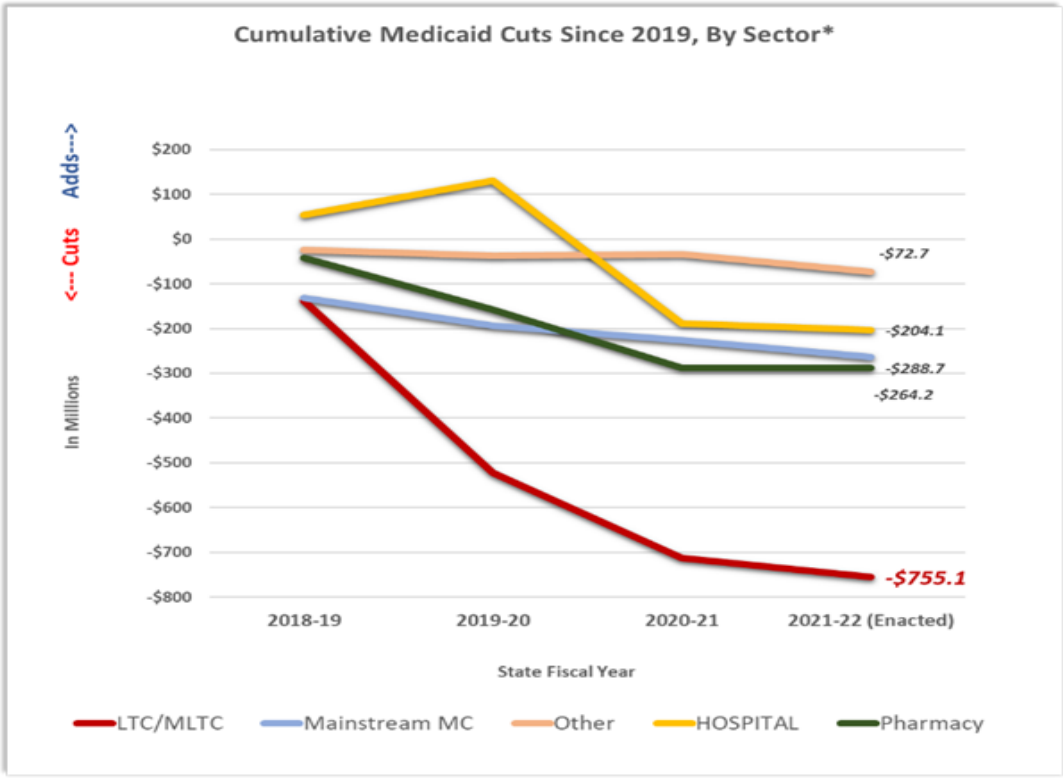
Conclusion

The efficacy and sustainability of New York's Medicaid program can be measured by how it performs for the state's most vulnerable residents, whose needs are greater due to chronic conditions and functional limitations and whose numbers are growing. In turn, Medicaid's status as the predominant insurer and payer for LTC services in New York State has a major bearing on the strength and quality of the service infrastructure. As Medicaid funding goes, so goes the system of LTC services and supports.

Looking to the future, we can expect that a significant portion of older adults will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs. Medicaid currently pays for over 70 percent of nursing home days and over 80 percent of home care and personal care services in New York State. These percentages are not likely to shrink as the later Baby Boomers age and retire without the substantial savings and generous pensions that their predecessors enjoyed. We must be willing to innovate and invest now to build capacity and secure resources for the future.

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, assisted living programs, and Managed Long Term Care plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.

Figure 1



**Note: Figures are based on State-calculated impacts of new Medicaid budget actions since 2018-19, as well as enacted cuts reflected in the SFY 2021-22 Medicaid spending plan. More than $1.5 billion in retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due to the pandemic are not reflected, nor are savings actions that are not attributable to a specific health care sector.*

Figure 2

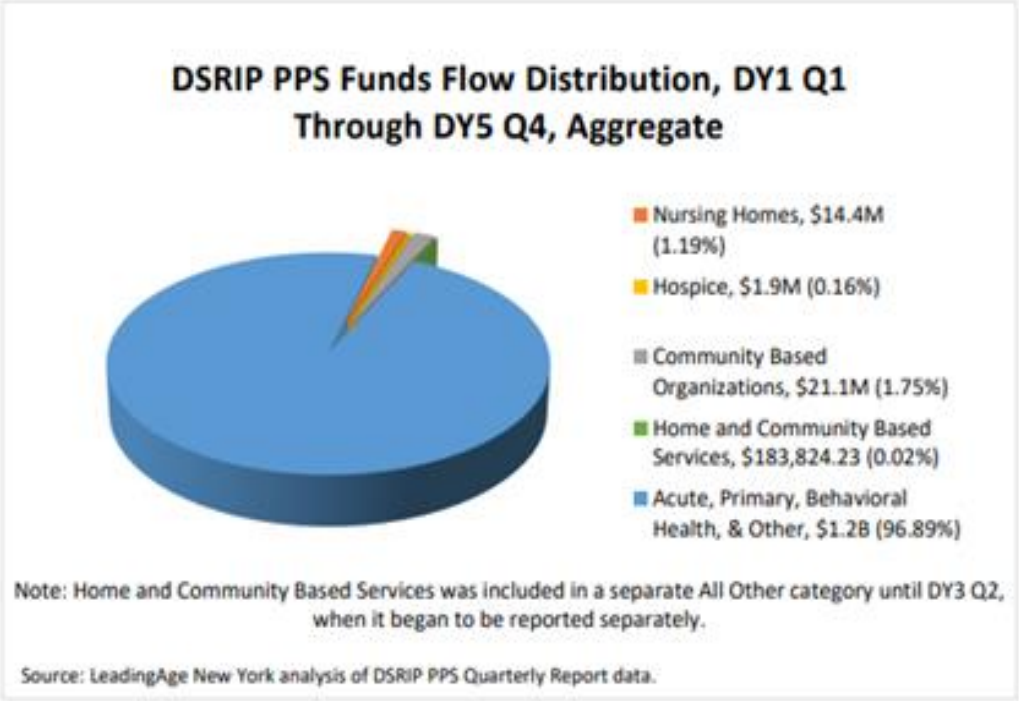


Figure 3