October 18, 2023

Adam Herbst
Deputy Commissioner
Office of Aging and Long Term Care
NYS Department of Health
Corning Tower
Albany, New York

Greg Olsen
Acting Director
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2 Empire State Plaza, 5th Floor
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Dear Deputy Commissioner Herbst and Director Olsen:

On behalf of the not-for-profit and government-sponsored providers of long-term care and aging services represented by LeadingAge NY, I would like to offer the following comments on the Master Plan for Aging preliminary report issued on August 28, 2023. First, we would like to commend the significant commitment of resources, comprehensive perspective, and engagement of stakeholders in the Master Plan for Aging process. The demographic changes facing New York -- the growing number and percentage of older adults and shrinking percentage of working age adults living in New York – demand a concerted and multi-pronged approach to meeting the needs of older adults.

We understand that much of the preliminary report was written just as the MPA the Subcommittees and Work Groups were getting under way and before they developed any recommendations. We hope that the next MPA report will more closely reflect the analysis, discussions, and recommendations of the Work Groups. Our comments begin with some overarching themes followed by more specific feedback on selected pillars discussed in the preliminary report.

To Support Aging with Dignity in One's Preferred Place Requires a Substantial Investment of Public Funds

We appreciate the report's recognition that recent medical advances have enabled individuals to live longer, but unfortunately have not necessarily enabled us to live without major illness or disability. Thus, as our population of older adults grows, an increasing number of those adults will need long-term services supports (LTSS) in order to live comfortably, safely, in good health, and with social engagement. We agree that steps must be taken to prolong the "healthspan," along with the lifespan. Senior housing with services, as described below, can play an important role in this effort. We also recognize that extending the healthspan is a long-term proposition and that healthy living will not eliminate age-related decline in physical and cognitive functioning.

We believe that the Master Plan for Aging should strive to ensure the availability of and access to a broad array of options for individuals as they age, aligned with their needs and preferences and supportive of a high quality of life, including both physical and social/emotional wellbeing. High-quality, financially-viable services and settings should be available and accessible at all levels of care, regardless of the individual's income and geography.

The Governor's Executive Order 23 establishing the Master Plan for Aging echoes the desire of most individuals to "age in place," and the preliminary report reflects that ambitious goal. We agree that it is critically important to enable people to live in their preferred place as they age. We wholeheartedly support the mandate of *Olmstead* to serve individuals in the most integrated setting appropriate to their needs. However, we must also acknowledge the realities of "aging in place," and the extensive services and supports needed, as one enters one's 80's and 90's. Fulfilling the goal of enabling people to age in their preferred place will require a substantial investment of public funds. This is where the preliminary report falls short.

Our Medicaid program is the principal payer for long-term care in New York State, promising access to a comprehensive array of high-quality long-term services and supports to older adults and people with disabilities. Sadly, years of underfunding are undermining this promise. High-quality, accessible long-term care is costly, and New York's Medicaid rates have not kept up with costs.

Older adults, people with disabilities, and their caregivers are feeling the pain of Medicaid's broken promises today. Consumers cannot access skilled home health care or necessary hours of personal care in many communities because home care agencies are unable to recruit sufficient nurses and aides within the reimbursement they receive. Adult day health care programs and adult care facilities that serve Medicaid and SSI/SSP beneficiaries are closing due to inadequate rates that prevent them from recruiting staff and covering costs, driving people to seek nursing home care when a lower level of care may be more appropriate. Older adults who need nursing home care cannot find high-quality care close to loved ones because quality nursing homes are limiting admissions, closing entirely, or selling to operators that have been willing to staff at the lean levels covered by the insufficient Medicaid rates. The situation will not improve without significant investment. Regulatory reform, changes in certificate of need, and age-friendly communities will not solve our system's problems. If New York is truly committed to health equity and aging with dignity in one's preferred place for people of all income levels and in all regions of the State, it must be prepared to pay for it .

Congregate Settings are Integral to Healthy Aging and Community Integration

In addition to the report's omission of concrete recommendations related to funding for LTSS, we are concerned that its emphasis on home-based care and "aging in place" overlooks the important role in the aging services continuum of community-based congregate services – whether residential or non-residential. These include housing with services, medical model adult day health care (ADHC) services, adult care facilities/assisted living (ACF/AL), social adult day services, and PACE programs. We agree

with the report's observations about the critical importance of home care to enable individuals to reside in the most integrated setting. However, congregate settings have been recognized as "vital to the vision of older adults' dignity, choice, and self-determination"[1] and integral to combating the social isolation that often leads to physical and cognitive decline. According to Advancing States' (formerly the National Association of State Units on Aging) 2023 Report, social isolation and loneliness negatively affect lifespan, physical health, and mental health, which further drive up Medicare spending.[2] Congregate programs can supplement and support overwhelmed informal caregivers, who are often older adults themselves. They can also be lifelines for older adults who lack informal caregivers.

For too many older New Yorkers "aging in place" entails complete social isolation – their children have moved away, their friends and neighbors have died, and they cannot manage to leave their homes without substantial assistance. They may conceal their declining health and functional status from loved ones because they don't want to be a burden or because they are embarrassed of their limitations. There are also many older adults whose devoted informal caregivers are stretched to the breaking point (and who are typically older adults themselves). They may be caring for a loved one with dementia that has triggered abusive behaviors or wandering in the middle of the night. Or, their loved one may have complex medical and personal care needs that require constant attention. For older adults who need and want a higher level of care, who desire additional social interaction, who lack informal caregivers, or whose caregivers need respite, high-quality services in congregate settings should be available and accessible to enable them to age in their preferred place.

While New York State has invested heavily in rebalancing its long-term care system to serve individuals in the most integrated setting, it has emphasized home-based care and neglected the array of congregate services and settings that can alleviate social isolation, support healthy aging and community integration, and serve as an alternative to nursing home care for those who cannot be served appropriately with home care alone. As a result, there is a gap in the aging services continuum in most communities, where housing with services, ADHC programs, and/or assisted living are either unavailable or unaffordable. Individuals who need and want congregate services and supports, such as medical model adult day health care or assisted living are not able to access those settings and may prematurely seek nursing home care as a result.

According to AARP's 2023 State Scorecard, **NYS has the lowest assisted living supply** in the nation with **20 beds per 1,000 population age 75**+. Measured another way, nationally there are **5.26** people age 85+ per assisted living bed, whereas New York State has **9.52** people age 85+ per assisted living bed

[1] Butler, S. and Hederman, C., Improving Care for Older Adults: Convergence Dialogue on Reimagining Care for Older Adults, Convergence Center for Policy Resolution, Aug. 2022, accessed at https://convergencepolicy.org/our-work/health-and-wellbeing/reimagining-care-for-older-adults/ .

[2] Advancing States, Services to Address Social Isolation: Findings and Recommendations, 2023, accessed at: http://www.advancingstates.org/sites/nasuad/files/Social%20Isolation%20Recs%20Report%208.22.23.pdf .

and **34.98** people per Medicaid Assisted Living Program (ALP) bed.[3] ADHC programs are similarly in short supply. Less than half of licensed ADHC programs have reopened since the pandemic closures, and only 24 counties have open programs.[4]

New York Must Not Abandon Individuals Who Need Nursing Home Care

The preliminary report seems to avoid any discussion of nursing home care – other than to point out that 70 percent of older adults are unwilling to live in a nursing home. No one wants to think about a time when they may be entirely dependent on others for basic needs. Nor does anyone want to think about needing hospital care or dialysis. But, if we do need those services, we want them to be close to home and high-quality. Just as we do not abandon individuals who need acute care or dialysis, we cannot abandon older adults with the highest care needs – those who require 24/7 care, skilled nursing, continuous medical oversight, and/or extensive assistance with activities of daily living. When nursing homes are under-funded and when they are forced to limit admissions or close, the consumers who need long-term skilled nursing care or short-term rehabilitation services (and their caregivers) suffer. Our efforts to promote care in the most integrated setting should not deny those who need nursing home care access to the best possible quality of care and quality of life in close proximity to their loved ones.

Our Master Plan for Aging should ensure the availability and accessibility of high-quality, person-centered nursing home care statewide that offers residents the opportunity to maintain their best possible physical, mental, and psychosocial well-being in homelike environments. It should support the development of innovative nursing home models like Green House and small house facilities. It should foster greater integration of nursing homes into the local community, for example by enabling partnerships with other health care and educational institutions, community-based organizations, and other aging services providers and facilitating the use of nursing home space for additional community services and programs.[5]

Comments on Selected Pillars

- **Housing and Community Development**

We appreciate that the preliminary report – and the MPA process – recognize housing as a determinant of long-term health for all New Yorkers and a critical option in the continuum of care for older adults. We also agree that one potential solution to reducing loneliness and isolation is to

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[3] LeadingAge NY analysis of Nat'l Center for Health Statistics 2020 LTC Providers & Services Users in the US: Residential Care Component; U.S. Census Bureau, American Community Survey 2021 Five-year Sample, Tables B01001A-B01001G, B01001I; Adult Care Facility bed data, https://healthdata.ny.gov/, downloaded July 27, 2023.

[4] NYS Dept. of Health data, Oct. 2022, updated by NYS Adult Day Health Care Council.

[5] Butler, S. and Hederman, C., Improving Care for Older Adults: Convergence Dialogue on Reimagining Care for Older Adults, Convergence Center for Policy Resolution, Aug. 2022, accessed at https://convergencepolicy.org/our-work/health-and-wellbeing/reimagining-care-for-older-adults/

"design affordable and accessible housing for health with connection to others." (Preliminary Report, p. 16).

We would like to recommend expansion of the senior housing with services model. Senior housing with on-site services or resident assistance can provide immense benefits to older adults and their communities at large. For example, resident assistants or service coordinators in affordable senior housing can help older adults to remain healthy and independent and combat social isolation by: (1) providing information and referrals to resources in the community, education on Medicaid and other public benefits, and assistance with accessing these benefits and preventative programming; and (2) assisting with tasks like arranging for transportation and using technology to support telehealth and social visits; and (3) supporting wellness and social engagement by coordinating on-site programs such as clubs, health fairs, exercise classes, and celebrations.

Extensive research has proven that these models – which include the New York-based Selfhelp Active Services for Aging Model, or "SHASAM" – are effective at helping low-income older adults delay or avoid higher, more costly, and more staffing-intensive levels of care and reducing the use and cost of hospital services for these individuals. [6,7,8]

This conclusion has been validated by a recent study by NORC at the University of Chicago, funded by a grant from the National Investment Center for Seniors Housing and Care, which found that vulnerability rises in the months prior to a move into a senior housing and care community. Approximately three months following move-in, however, vulnerability plateaus and thereafter improves. This result is consistent across all senior housing and care property types – independent living, assisted living, memory care, nursing care, and continuing care retirement communities (CCRCs).[9]

While we are pleased with the preliminary report's focus on housing, we are puzzled by the specific reference on page 24 of the report to the Bedford-Stuyvesant Restoration Corporation model. This organization does not appear to focus on older adults or access to senior services. In addition to the SelfHelp SHASAM program, another example of a community-based approach to healthy aging is Episcopal Senior Life Communities' (ESLC's) Neighborhood Program in Rochester. For a very affordable

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[6] Gusmano, MK. Medicare Beneficiaries Living in Housing with Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* Oct. 2018. Accessed at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.0070

[7] The New York Housing Conference. Spotlight: A Conversation with Mohini Mishra, Selfhelp Realty Group. July, 2021. https://covid19.nhc.org/best-practice/a-conversation-with-mohini-mishra-selfhelp-realty-group/

[8] 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. https://mthcf.org/wp-content/uploads/2018/01/core_health_in_housing_full_report_feb_2016.pdf

[9] Munevar, D. and Gorman, C. (2023, September). *Vulnerability to Adverse Health Outcomes Amongst Senior Housing Residents* [PowerPoint slides]. NORC at the University of Chicago. https://www.norc.org/content/dam/norc-org/pdfs/20230922_NIC%20Frailty%20DAC%20Chart%20Pack_FINAL.pdf

price, older adults in the neighborhoods surrounding ESLC's senior housing may join the senior housing residents in extensive social and recreational programs.

We are also interested in further information regarding the reference on page 15 of the report to zoning relief and as-of-right use approval for residential "continuum of care communities." We would like to provide informed feedback on this recommendation from appropriate providers and stakeholders.

- **Informal Caregiver and Workforce Support**

We agree that support for both informal and formal caregivers is a critical element of quality of life for older adults. The potential solutions identified in the preliminary report show promise, and we are particularly interested in efforts to facilitate attainment (and retention) of multiple certifications, e.g., Personal Care Aide (PCA), Home Health Aide (HHA), and Certified Nursing Assistant (CNA). We urge the Governor and the Department to advance again the proposal to authorize the use of Medication Aides in nursing homes as a career ladder for CNAs and to enable nurses to focus on higher level tasks.

We also note that the ability to pay appropriate wages to support the challenging and skilled work that formal caregivers provide depends on payment of adequate Medicaid and SSI/SSP congregate care rates. As noted above, providers cannot compensate their staff appropriately and cannot recruit staff in sufficient numbers if Medicaid rates do not cover the costs of doing so.

In addition, we would like to highlight the important roles played by licensed professionals in delivering services to older adults, including home care and nursing home care. Shortages of nurses, social workers, and other professionals are impacting access to, and quality of, care. We understand that the Master Plan for Aging team will be creating a work group focusing on licensed professional staff. We look forward to working with the team on this initiative.

- **Modernization and Financial Sustainability of Healthcare, Residential Facilities, and Community-Based Aging Network Service Providers**

We commend the preliminary report's inclusion of this pillar among its areas of focus. As older adults enjoy longer lifespans due to medical advances, they are likely to require long-term services and supports. A high-quality, geographically-accessible, and financially-viable continuum of facility-based, home-based, residential and non-residential long-term care providers is critical to the well-being of New Yorkers as we age.

However, it is difficult to envision how the keys to resolution and potential solutions identified in the preliminary report will achieve the goals embraced by this pillar. Without Medicaid reimbursement that covers the cost of care, our system of long-term care will not be financially sustainable and will not deliver the high-quality care and high quality of life that we all want for our loved ones and for

ourselves. Regulatory reforms and best practices cannot stabilize providers that are unable to hire and pay the staff they need. Instead of the potential solutions outlined in the preliminary report, we recommend the following:

- Provide an immediate increase in Medicaid rates for LTC providers in the 2024-25 budget.
- In addition to the immediate rate increase, reform nursing home, ADHC, and ALP rates by updating the cost base year and rationalizing the acuity adjustment method that determines nursing home rates.
- Support the creation of homelike and dementia-friendly environments in facility-based settings, as well as facility upgrades to prevent the spread of infections and facility investments in technology, through targeted capital grants.
- Update or waive the nursing home per bed construction cost caps. Current caps do not reflect current costs of constructing or renovating facilities and do not accommodate the costs of single-bedded rooms and of developing Green House/small house and specialty care units or facilities. In addition, reduce the required equity contribution to 10 percent of total project costs.
- Prioritize long-term care providers for grants under the Statewide Health Care Facility Transformation Program and expedite awards under the pending rounds.
- Allow the development of new ALP beds before the completion of the need methodology that must be developed by 2025, in order to enable Medicaid-eligible individuals who need this level of care to be served in the most integrated setting.
- Update environmental and life safety codes for nursing homes and assisted living facilities in order to facilitate the creation of homelike, dementia-friendly settings.

In addition to advancing the above alternative recommendations, we would like to provide feedback on the Preliminary Report's potential solutions under this pillar. We provide this feedback with the caveat that we will need more detail on many of the recommendations in order to provide productive input. The following are some preliminary comments:

- The report refers to "enhanced community service obligations" for all health service providers. We are familiar with the "community benefit" obligations of hospitals and the community reinvestment obligations of banks. We are wondering whether this recommendation is intended to require similar obligations of long-term care providers. Currently, most long-term care providers are operating with thin or negative margins. Requiring them to invest in their communities will only deplete their ability to continue to fulfill their mission of serving older adults with long-term care needs.

- The report references capital assistance for 'advanced technology.' We are unsure of the technology under consideration here. Long-term care providers have been under-represented in state capital grants and were not eligible for federal funding for electronic health record adoption.   Grants to support technology acquisition and implementation would be welcome.

However, facility-based long-term care providers need capital grants (and regulatory reforms related to project costs and equity as noted above) not only for technology, but also for modernizing facilities to enable the delivery of more person-centered care, to strengthen environmental infection prevention controls, and to create more homelike environments.

- The report suggests that one potential solution to support modernization and financial sustainability is reducing regulatory barriers to transitioning facilities to lower levels of care and "alternative uses (e.g., from nursing home to assisted living or other lower-support housing options)." As the MPA team considers lowering barriers to converting nursing homes to lower levels of care, it should also consider allowing the creation and expansion of assisted living programs (which are currently frozen while the state develops a need methodology) and the impact of the health equity impact assessment requirements on efforts to reduce nursing home beds.

- Another potential solution identified in the report is to "review/streamline adult care facility and skilled nursing facility need methodologies and Certificate of Need processes." Currently there is no need methodology for adult care facilities or assisted living programs. In fact, as noted above, there is no avenue to increase assisted living program capacity until the State creates an ALP CON methodology, which it is statutorily required to complete by 2025. (As discussed above, this freeze should be lifted to enable development of additional ALP capacity prior to 2025.) Unlike ACFs, nursing home beds are subject to a need methodology and to health equity impact assessments when facilities seek to increase or reduce them significantly. However, there is little to no development of additional nursing home beds.

  While we see little connection between updates in need methodologies and the financial sustainability of nursing homes or adult care facilities, we believe that updates in construction cost caps, equity requirements, and environmental standards, as noted above, would be important to facilitate modernization of facilities.

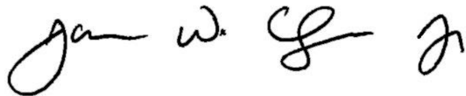
- The report also suggests that allowing flexibility in bed licensing to maximize efficiency would provide help to modernize and stabilize the system. It is unclear what is intended here, how this would support stability of the system, or how it would be funded.

- While a statewide study on the quality, accessibility and affordability of skilled nursing and adult care facilities to determine best practices to support sustainable quality-driven operations might be helpful, the system will deteriorate further and the pool of facilities able to implement those best practices will be extraordinarily limited, by the time it is completed. We already know what the issues are; immediate action is needed to preserve access to quality providers.

- Finally, the report suggests that sharing of best practices by trade associations and financially advantaged health care providers would help to support the financial viability of providers. As an association of long-term care and aging services providers, we regularly disseminate best practices to our members, both from experience gained in New York State and nationally. In the absence of adequate reimbursement, unfortunately, best practices cannot stabilize and preserve high-quality providers.

We very much appreciate the opportunity to comment on this report and look forward to working with you on the next report.

Sincerely yours,



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