A FRAMEWORK FOR REVITALIZING LONG-TERM CARE IN NEW YORK STATE

An overwhelming 87 percent of the people who died from COVID-19 in New York State were over age 60.[1] This devastating outcome underscores not only the vulnerability of older adults to the virus, but also the importance of targeting resources at the long-term care (LTC) system that serves those with complex medical conditions and functional limitations. Unfortunately, the prior administration failed to prioritize long-term care providers for PPE, COVID testing, or staff support when the pandemic hit. Instead, it cut Medicaid rates and prevented collaboration among relevant government agencies and with the provider community. By contrast, over two-thirds of states have increased Medicaid payments for home and community-based services during the pandemic, and over half have increased Medicaid payments to nursing homes.

This issue brief describes the current state of our LTC system and how the prior administration's policies depleted its resources, devalued its role, and prompted the closure and sale of dozens of non-profit and public nursing homes since 2014. It then presents a framework for revitalizing LTC that will promote access to high quality services and supports for New York's growing population of older adults and individuals who need long-term care services.

I. THE CURRENT STATE OF LTC IN NEW YORK

Inadequate and Ill-Designed Rates

New York's LTC system has been built on fragmented financial foundation, relying principally on government funding. The Medicaid program is the largest payer for LTC in New York and nationwide. Nursing homes and certified home health agencies (CHHAs) deliver post-acute care services covered by Medicare, as well as LTC. Long-term care providers also receive funding, in much smaller amounts, through the Older Americans Act, NYS Office for the Aging, and the Supplemental Security Income (SSI) and State Supplement Program (SSP). Each source of funding has its own eligibility and coverage rules, and administrative requirements, leading to conflicting and overlapping program goals, cost shifting and, too often, disjointed services.

Medicaid is undeniably the *de facto* LTC insurance program in New York State, covering three-quarters of all nursing home residents and even higher percentages of individuals receiving certain community-based services. As the primary LTC payer in New York, Medicaid bears significant responsibility for access to high-quality LTC services and supports, the financial viability of the LTC sector, and its capacity to compensate staff appropriately for the demanding work they perform.

The prior administration largely abdicated that responsibility. For too long, New York's principal LTC policy focus has been on cutting Medicaid spending on these services. Year after year, New York's LTC sector has borne deeper Medicaid cuts than any other health care sector, amid rising costs and administrative requirements (See Figure 1). Even before the pandemic, for example, New York had the largest shortfall in the nation between the cost of care and its Medicaid

[1] NYS Dept. of Health, COVID-19 Fatalities by Age Group, accessed 8/26/2021, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n

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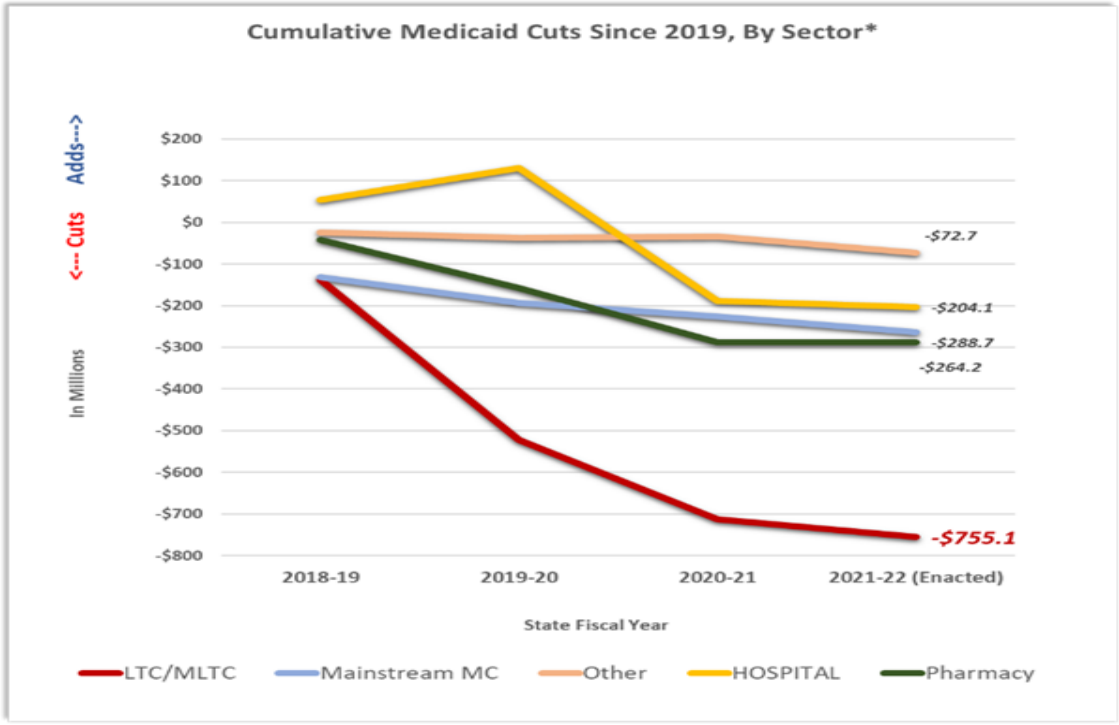
nursing home rates.[2] Similarly, the State has failed to increase the state portion of the SSI benefit – SSP -- for residents of adult care facilities (ACFs) since 2008 – requiring providers who serve SSI/SSP beneficiaries to offer room, board, personal care, case management, medication management and more at a rate of little more than **$42 per day**.

The State has also consistently neglected the need for investments in the LTC infrastructure. A meager 2 percent of Medicaid waiver Delivery System Reform Incentive Program (DSRIP) funds and 10 percent of Statewide Health Care Facility Transformation Program funds have been allocated to LTC providers (See Figures 2 and 3).

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.

[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.

Figure 2

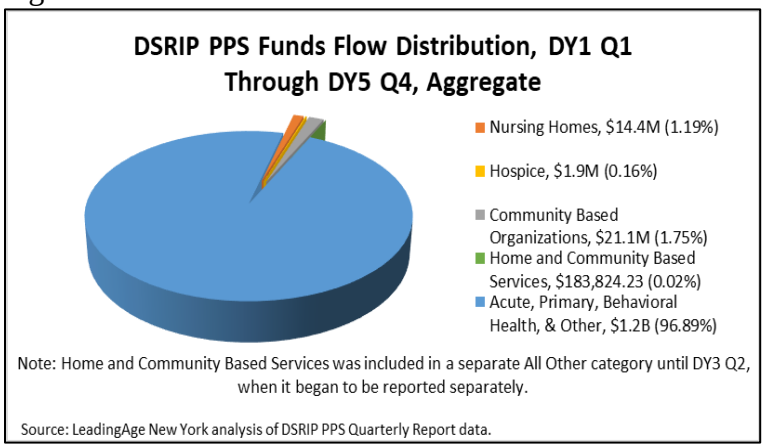
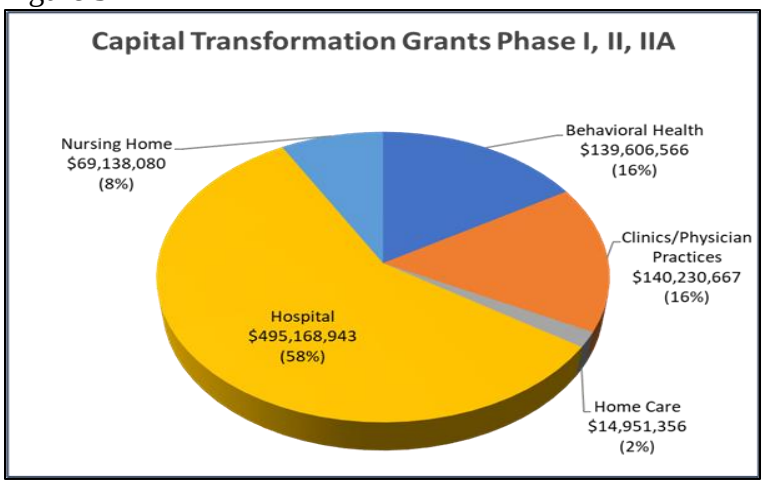


Figure 3



The prior administration's policy of cutting LTC funding continued even when COVID-19 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 across the board and imposed additional cuts on nursing homes.

The State's Medicaid payment methodologies are not only inadequate, but also too often result in inequitable allocation of resources, exacerbating the impact of overall funding inadequacy. For example, under statewide pricing of nursing home care, implemented in 2012, neighboring facilities are paid essentially the same rate without regard to their level of investment in direct care. This has predictably led to closures and sales of facilities that spent greater amounts on resident care than the prices allowed. As a result, high-quality options for long-term and post-acute care in nursing homes is more limited today than it was 10 years ago.

This exclusive focus on containing spending has also weakened cost-effective LTC services that delay or prevent the need for more expensive Medicaid-financed services. For example, about

13,000 older adults rely on SSI/SSP to pay for services they receive in ACFs at the current rate of just over $42 per day. This reimbursement covers only half of the actual cost of providing a comprehensive array of services -- a gap that is growing due to COVID-related costs and new mandates. If ACFs continue to close or cannot afford to serve SSI/ Medicaid-eligible seniors, more of these individuals will need to seek care in nursing homes at a much higher cost to the State.

The Impacts of Under-Funding and Skyrocketing Pandemic-Related Costs

The financial position of many providers, especially not-for-profit providers, was shaky before COVID, and the situation is now dire. Costs have skyrocketed, and revenues have plummeted. Providers have spent millions on hazard pay, overtime, bonuses, and extortionate staffing agency fees to recruit and retain workers. They have spent as much on PPE, COVID testing, disinfectants, partitions and cohorting, and visitation spaces and staff. While the federal government has made available Provider Relief Funds, these have covered less than half of the expenses in nursing homes and an even smaller percentage in assisted living and home care.

At the same time that costs have soared, patient/resident censuses have shrunk, reducing the revenue available to cover fixed costs. Further, as a result of reduced occupancy, nursing homes are unable to claim the full amount of Medicaid reimbursement for their capital costs – a rate-setting decision that the Department could easily reverse.

In 2019, two-thirds of not-for-profit (NFP) nursing homes and 90 percent of public homes were operating at a loss, a worsening trend that continued into 2020. Based on a comparison of 2019 and 2020 cost report data, patient care revenue coverage of expenses declined in almost every facility that shared their 2020 data. Similarly, it is estimated that most home care agencies are operating with negative margins and that their financial condition has worsened significantly since the onset of the pandemic. As the predominant payer, Medicaid is a driving factor in this financial turmoil.

Likewise, ACFs that serve low-income individuals are struggling to stay open, given inadequate SSP reimbursement. Since 2017, 38 ACFs have closed voluntarily; eight of which closed in 2021. We know that more are in the process of closing. When people without financial resources are displaced from ACFs, they typically go to a nursing home, with Medicaid as the payer, at a higher cost to the State. While new assisted living facilities are obtaining licenses, they are generally being developed to serve the private pay market.

The Shrinking Not-for-Profit Nursing Home Sector

The extraordinary unbudgeted costs of the pandemic and years of under-funding, coupled with dire workforce shortages, are decimating our not-for-profit nursing homes. Since 2014, 50 public and NFP nursing homes have been sold to for-profit entities, and 20 nursing homes have consolidated or closed. In addition, since beginning of the pandemic alone, 4 non-profit nursing homes have closed, and several homes throughout the State, including in NYC and LI, are in various stages of closure or sale. We fully expect these numbers to grow.

Our not-for-profit nursing homes cannot remain viable without immediate assistance from the State, and we have proposed a series of Medicaid and quality-related adjustments to preserve access to high-quality nursing home care. These proposals are attached for your review.

The Growing LTC Workforce Crisis

As you are well aware, providers across the health care continuum are facing unprecedented workforce shortages. The workforce shortages are particularly intractable for LTC providers because the State's Medicaid and SSP payment rates do not allow LTC providers to offer competitive compensation to their personnel. Unlike hospitals and other employers, they cannot raise revenue to cover higher wages by raising prices. Reimbursement from commercial insurance or other private sources simply does not represent a significant portion of their revenue.

Last week, 60 percent of our nursing home members reported that they had been forced to suspend admissions due to staffing shortages; 40 percent had closed units. Our home care members are turning away new patients because they don't have nurses to conduct admission assessments, and they are unable to fill needed home care hours. This lack of capacity will create growing challenges, as hospitals are unable to find discharge destinations for patients who need post-acute care. In the long term, we will be unable to serve a growing number of older adults who need assistance with activities of daily living and skilled nursing care.

LeadingAge NY has proposed a multi-faceted workforce plan featuring investments and no-cost regulatory and statutory reforms to reduce support the recruitment, retention, and efficient deployment of nursing home, assisted living, and home care staff. Key proposals to build the workforce are outlined in Part II below.

Outdated LTC Infrastructure

In order to ensure the delivery of high-quality care, the state must support investments in critical infrastructure improvements in LTC from technology and health information exchange to physical plant upgrades that support infection prevention, energy efficiency, and homelike environments in nursing homes, assisted living programs, and adult day health care programs. As noted above, previous distributions of capital grants have largely overlooked the LTC sector. In the midst of a pandemic involving an airborne virus, it is critically important for facility-based providers (e.g., nursing homes, assisted living facilities, adult day health care programs, and PACE programs) to make capital investments that support cohorting, ventilation, safe visitation, and staff safety.

We recognize that the recent Statewide Health Care Transformation request for applications dedicates $23 million to nursing homes of the $208 million available. **Unfortunately, the minimum direct care spending regulations recently published by the Department of Health will prevent nursing homes from undertaking any significant capital projects, even if funded with state grants.** The regulations do not provide an avenue to disregard capital grants from the calculation of the required direct care spending, and the Department's published Q&A on the grants do not provide any reassurance. Moreover, even if facilities fund capital improvements with bond financings or bank loans, any capital reimbursement they receive through Medicaid would be included in the minimum direct care calculation, with the exception of a 3-year incremental amount. **These regulations will actually discourage, if not outright prevent, facilities from making capital improvements that support infection control efforts during a pandemic involving an airborne, highly contagious virus.**

Ballooning Administrative Requirements

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 HERDS reports, 365 days per year, to the Department of Health (DOH) with approximately 85 data elements. In addition, they must submit weekly reports to DOH with other data, and nursing homes must also submit weekly reports to CDC with similar, but not identical, data. Home care agencies must also submit reports regularly to DOH. Providers are subject to extensive documentation and reporting requirements on a variety of COVID-related activities, including (among others) visitor screening; personal protective equipment stockpiles; COVID testing and vaccination of staff, patients and residents. Nursing homes are also now required to summarize every contract for goods and services, post the summaries on their websites, and notify the Department 90 days in advance of entering into any contract for consulting or staffing (a requirement that is impossible to meet in the context of a staffing crisis).

These new mandates are not only costly; they divert precious staff resources from the all-important responsibilities of caring for patients and residents. Moreover, it is not clear that all of these mandates contribute to the quality of care delivered or the ability to respond to the pandemic.

II. A FRAMEWORK FOR LTC REVITALIZATION

New York must take bold action now, leveraging available federal support and state dollars, to revitalize its LTC system. Just as our LTC system teeters on the brink of collapse, our State is on the brink of a major demographic shift. Between 2015 and 2040, the number of adults aged 65+ will increase by 50 percent, and the number of adults over 85 will double.[3] At the same time, the percentage of potential caregivers aged 18 to 64 is shrinking. Without proper planning and decisive action, these demographic realities will result in lack of LTC capacity to meet growing need. As we are already seeing, the implications of that will ripple throughout the healthcare system and have dire consequences, not just for older adults, but all New Yorkers.

In order to rebuild and revitalize our long-term care system in preparation for this demographic shift, we will need a multi-pronged, inter-agency effort that includes Medicaid dollars, other state and federal funds, regulatory reforms, and private and public sector engagement in workforce development.[4]

Policy Priorities and Goals for LTC

Simply put, the State's policies and investments should promote the creation of a LTC system that prioritizes health equity across all dimensions. Our policies and investments should further be guided by the following goals:

[3] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/ ; accessed 1/4/19.

[4] Our vision for the LTC system is also reflected in many of the proposals set forth in a recent publication by the National Association of Medicaid Directors. .Browning, L., Hammer, G. "Medicaid Forward: Long Term Services and Supports. Fall 2021. Accessed at https://medicaiddirectors.org/medicaid-forward-executive-working-groups/ .

- ***Promoting Access and Choice***: Our 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 assisted living.
  - Include nursing homes that offer homelike environments, vibrant social, lives, and personal privacy, 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 should have the resources to make capital investments that mitigate the risks of infectious diseases and to deliver advanced clinical care that reduces avoidable hospital use.
- ***Developing a Well-Qualified, Appropriately Compensated, and Ample Workforce:*** The State must take immediate steps to bring more people into the LTC field, retain existing staff, and deploy available staff efficiently given demographic changes. Those steps should include:
  - Raise Medicaid and Congregate Care Level 3 SSP rates to enable providers to pay competitive compensation and provide work-related supports for their staff;
  - Expand access to aide training and nursing programs, by supporting the development of new programs, paying stipends and providing supports to trainees, increasing the availability of financial aid for nursing students, and increasing the availability of instructors for aide training programs and professors for nursing programs by reducing requirements;
  - Reduce regulatory barriers to obtaining and retaining aide certifications, including certifications in multiple categories;
  - Optimize the use of existing workers and improve retention by allowing medication technicians in nursing homes and enabling professionals to practice at the top of their scope;
  - Expand the availability of nurses by joining the interstate nurse licensure compact; and
  - Reduce barriers to onboarding new staff, including expansion of fingerprinting access points.
- ***Driving Quality and Value:*** The State's policies should incentivize the delivery of high-quality, person-centered care, through financial incentives that are reliable, timely, additive, and non-punitive.
- ***Strengthening Integration:*** Our policies should support integration and coordination along the spectrum of LTC 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.
- ***Targeting High Priority Social Determinants of Health (SDOH) for Older Adults:*** The State should address the SDOH for older adults through strategies tailored to their unique needs and preferences. It should expand and effectively use existing community programs and services that serve older adults, rather than spending precious resources on new layers of administration and building new programs from scratch. These strategies should target investments to delay the need for higher levels of care and slow the growth rate of public expenditures. The State should also expand support for unpaid, informal caregivers.

Sources of Funds

A meaningful investment of Medicaid dollars must be the foundation for achieving these goals. This should be accomplished through a combination of:

- Medicaid rate enhancements and targeted funding pools,
- the $17 billion Medicaid 1115 waiver under development, and
- the Home and Community-Based Services Enhanced Federal Medical Assistance Percentage (HCBS eFMAP) and federal Build Back Better funds if they become available (note that Build Back Better does not appear to provide a meaningful investment in nursing home care).

With these three funding sources, we could revitalize LTC services and prepare for the coming demographic wave.

The State's new 1115 waiver demonstration presents a unique opportunity to make transformative and critically needed investments in LTC. We are concerned, however, that the new $17 billion Medicaid waiver once again overlooks long-term care. **The new waiver funds must focus on LTC to address the needs of our growing older adult population that has been so disproportionately affected by the pandemic.**

We further urge the State to distribute the HCBS eFMAP equitably in a manner that supports choice and access across the State's diverse communities and various HCBS provider types. Specifically, it should ensure that the new eFMAP funds are used to support the workforce not only in large licensed home care services agencies (LHCSAs) serving populous areas, but also in those that serve rural areas or specialized populations. Funds must also be made available to LHCSAs associated with ALPs or with continuing care systems and to certified home health agencies and hospice programs.

In addition, LTC should be prioritized for the Statewide Health Care Transformation capital grants. Further, these grants and the reimbursement associated with the capital projects must be excluded from revenue in the nursing home minimum direct care spending calculation. Otherwise, our nursing homes will not be able to invest in improvements to protect residents and staff from COVID and to offer more homelike environments and innovative models, like the Green House and small house models.

Notably, we support investments in all services on the LTC continuum and are strong proponents of serving individuals in the most integrated setting. However, we cannot support policies that invest only in HCBS to the exclusion of nursing homes. There are approximately 90,000 residents who live in New York's nursing homes – many have no other home and no loved one who could assist with their care in the community. Ninety-seven percent require assistance with toileting, forty percent require two people to assist with sitting up or turning in bed, and over half have diagnoses of dementia. We owe it to them to invest in high-quality nursing home care.

Finally, for those who do not need nursing home care, we support investments in affordable housing with services and Medicaid-funded assisted living. Our Affordable Independent Senior Housing Assistance Program proposal would expand funding for affordable senior housing with services. This proven model saves both Medicaid and Medicare dollars, while optimizing the health and independence of older adults and delaying entry into nursing homes.

A Call for Collaboration

We look forward to an ongoing dialogue with the Department of Health on these issues and many others – especially pandemic response. Our members and the individuals they serve would benefit from active engagement, two-way information exchange, and sharing of ideas with the Department. We also believe that the State's response to the pandemic and staffing shortages would benefit from information about conditions in the field and feedback on proposed initiatives that could be gained from speaking with the associations. Engagement with the Department of Health has certainly improved since August, and we would welcome the opportunity to have more regular interaction with your staff.

Notably, the Department of Health's oversight of nursing homes, in particular, has become antagonistic and unpredictable over the course of the pandemic. For example, facilities are cited and threatened with license revocation for submitting their daily HERDS survey 15 minutes late on even one occasion after 17 months of consistent compliance. There is frequent confusion among facilities, surveyors, and regional epidemiologists concerning the applicable COVID guidance and its interpretation for ACFs and nursing homes. On occasion, local health departments weigh in with conflicting directives. Nevertheless, surveyors seem reluctant to exercise any enforcement discretion and do not hesitate to issue citations for inconsequential matters unrelated to care (e.g., a missing signature/date; a menu change from baked to boiled potatoes) and will often select the most serious level of citation even when guidance is unclear or conflicting. Further, there appears to be no recognition of the severe staffing crisis confronting facilities in the way that surveys are conducted and the nature of deficiencies cited.

We agree that facilities must be held accountable for poor quality care. However, in the midst of a pandemic where guidance and science are evolving, and staffing is short, regulators should be able to work with providers to promote the best possible care for the residents, rather than searching high and low for any minor deviation from regulatory guidance.

Conclusion

New York is falling behind in responding to the demographic change already under way, and we are failing New York's older adults and other vulnerable populations. We must implement strategies immediately to build the LTC workforce and to ensure that high-quality, mission-driven nursing homes, assisted living, and home care agencies are available as the Baby Boom generation ages.

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