Joint Legislative Public Hearing on Health/Medicaid
Testimony Presented By:
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Senate Finance Committee Chair John A. DeFrancisco
&
Assembly Ways and Means Committee Chair Herman D. Farrell, Jr.

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Introduction

My name is James W. Clyne, Jr., and I am the president and CEO of LeadingAge New York. Thank you for the opportunity to testify on the health and Medicaid aspects of the SFY 2013-14 Executive Budget.

My comments today will focus on six broad themes: (1) the Medicaid cap; (2) payment adequacy and oversight; (3) mandate relief; (4) care management for all; (5) infrastructure investments; and (6) ownership of health care facilities. Left unaddressed, these issues could derail efforts to meaningfully redesign the Medicaid program and prepare for implementation of federal health reform. Frail elderly and disabled New Yorkers could be displaced; additional providers could go out of business and more health care workers could lose their jobs if the current trajectory of change is left unaltered.

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 (MLTC) plans. LeadingAge NY's 600+ members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives LeadingAge NY a unique understanding of the potential impact of the 2013-14 Executive Budget on the entire system of services for seniors and disabled people of all ages.

Global Cap

The proposed budget continues and extends for one additional year authorization for both the Medicaid global spending cap and the "super-powers" granted to the Commissioner of Health to reduce spending if expenditures exceed projections.

Several factors entirely out of the control of the provider community could cause the cap to be breached (e.g., an expansion of Medicaid services due to federal mandates or a further economic downturn), and yet it is the providers that would likely have to bear the brunt of dealing with the issue. Furthermore, how the administration develops spending projections for each category of

service (which is not well understood) could have a bearing on whether a certain type of provider could face a non-uniform cut if the cap is exceeded.

Under the Executive Budget, the annual cap on state share Medicaid expenditures would increase from $15.9 billion in SFY 2012-13 to $16.5 billion in 2013-14, for a less than 4 percent increase. The governor's budget would further establish the Medicaid global cap for SFY 2014-15 in law at $17.1 billion.

These increases are based on 10-year average growth rates in the medical component of the consumer price index, which is a measure of price inflation in health care. However, changes in the cap are not being applied as limits on allowable price increases in health care services. Instead, the cap acts as a limit on total state share Medicaid health spending which is affected by a complex array of variables including changes in: (1) Medicaid enrollment; (2) patient acuity; (3) composition of services; and (4) payment arrangement (i.e., fee for service vs. managed care). For example, Medicaid enrollment has increased by 114,700 recipients (2.3%) in the first eight months of the current fiscal year alone. Providers should not be at risk of being arbitrarily penalized for macroeconomic factors that negatively impact on the global spending cap.

Other factors which increase the costs of providing services are not even showing up in state Medicaid reimbursements including pay increases for staff and expenses associated with new mandates such as the wage parity law for home health workers. Ironically, increases in the global cap are tied to an inflationary index and yet the Executive Budget would permanently eliminate trend factor (i.e., inflationary) adjustments to provider and plan payments.

Recommendation: *Adjust the $16.5 billion Medicaid global spending cap for SFY 2013-14 to provide sufficient funding for recipient enrollment growth, increases in patient acuity in fee-for-service and managed care settings, elimination of the 2 percent across-the-board cut, and instituting quality payments and performance-based inflationary adjustments. As Medicaid redesign proceeds and funding shifts among service categories, the Legislature should also continue to closely monitor the development of spending projections by service category as well as actual spending trends by service sector.*

Payment Adequacy and Oversight

Medicaid is the predominant funding source for long term care (LTC) services in New York State. With no full inflation factors paid to providers in 5 years, changes to reimbursement methodologies that divorce payments from providers' costs of delivering care and increasing pressures from other payers, providers are facing growing gaps between Medicaid reimbursement levels and the actual costs of delivering high quality care. As a result, the majority of not-for-profit and public providers are losing money on operations; programs and facilities are closing and others are being downsized. Access to services is in growing danger of being seriously compromised.

In spite of growing operating costs – including costly mandates like the wage parity law passed in 2011 and further mandates discussed below – providers will receive no cost-of-living adjustment once again in 2013. Making matters worse, the Executive Budget includes a proposal to permanently eliminate any statutory requirements to provide needed inflationary adjustments to Medicaid rates and other state payments to providers. In the context of the global spending cap, this action would make it unlikely that service providers will receive necessary inflationary adjustments anytime soon.

Furthermore, the Executive Budget would consolidate (and eventually reduce) funding for a series of public health programs, and authorize the Commissioner of Health to unilaterally allocate and award funding in six areas. Besides freezing the level of funding and eventually reducing it by $40 million annually, this proposal would effectively eliminate any legislative input into the funding levels for programs such as EQUAL, which supports quality improvements in adult care facilities that serve low-income seniors.

Recommendation: *Lawmakers should reject the permanent elimination of the requirement in state law to provide inflationary adjustments to payments made to Medicaid and other service providers. The Legislature should also take affirmative steps to ensure the adequacy and integrity of funding for public health programs in the final budget.*

Nursing home care reflects large fixed investments in physical plants, with financing that is predicated on a reliable stream of Medicaid capital reimbursement. For over 30 years, the state's policy has been to reimburse nursing home capital expenses based on actual (i.e., "historical")

costs, subject to certain limitations. This policy, which has been controlled through the state's Certificate of Need process, has encouraged providers to maintain safe, up-to-date physical facilities and adopt more resident-centered models of care, while assuring mortgage lenders, bondholders and insurers of a loan repayment source.

At issue is the potential abandonment of this model as Medicaid nursing home residents are gradually enrolled in managed care, and capital costs are subsumed into the rates negotiated between Medicaid managed care plans and facilities. Left unaddressed, this could have a significant chilling effect on existing mortgage financings, facility updates and on lenders' willingness to finance needed nursing home capital projects. The state has asked the federal Centers for Medicare & Medicaid Services (CMS) for a regulatory waiver to allow nursing home capital to be carved out of Medicaid managed care. The fate of this proposal – and the potential effect of an Executive Budget proposal to allow the Department of Health (DOH) to establish capital reimbursement through regulation – are unclear.

Recommendation: *The Legislature should support efforts to obtain a waiver from CMS to continue historical cost capital reimbursement for nursing homes. Legislators should also seek clarity from the administration on the proposal to confer regulatory authority for capital reimbursement on DOH.*

Mandate Relief

The Executive Budget includes various initiatives aimed at providing mandate relief to local governments and other regulated parties. In this regard, LeadingAge NY supports Executive Budget efforts to reform the workers' compensation insurance program and reduce employers' costs without adversely affecting employees.

However, the budget not only fails to address the costs associated with recently authorized health care mandates, it would create a significant unfunded mandate for nursing homes and potentially Medicaid managed care plans.

A prime example of a recently imposed unfunded mandate is the Home Care Worker Wage Parity law passed in 2011, which establishes a minimum wage for home care aides who perform Medicaid reimbursed work for certified home health agencies (CHHAs), long term home health

care programs (LTHHCPs) and managed care plans within New York City and the counties of Nassau, Suffolk and Westchester. This unfunded mandate – which could cost hundreds of millions of dollars annually when fully implemented – will be unaffordable to providers in a climate of shrinking revenues, and is tantamount to government-imposed wage controls that may well have ripple effects on other health care providers.

Recommendation: *The state should acknowledge that the Home Care Worker Wage Parity law represents an unfunded mandate on MLTC plans and home care providers, and take appropriate action to either: (1) incorporate the compliance costs in Medicaid fee-for-service and capitated rates of payment; or (2) repeal or revise the provisions of this law.*

The Executive Budget includes a requirement that all managed care contracts include a provision requiring a standard rate of compensation be paid to employees who provide inpatient nursing home services including nurses, nurse aides, orderlies, therapists and any other occupations determined by DOH and the Department of Labor. The standard rate would be required to include a basic hourly cash rate and a supplemental benefit rate which would be annually determined by these two state agencies. It is unclear from the Executive Budget proposal what these rates would be and how they would be determined.

With increasing numbers of LTC recipients being enrolled in Medicaid managed care, and the state's plans to incorporate the nursing home benefit in managed care and eventually mandate that nursing home residents enroll in managed care, this requirement would eventually apply to nearly all Medicaid-covered nursing home services. A nursing home that "materially" fails to comply would risk having all its Medicaid admissions suspended, as well as incurring other penalties and contract violations. With no additional reimbursement proposed in the Executive Budget for these requirements, nursing homes and Medicaid managed care plans would bear the financial burden of yet another potentially major unfunded mandate.

LeadingAge NY's mission-driven members work hard to offer their employees fair and competitive compensation and benefits. However, Medicaid reimbursement rates simply do not meet the cost of providing care, much less the added costs of this mandate. Absent additional funding to support the associated increased wages, this law will ironically force providers to cut direct care staff, threatening the viability of many programs and impacting quality. These

requirements would also place added financial pressure on MLTC plans, as they would bear responsibility for paying rates to facilities that support the required compensation levels.

Recommendation: *The Legislature should reject this proposal outright, unless the state is prepared to identify additional resources to fully incorporate the associated compliance costs in Medicaid fee-for-service and capitated rates of payment.*

Care Management for All

The state has established aggressive timeframes for accomplishing the transition to care management for all for the LTC population. DOH officials have publicly stated that the migration of all Medicaid recipients into managed care plans will be accomplished within three years. This ambitious overall timeframe is also reflected in the individual Medicaid Redesign Team (MRT) proposals. Most notably, MRT #90 requires that all Medicaid recipients aged 21+ and receiving more than 120 days of home and community-based services will be required to enroll in MLTC plans/care coordination models.

DOH has published a schedule for the transition to mandatory MLTC enrollment across the geographic areas of the state. This schedule already leaves little time for established providers to make the necessary adjustments in operations and to enter into contracts with plans, and for MLTC plans to ramp up capacity to accommodate the influx of enrollees. With that said, this timeline could even be accelerated based on a determination by DOH that the necessary managed care network is in place in a given county. Providers already struggling to stay afloat and adapt their operations could suddenly find their planning and operations significantly disrupted due to a faster than anticipated move to mandatory enrollment. It is almost impossible for these providers and MLTC plans to orderly continue operations and serve Medicaid recipients under this high level of uncertainty.

Recommendation: *Lawmakers should take steps to ensure that the state publishes and implements a definitive and reliable timeline for mandatory enrollment of LTC recipients in Medicaid managed care plans. The timeline should provide for a more deliberate transition that allows providers and managed care plans adequate time to plan their operations and adapt to the associated changes.*

The state has at least tacitly recognized the value of preserving the infrastructure of providers that have significant expertise and experience in caring for and coordinating services for frail elderly and disabled recipients in the community. For example, DOH has agreed to allow home health care providers such as LTHHCPs to act as subcontractors to MLTC plans to provide care management services. DOH has also expressed conceptual support for enabling ADHC programs to expand the populations they serve and reconfigure their services in order to act as subcontractors of MLTC plans. Finally, the state has also recognized the need to expand the supply of short-term certified home health agency (CHHA) services.

These ongoing roles for the LTHHCPs, ADHCs, and CHHAs are absolutely necessary to the success of this process. LeadingAge NY members have stepped up to the plate in seeking to adapt their care provision and business models. However, the current pace of transition creates serious concerns for many of these providers as to whether they will remain in operation long enough to fulfill their evolving roles. Should many fail before the new system is in place, there is the potential for serious gaps in service.

Recommendation: *With ADHC registrants already being mandatorily enrolled into Medicaid managed care, the state needs to quickly approve the "hybrid option" so that adult day services, currently so vital to so many seniors, can best be adapted to effectively serve MLTC enrollees. Otherwise, the system of ADHC services will continue to unravel and more programs will be closed or downsized.*

Mandatory enrollment and rapid expansion of MLTC capacity also brings with it some significant financial challenges to MLTC plan sponsors, including the need to ensure actuarially sound rates that are adjusted in real time or prospectively to reflect the increasing risk that MLTCs are being asked to assume. MLTC plans will not be able to sustain the two-year lag in rate adjustments currently built into the system, and the financial consequences of not addressing this issue could greatly undermine the success of this initiative.

Recommendation: *Given the central importance of MLTC rate-setting to the future of Medicaid-funded LTC services, the Legislature should closely monitor the continued development and refinement of these rates to ensure they properly reflect the populations, services and provider payment levels needed to ensure access to high quality LTC services.*

Infrastructure Investments

The move to care management for all cannot succeed if Medicaid recipients do not have safe, affordable places to live. LeadingAge NY commends the state for acknowledging that there needs to be an expansion of affordable housing as the foundation for delivering home and community-based services that keep people out of institutions, and for proposing initiatives in this direction. However, the focus of housing investments to date has been on the homeless, the mentally ill and persons with HIV/AIDS.

While congregate senior housing is an ideal location for low-income seniors to remain independent and receive supportive services, there is a severe and growing shortage of this much needed resource, especially in downstate communities. In addition, much of the current infrastructure needs rehabilitation and would benefit from co-location of supportive services.

Investment is needed in senior housing with services. MLTC will always be essentially a home and community-based model of service delivery. That model cannot work unless the foundation of senior housing is in place as the platform from which that service can be delivered. Furthermore, there are large numbers of seniors who are at risk both financially and health-wise of having to rely on expensive Medicaid-funded care. Affordable senior housing paired with supportive services would enable such individuals to age-in-place and delay or prevent reliance on more expensive services.

Recommendation: *The Legislature should support LeadingAge NY's proposal to create a New York State Supportive Senior Housing Services Program (SSHSP), out of the funds allocated in the state budget to developing supportive housing, to meet this essential need.*

The new world of quality-driven payments, patient centered care and care management for all will be data-driven. To date, providing funding for technology applications in LTC service settings (e.g., electronic medical records, telehealth and remote monitoring capabilities) has not been a priority of either the federal or state governments. However, as the state pursues its goals of containing Medicaid costs, ensuring that the care of every Medicaid recipient is coordinated across settings and serving more individuals in community settings, added investments in technology in LTC facilities and community-based programs are critically important. LeadingAge NY cautions that without such investments, the current pace of change may widen

the gap between the current technology infrastructure in LTC settings and the infrastructure needed in the future.

Recommendation: *Through the 2013-14 budget, the Legislature should support strategic investments in funding for technology applications in LTC service settings.*

Ownership of Health Care Facilities

The Executive Budget includes a proposal for a pilot program that would allow for increased capital investment in health care facilities. The proposal would allow the Public Health and Health Planning Council to approve the establishment of two business corporations, one as the operator of a hospital in Kings County and one in another county in the state. The corporations would have the authority to operate CHHAs, licensed home care services agencies or hospices.

LeadingAge NY remains very wary of any arrangements that would have the practical effect of allowing the principals of a publicly-traded corporation to establish a New York affiliate and offer health care services. We remain strongly opposed to allowing publicly-traded corporations to operate nursing homes and home care agencies in the state.

In other states that allow these ownership structures, these corporate entities are much less accountable to the state and local communities and more accountable to shareholders. As a result, serious quality of care lapses have more often been associated with these corporately operated providers than with community-based providers such as those that characterize New York's health care system. For example, according to a July 2011 report from the U.S. General Accounting Office, nursing homes owned by private investment firms had more total deficiencies, were more likely to have been cited for a serious deficiency, and had lower total nurse staffing ratios than other facilities.

Recommendation: *The Legislature should carefully review this proposed pilot program, confirm that the use of the term "hospital" would not include a nursing home, carefully circumscribe the use of any such ownership structure to compelling situations involving public health and safety, and thoroughly evaluate the outcomes of any such pilot.*

Service Line Summaries

The balance of this testimony provides summaries of key issues and recommendations for various LTC and housing service lines.

Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs), Assisted Living Programs (ALPs), and Assisted Living Residences (ALRs) are critical services for seniors in New York. While each category of licensure offers something somewhat different, they all provide an option for seniors who cannot or do not want to live at home, but do not need continual skilled nursing that a nursing home provides. ACFs and assisted living provide services in an environment that is home-like, where community integration and independence is encouraged.

At issue in this budget proposal is those ACFs and ALPs that serve low-income seniors. Support of such facilities is essential, because without them many low-income seniors would need to be in a nursing home, at great cost to Medicaid.

Adult Care Facilities

We are extremely concerned that the budget does not contain a specific and individual appropriation for the Enhancing the Quality of Adult Living (EQUAL) program. Rather, this appropriation is subsumed in an aggregate lump sum, which is then cut by a percentage which is currently being disputed, and then would be distributed at the discretion of state agencies. This approach lacks the kind of transparency and accountability that is necessary for meaningful public input. Further, it provides no predictability for the beneficiaries of such funding, who rely on this support. EQUAL seeks to improve the quality of life for ACF residents, and funding is distributed based on the financial status of the facility as well as resident needs.

Recommendation: *The Legislature and Executive should identify the specific programs and their appropriations. Within the delineation of such programs, the EQUAL program should be reinstated at $6.9 million. The Executive Budget proposal to include last year's EQUAL funds, yet to be distributed, must be maintained as well. In addition, the Enriched Housing Subsidy should continue to be funded at $502,900. The subsidy is for up to $115 per month for each*

Supplemental Security Income (SSI) recipient who resides in not-for-profit certified enriched housing programs, and is paid directly to the certified operator.

Both the EQUAL and SSI Enriched Housing Subsidy programs support ACFs that serve low-income seniors who, if not for the ACF, would likely have to go a nursing home supported by Medicaid. These programs are modest investments that can have a significant return. We are pleased to see that past year's unspent appropriations for EQUAL, EnAbLE, and the SSI Enriched Housing Subsidy are reappropriated in this year's budget. Unfortunately, these funds were not reappropriated in full.

Recommendation: *It is critical to support ACFs that serve low-income seniors. We must also ensure that the decisions that were made in past year's enacted budgets are executed. Thus, the full amount of unspent appropriations must be reappropriated, specifically:*

- *The Executive proposal reappropriates$1.3 million for Enhancing Abilities and Life Experience (EnAbLE) grants for ACFs, however $11.7 million was reappropriated in last year's budget from prior years that still has not been paid out. In fact, DOH even issued a request for applications for some of these funds. While EnAbLE grants have differed somewhat in their focus, the program was designed specifically to improve the quality of life and independence for residents and typically supports ACFs that serve low-income seniors and/or have a financial need. A total of $5.7 million remains for traditional EnAbLe grants for various quality of life initiatives. The remaining $6 million also allowed for spending on air conditioning in resident rooms, improving the quality of food services, and providing generators. Superstorm Sandy and other weather events have highlighted the importance of having generators, and yet some facilities – particularly those that serve a low-income population – simply do not have the funds to purchase them.*
- *The Executive budget proposal also fails to reappropriate the full amount of past years' Enriched Housing Subsidy funding that has yet to be distributed. In addition, the proposed budget omits $164,000 of past years' ACF quality incentive payment program funding.*

Assisted Living Program

The Executive Budget proposal includes expansion of the ALP program, along with capital reimbursement to support the transition. Both are targeted specifically to adult homes in New York City that meet the definition of "transitional adult home", meaning that they have 80 beds or more in which 25 percent of more of their residents have a serious mental illness. While LeadingAge NY appreciates the need for a thoughtful transition for these providers and the residents they serve, we object to the narrow focus of these initiatives.

Recommendation: *State lawmakers should broaden this initiative to enable a true capital component in the ALP Medicaid rate for all ALP providers, along with a plan on how such reimbursement will continue in a managed care environment. There are ALP programs which, if granted a capital component, would actually save the state money by allowing the decertification of nursing home beds. Some existing ALPs also have aging infrastructures that need to be updated for the benefit of their residents. In addition, the ALP expansion should not be targeted solely on transitional adult homes, but also on other worthwhile projects. Existing ALPs with long waiting lists should be able to expand their capacity, and new ALPs should be developed in areas where an ALP would help relieve pressure on other parts of the system.*

As described more thoroughly below, the Executive Budget includes a proposed expansion of home health aide duties, with proper training and supervision.

Recommendation: *LeadingAge NY supports the concept of an expansion of practice for home health aides, and recommends specific clarification that this opportunity would apply to such aides that work in ALPs.*

Adult Day Health Care

The Adult Day Health Care Council (ADHCC) is an affiliate of LeadingAge NY and represents 148 adult day health care programs across the state providing services to more than 10,000 New Yorkers.

The ADHCC shares LeadingAge NY's concerns and endorses their recommendations with respect to the global cap and payment adequacy and oversight, since ADHC programs will be negatively impacted if these issues are not addressed. In addition, the ADHCC hopes that the

waiver from CMS to allow nursing home capital to be carved out of Medicaid managed care would also apply to ADHC capital. This would be appropriate since ADHC programs must be and are currently sponsored by nursing homes.

Perhaps, however, the greatest concern with respect to ADHC programs lies in the area of mandate relief. Seventeen months ago, in anticipation of the statewide expansion of MLTC, the ADHCC developed a proposal for a new model of adult day health care called the "hybrid option." This proposal: (1) allows the ADHC model to be flexible as MLTC expands by allowing ADHC programs to unbundle their services and provide only those services the MLTC requires; (2) reduces the possibility of disruption of the 10,000 ADHC registrants since it would allow them to receive both ADHC services and social adult day services provided by MLTC plans in the same place; and (3) addresses the shortage of social adult day capacity throughout the state.

Although this concept was widely discussed with and ostensibly approved within DOH and the Administration, the regulations to allow it (which were presented to the DOH in draft format in Jan. 2012) have yet to be approved following delay after delay. After sixteen months of discussion and twelve months of review, the ADHCC was just advised that the regulations required revision. However, although the Administration has indicated hat they have a "fix" for these proposed regulations, they have adamantly refused to share this revision with the ADHCC.

In the midst of this process and in the hope of moving these regulations forward, Senator Hannon and Assemblywoman Gunther sponsored legislation, S. 7383 and A.10274 respectively, in the 2012 legislative session to allow these regulations to be adopted on an emergency basis. Unfortunately this legislation was not passed.

The ADHCC has consistently stated that adapting the ADHC model is extremely time sensitive. We have continually stressed that if ADHC registrants and providers are to adjust to the changes that will occur with MLTC expansion, the model must be flexible and be able to be adapted quickly. The opportunity for downstate programs to adapt using this model is now disappearing.

The lack of timely mandate relief has and will result in the closure of additional downstate ADHC programs and the displacement of ADHC registrants. In addition, it is causing unnecessary stress for ADHC providers and registrants upstate as they observe MLTC expanding and their opportunities to adjust to this expansion dwindling. Finally, the failure of the state to

allow known, respected and time-tested ADHC programs to adjust their operations and provide services to social adult day level clients is at least partially responsible for the recent vast expansion of for-profit social model adult day care in New York City. This expansion has often involved exposing our most vulnerable citizens to business entities focused on profits rather than providing quality services. This "unintended consequence" does not bode well for either ADHC programs or long-standing social model adult day programs that have provided valuable services to New Yorkers for decades.

Recommendation: *Advance the proposed "hybrid option" regulations for ADHC as originally envisioned.*

Continuing Care Retirement Communities

In the drive towards implementing managed care initiatives, one exemplary model of managed care – the continuing care retirement community (CCRC) – seems to be almost completely overlooked. The CCRC is in many ways an ideal model of managed care, in that it:

- does not rely on public funding and instead creates a strong incentive for individuals to invest the own assets in their care, rather than divesting assets through Medicaid estate planning strategies;
- further creates an incentive for individuals to plan for their needs well in advance of the onset of requiring assistance with chronic health conditions;
- is generally recognized for providing high quality service; and
- covers the complete spectrum of housing and health care needs.

The challenge, however, is that in New York there are currently only 13 operating CCRCs – a direct and immediate result of an excessive and unnecessary regulatory climate. Other states, including our immediate neighbors, have established dozens of CCRCs while we lag in development. In addition to lessening the regulatory burdens to establish new CCRCs, efforts are needed to address current regulations that severely limit existing CCRC operators' ability to implement new and innovative programs that would help both current residents and expand high quality services to new populations. Efforts in both areas would also promote economic development throughout the state and lessen dependence on Medicaid.

Recommendation: *Lawmakers should support efforts to address the excessive and unnecessary regulatory burden that currently limits both the development of new CCRCs and the ability of current operators to develop new and innovative programming. State regulations must be revised and brought more in line with the more reasonable levels of regulations in place in states where CCRCs have become a mainstay of high, quality managed care services and housing for seniors.*

Home and Community-based Services

Home and community-based services are vitally important to enabling seniors to stay at home safer and for a longer period of time, and must be a key partner in the continuing transition to managed care. Unfortunately, more so than any other provider group, home care agencies continue to struggle with an untenable level of operational uncertainty and are now experiencing the effect of mandatory MLTC enrollment of many of their patients. In addition, across-the-board cuts, provider taxes, elimination of inflation adjustments and unfunded mandates which would be continued from previous budgets are exacerbating the operational and financial uncertainty facing many of the state's home and community-based services providers.

As previously noted, LeadingAge NY's home care agency members remain particularly concerned with two MRT initiatives, mandatory MLTC enrollment and the wage parity law. These two initiatives have put several providers in an extremely difficult financial situation. Some home health agencies that have signed contracts with MLTCs are struggling and have reassigned staff within their agency, scaled back full time employees to part-time status or have had to lay off employees. The end result of these actions will be more limited access to home care services, more patients having to be served in more expensive levels of care at a higher cost and potentially more hospitalizations due to less continuity of care. These outcomes would be directly inapposite to the broader Medicaid redesign objectives of better population health, better outcomes of care and reduced cost. More needs to be done to assist home care providers and recipients in transitioning to managed care.

Continuity of care provided by community-based programs is jeopardized because of the continued uncertainty and the timing of managed care enrollment. A prime example is the

outlook for LTHHCP providers, which has been characterized by a year of uncertainty over if and when CMS will approve a Medicaid waiver amendment requiring their patients to be enrolled in MLTC plans. Several LTHHCPs have seen their referral base shrink by as much as 50 percent. For those LTHHCPs that wanted to continue serving their patients by applying for CHHA licensure, that too has been a struggle. Of the 142 CHHA applications received, only a couple dozen have been approved, again leaving the majority of the LTHHCPs that applied for CHHA licensure in limbo.

Finally, providers continue to make financial, operational and staffing decisions based upon the state's draft phase-in schedule. To allow a county to implement mandatory enrollment months or years ahead of schedule would put local providers at risk of being locked out of contracts by larger and/or commercial managed plans that are not familiar with the fabric of their communities.

Recommendation: *Home care providers need predictability in order to manage operations and continue providing care and employment during the transition to managed care. Absent additional funding for the wage parity mandate, providers are at greater risk of having to reduce their staffing which is likely to undermine the transition to managed care. The Legislature should help to ensure that this transition is managed effectively by solidifying the mandatory phase-in schedule, ensuring rate adequacy to pay for the wage parity mandate and advocating for timely processing of the pending CHHA licensure applications.*

We appreciate that the Executive Budget includes a career ladder proposal for an Advanced Home Health Aide (AHHA). An AHHA would be authorized to provide nursing services to a self-directing individual, while under the supervision of a registered nurse (RN) and pursuant to an authorized practitioner's ordered care. We also appreciate the inclusion of a proposed demonstration program for home health aides (HHAs) to administer medications while under the supervision of a RN employed by a home care or hospice program. Both of these innovative ideas could advance the field of direct care workers, increase efficiencies and lower costs.

However, both the AHHA scope of duties and the administration of medications by HHAs need further clarification. For example: (1) what training requirements and qualifications would AHHAs be required to meet; (2) what nursing services could the AHHA perform; and (3) for this

purpose, how would a self-directing individual be defined? For HHAs administering medication: (1) which medications would be included; (2) would narcotics be included in the list; and (3) what training/competency evaluation requirements would an HHA have to complete before he/she would be permitted to administer medications?

Recommendation: *The Legislature should consider supporting these proposals, provided sufficient clarity is received on these unanswered questions.*

Managed Care Plans

As lawmakers are well aware, much of the responsibility for making Medicaid reform work falls to the managed care community, including the not-for-profit provider-based MLTC plans represented by LeadingAge NY. As previously noted, there are serious concerns about the state's timetables for mandating managed care enrollment and other aspects of MLTC operations:

- Addressing the two year lag in Medicaid premium adjustments currently built into the system. Unless the state is flexible and willing to make exceptions in its process, this could undermine the success of mandatory MLTC enrollment;
- Ensuring actuarial soundness of MLTC premiums that are adjusted in real time to reflect the increasing risk that plans are being asked to assume, or make prospective adjustments based on trends;
- Reflecting the costs associated with the Home Care Worker Wage Parity law in current MLTC premiums; and
- Preventing new entrants into the MLTC market from "cherry picking" the more desirable urban markets while shunning the less lucrative rural markets. A system must be devised so that all players take on their fair share of more and less desirable markets.

Recommendation: *The pace of mandatory MLTC enrollment should be moderated, with more definitive schedules for providers and Medicaid recipients to plan and adapt to change. Current providers need to be able to plan operations and adapt based on a clear set of rules. Ensuring reasonable and adequate premiums to MLTC plans and fair ground rules around enrollment are necessary for an orderly expansion of MLTC capacity and transition of the fee-for-service population.*

The Executive Budget proposal envisions transitioning an even larger Medicaid population into managed care, while the details for transitioning some recipients already slated for transition have yet to be developed. A prime example of this uncertainty is enrollment of the nursing home population into Medicaid managed care.

Recommendation: *Before a major segment of the currently under-care population is transitioned, the Legislature should seek clarity on how that population is to be covered and how providers are to be reimbursed. This is critically important for both the nursing home and ACF/assisted living populations. Although there is no set deadline for transitioning the majority of these consumers to managed care, clarity is needed sooner rather than later since community-based recipients are already starting to require facility-based care. Payment mechanisms on both sides need to be adequate to ensure that neither the MLTC plans nor the providers are disadvantaged during the transition.*

Another key to the success of MLTC plans is the development of adequate risk pools and economies of scale. As new populations are covered in geographic areas that to date have seen little managed care activity, the MLTCs are taking on greater insurance risk. The proposed elimination of the cap on MLTC certificates can only undermine the ability of current plans to maintain the population base and risk pool necessary to expand services in an actuarially sound manner. Rather than authorizing an "unlimited" number of plans, the focus should be on ensuring that current plans with proven track records have the support needed to succeed. Expanding the number of providers merely creates a "shot gun" approach to seeking to cover new markets, inviting fly-by-night operators to move in. This in turn will only exacerbate many of the transitional concerns already raised.

Recommendation: *The Legislature should reject the budget provision to eliminate the cap on MLTC certificates and instead focus efforts on ensuring that the current plans have the resources and support needed to successfully expand their enrollments and offer high quality services.*

The budget also seeks to expand authority to use an enrollment broker to manage the mandatory enrollment of Medicaid recipients into MLTC plans in counties where that role is currently administered by the local department of social services. As MLTC expands into rural upstate counties, new complications will arise relative to workforce availability and the proximity of

services to enrollees. We believe that some local authority, with knowledge of the unique personnel, geographic and travel concerns impacting the provision of services in rural areas needs to be maintained.

Recommendation: *Any added authority granted by the Legislature for a standardized managed care enrollment broker function should be accompanied by a requirement to obtain local input, especially in rural areas that present unique service delivery challenges.*

Finally, the Executive Budget also includes a proposal to expand the Fully Integrated Duals Advantage (FIDA) program to include individuals with developmental disabilities, and would authorize managed care plans to provide care coordination services to this population. However, many of the FIDA provisions have to yet to be clarified, and the notion of integrating Medicaid and Medicare benefits is extremely complicated and could have major implications for plans, recipients and providers. MLTC plans and others previously submitted letters of intent to participate in FIDA, with little knowledge as to the program's specifications, and MLTC plans will be expected in less than one year to offer a Medicare managed care product.

Recommendation: *The Legislature should carefully monitor the development of specifications for the FIDA initiative, both as it relates to the proposal to cover developmentally disabled recipients and the intent to apply it to the MLTC mandatory population in the downstate area. More information is needed quickly for prospective FIDA plans to develop proposals and make arrangements to participate in FIDA.*

Nursing Homes

Nursing homes are facing a dire situation, even without the wage mandate proposed in the Executive Budget. Costs, especially for wages and benefits, have continued to increase while reimbursement to many of the state's homes is decreasing due to the new "statewide pricing" system implemented in 2012. Making matters worse, homes are facing continuing and additional across-the-board cuts including: (1) $40 million in reductions from last year's bed-hold initiative; (2) an impending $50 million cut to fund a quality pool; and (3) continued cuts and tax increases to ensure that state budget deficits are reduced.

Additionally, the budget includes a proposal to permanently eliminate inflation adjustments to Medicaid rates. Although these adjustments have been reduced or eliminated for the last five budget cycles, this was done due to the fiscal emergency the state has been facing and should not be memorialized as state policy, especially when a global spending cap already limits total Medicaid spending to a set amount. All of these actions are taking place or being considered at a time when providers are attempting to reposition themselves for a managed care world that could result in further reductions to reimbursement and volume.

LeadingAge NY supports efforts to ensure that shifting nursing home residents into MLTC does not result in a "race to the bottom" on employee compensation if homes are pressured to further reduce costs to be included in managed care plan provider networks. Our not-for-profit members recognize that quality staff is crucial for quality care and support paying competitive wages and benefits.

However, the notion of having the state set the standard rates of compensation for employees is problematic. Here's why: nearly 45 percent of all nursing homes in the state are facing decreasing Medicaid rates due to statewide pricing. Discounting variation in acuity, these homes will be receiving *less* for caring for our frail elders in 2016 than they did in 2011. Almost half of the homes facing reductions are losing money on operations, yet as a group have higher quality ratings than their peers. A potential consequence of wage standards is that homes will be limited in the strategies they can employ to retain their most qualified staff and may even face the need to reduce staff to comply with the wage mandate.

Recommendation: *As previously indicated, the Legislature should reject the nursing home mandatory wage proposal outright, unless the state is prepared to identify additional resources to fully incorporate the associated compliance costs in Medicaid fee-for-service and capitated rates of payment.*

The Executive Budget also includes a proposal to eliminate the $30 million in funding for the financially disadvantaged (FD) nursing home program, and transfer the funds to the Vital Access Provider (VAP) program. While LeadingAge NY understands some of the timing issues and perceived inflexibility of the FD program, the distribution methodology provides an objective, transparent method for allocating funding to needy facilities. The VAP is a discretionary

program administered by DOH for which there is little available detail about how awards will be determined and administered.

Recommendation: *The Legislature should obtain more specific information about how the VAP program will be administered by DOH, and a commitment that any funds reallocated from the FD program to the VAP program will be committed to assisting nursing homes and not be used to offset other VAP funds that would otherwise be allocated to nursing home applicants.*

Under the Executive Budget, nursing homes' 2002 cost reports – which were used for a short time to set operating rates prior to statewide pricing – would be subject to audit through 2018. Current law allows the Office of the Medicaid Inspector General to initiate audits of these cost reports anytime before Dec. 31, 2014, nearly two years from now. Subjecting these cost reports to audit for four more years will require facilities to retain records for *sixteen* years, and subject them to potential audit liabilities for six or more years. Ironically, another Executive Budget proposal would eliminate the requirement for DOH to reconcile provider payments that were made in 2007 and 2008 using these very same cost reports. This cost report audit proposal is inapposite to the state's plans to further cap providers' administrative costs and provide mandate relief to regulated parties.

Recommendation: *The Legislature should reject the proposal to extend the audit timeframe for 2002 nursing home cost reports to Dec. 31, 2018.*

Supportive Senior Housing

New York State faces a significant growing gap in the supply of safe and affordable senior housing as well as health care and other support services due to the steep growth in the number of senior citizens. LeadingAge NY will soon issue a report entitled "Senior Housing in New York State" that details the growing need for senior housing and supportive services to promote healthy aging-in-place and reduced dependence on the Medicaid program. The paper includes extensive research on the demographics of the aging population in New York State; various types, features and benefits of senior housing; supportive services in senior housing; health care services available to seniors; and policy issues affecting senior housing including Medicaid reform and federal initiatives. As the paper conclusions suggest, affordable senior housing is a

vitally important element of the infrastructure needed to support the goals of Medicaid redesign while enhancing resident quality of life and promoting independence.

The Executive Budget includes proposals for three housing programs that offer opportunities to advance the development of affordable senior housing with supportive services:

- *House NY Program:* This new program would invest $1 billion of additional resources over five years to preserve and create 14,300 affordable housing units statewide;
- *Supportive Housing:* Funding for this existing program is increased from $75 million to $95 million. The Governor's proposed budget would also dedicate inpatient bed reduction savings to support the development of additional supported housing units; and
- *Pay for Success.* Under this proposal, the state would undertake up to $100 million in Pay for Success initiatives (also known as "Social Impact Bonds") over the next five years to invest in programs in health care, aging, education, juvenile justice and public safety.

Recommendation: *State lawmakers should support programs that fund capital and supportive services in senior housing that preserve and update existing affordable senior housing properties; providing gap funding for new senior housing construction to include supportive housing building features; and infuse supportive services into existing affordable senior housing. The above-noted programs in the Executive Budget offer opportunities to address the growing need for low-income senior housing and support services.*

Conclusion

As this testimony illustrates, there are a number of concerns and unanswered questions relative to how the Executive Budget would affect elderly and disabled New Yorkers, and the not-for-profit and public agencies that serve them. At the same time, there are several proposed initiatives that have the potential to meaningfully advance population health, improve the patient care experience and reduce the cost of services. LeadingAge NY looks forward to working with the Legislature and Executive on the 2013-14 budget and the state's ongoing reform initiatives.

Thanks again for the opportunity to testify today. I would be happy to answer any questions you may have on our testimony.