MEMORANDUM

S.6611 (May)

AN ACT to amend the public health law, in relation to quality improvement and increased consumer transparency in assisted living residences

LeadingAge New York and our non-profit member providers recognize and appreciate the importance of transparency, quality, and consumer protections. However, we must oppose this legislation given a variety of concerns; the first of which being that Assisted Living Residences (ALRs) are still contending with the COVID-19 pandemic. Assisted living was affected more than nearly any other sector by COVID. ALRs continue to work daily to protect their residents and staff from COVID, while also trying to recover. Providers are exhausted and struggling to survive. Meanwhile, the state has provided no financial relief to these settings, nor any meaningful relief from the mandates. Providers simply do not have the time or resources to take on additional requirements currently, and the states' focus should be on support and recovery.

This legislation would enable the Department of Health (DOH) to establish publicly reported quality standards for Assisted Living Residences (ALRs), Enhanced Assisted Living Residences (EALRs), and Special Needs Assisted Living Residences (SNALRs), and requires that these quality measures be reported annually. Currently, there are no standard quality measures for this setting, and no mechanism by which to collect the data in a standardized way. Any data used for this purpose must be clearly established, commonly understood and defined, and easily measured. This is a tremendous endeavor that would require the input and feedback from the ALR provider community. This bill makes no mention of that critical input and participation, rather allowing the Department to simply develop measures and a reporting mechanism in a relatively short timeframe given the scope of the endeavor.

The bill fails to recognize the wide variability that exists under the ALR umbrella. ALRs may be standalone ALRs, have some or all beds licensed as EALR, have an SNALR unit, and any combination thereof. EALRs each identify the services they will provide and may provide them directly or through contract with a homecare agency. There is wide variability, thus, in the services provided, the populations served, and the entities providing such services. The ALR model was developed with a focus on preserving the dignity, independence and freedom of seniors as they age. Residents see their own physicians in the community, who drive the care of the residents. Nurses working in these settings are not even permitted to provide nursing services, unless licensed as an EALR. Interestingly, despite this limitation on the use of clinical resources, we increasingly see nursing home-like standards being imposed on assisted living, such as this one. Given both the variability among ALRs, EALRs and SNALRs, and the state-imposed limits on clinical services provided, it is difficult to conceive what standard measures could be identified that are broadly applicable or that the ALR has influence over. If the quality standards being considered will be informed by the DOH survey process, this poses unique

concerns given the inconsistency among the state, the lack of interpretative guidelines and the lack of a dispute resolution process with an independent party. Survey data is currently publicly reported, as well.

ALRs already conduct multiple reports to the state on a daily, quarterly and annual basis. Any additional reporting would be yet another burdensome requirement taking administrative attention away from the activities that help improve residents' quality of life. Further, with no funding support, the costs of implementation end up driving up the costs of the consumer.

The bill also requires facilities to publicly post their service rate and staffing complement. As previously noted, every ALR is different, both in size and various combinations of licensure, as well as the role of the nurse. Consumers may not understand the differences between the ALR, EALR and SNALR. While it is a laudable goal to ensure consumers understand what provider they are choosing as a future home, the data does not actually allow for a true comparison and may lead to additional consumer confusion around what services to expect from ALR. We question the benefit of this burdensome reporting if ultimately not useful to the consumer.

This legislation also revises the state survey schedule for ALRs, allowing high-scoring facilities in advanced standing to be on an 18-24 month survey schedule. While this would be a way to streamline the state survey process for DOH, the criteria for being considered high-scoring would need to be vetted with those that work in these settings every day. Further, discussions around increasing the per day penalty for violations could increase costs for providers with an extended timeframe between surveys.

Finally, LeadingAge NY members are open to the discussion of the standardization of the definition of memory care for all licensed facilities advertising memory care units, as well as training protocols and resources, but only with the input of the provider community. It is critical that these discussions take place with an understanding of the current financial distress most ALRs are under due to COVID, as well as the workforce challenges that providers throughout long-term care are experiencing. Such discussions must consider how low income seniors can access specialized dementia care in assisted living, since the Medicaid Assisted Living Program (ALP) rate does not support this. Steps to better prepare people to work in ALRs should be offered as resources, not complicated or costly mandates. The state must work with providers in earnest to ameliorate workforce challenges and provide resources to encourage and support working in this sector.

In summary, while the intent of this legislation is laudable, a great deal of collaboration and consideration is needed to address these objectives, which will only be successful when we address the related issues. Therefore, LeadingAge New York opposes S.6611 and urges that it be rejected.

LeadingAge New York represents nearly 500 not-for-profit and public long-term care providers, including nursing homes, home care agencies, senior housing, retirement communities, assisted living, adult care facilities, adult day health care and managed long term care.