August 9, 2024

Sherry Glied, Ph.D.
Chair
New York State Commission on the Future of Health Care
Executive Chamber
The Capitol
Albany, NY 12224

Dear Dr. Glied and Members of the Commission:

I am writing on behalf of the 400-plus members of LeadingAge New York, an association of not-for-profit and government-sponsored long-term and post-acute care and aging services providers. Our members span the continuum of services for older adults, from housing, home care, and adult day health care (ADHC) to assisted living (AL), nursing home, and hospice care and provider-sponsored Program of All-Inclusive Care for the Elderly (PACE) and Managed Long Term Care (MLTC) plans. We share the Commission's commitment to providing consumers with a robust continuum of high-quality, accessible long-term and post-acute care services, supported by an appropriate level of qualified staff and the necessary funding to sustain them and enable innovation.

I am sorry to report that New York State's long-term and post-acute care systems are at the edge of a precipice. Nearly every week, I hear from LeadingAge New York members who are considering or actively planning to close or sell their not-for-profit facilities or programs. For over a decade, New York State has devalued long-term and post-acute care providers, depleted their resources, and turned a blind eye to the closure of dozens of nursing homes, ADHC programs, and adult care facilities (ACFs) – mostly not-for-profit and public facilities. As a result, older adults in New York are facing a future in which the choice of long-term care (LTC) setting and provider is severely limited. Some communities will lack options altogether, requiring older adults to seek care far from their loved ones or do without needed services. Nursing home care will be predominantly delivered by for-profit enterprises in outdated, institutional facilities, and high-quality care will be accessible only to the affluent.

The tragic results of years of neglect are not just future prospects; they are being felt today. Insufficient long-term and post-acute care capacity in both the community and in residential settings is creating gridlock in hospitals and is impairing access not only to needed long-term and post-acute services, but also to emergency and acute care for all New Yorkers.[1] Older adults in hospitals are experiencing prolonged stays because they are unable to find post-acute care close to home. They are filling hospital beds that are needed for new hospital admissions, and emergency departments are overflowing. For consumers in need of LTC, like those seeking post-acute care, high-quality options are limited and shrinking with each passing month.

[1] "Strong Memorial Hospital Sets Record for Most Patients on a Single Day," WROC, Jan. 19, 2024, accessed at https://www.rochesterfirst.com/rochester/strong-memorial-hospital-sets-hospital-record-for-most-patients-on-a-single-day; "Some Hudson Valley ER Wait Times Spiked 20% Last Year, LoHud.com, May 15, 2024; Munson, E., "Emergency Room Visits to Albany Med are Some of the Longest in the Country, *Times Union,* July 5, 2024.

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The loss of capacity and constriction of access is occurring not just in nursing homes, but across the long-term and post-acute care continuum. The Commission's post-meeting slide deck (slides 16 and 20) notes that utilization of personal care and nursing home care is higher in New York than in other states, while utilization of other LTC settings on the continuum between personal care and nursing home care is lower. As detailed below, a combination of inadequate reimbursement and affirmative policy decisions have led to the elimination of a substantial portion of the state's ACF beds for individuals on Supplemental Security Income (SSI), its Medicaid Assisted Living Programs (ALPs), and its ADHC programs. At the same time, the State has blocked the creation of any additional ALP capacity for Medicaid beneficiaries. These community-based options – ACFs, ALPs, and ADHC programs – can provide a valuable resource for older adults and their families, when extensive services are needed. The loss of these programs and the ban on new ALP beds have undoubtedly created greater demand for nursing home care.

If the State is truly committed to health equity (including equity for older adults), and to maintaining a robust continuum of LTC that enables older adults to live well and thrive in their preferred settings, it must reverse decades of neglect. As detailed below, the State should take five common-sense steps to ensure access to appropriate levels of high-quality care for older adults with complex medical conditions and functional limitations and to alleviate backups in hospitals:

1. Update Medicaid rates for LTC providers to align with the costs of care (including appropriate compensation of the workforce), to incentivize desired outcomes, and to support innovation in residential environments and care delivery. Nursing home rates, for example, fall short of costs by $1.6 billion on a statewide basis, resulting in negative operating margins for 70 percent of nursing homes in 2022.
2. Support community-based congregate LTC settings, including ACFs, ALPs, and ADHC programs, in order to expand options for older adults.
3. Build upon the platform of existing affordable senior housing by funding a Resident Assistant Program to offer social supports that prolong independence and improve health outcomes.
4. Prioritize LTC for workforce development programs and funding, including Nurses Across New York, the waiver Career Pathways Program, Department of Labor apprenticeship programs, and training and worker financial burden relief grants.
5. Promote alternatives to Medicaid-funded LTC by expanding the Special Needs Assisted Living Residence (SNALR) Voucher Program, expanding options for State Office for the Aging (SOFA)-funded home care programs that include cost sharing, and facilitating expansion of Continuing Care Retirement Communities (CCRCs).[2]

I. Long-Term and Post-Acute Care: Distinct Services Uniquely Reliant on Public Payers

Any policy analysis of New York's LTC system must begin with an understanding of the distinct, but intertwined, roles and financing of LTC and post-acute care. Both types of services are delivered to overlapping cohorts of consumers by overlapping categories of providers, and both are financed principally by government payers – Medicare and Medicaid. However, they are clinically distinct and serve different purposes.

[2] *See, "Improving Care for Older Adults,"* Convergence Dialogue on Reimagining Care for Older Adults, Final Report, Aug. 2022.

Post-acute care is delivered on a short-term basis following a hospitalization, with the goal of returning the consumer to his/her prior health and functional status or preventing further decline. It is generally provided by home care agencies, nursing homes, and inpatient and outpatient rehabilitation facilities. LTC, by contrast, often involves custodial care and management of chronic conditions, rather than rehabilitation. Like post-acute care, it is often delivered by nursing homes and home care agencies. LTC may also involve a broad array of health care, residential services, and social supports, including medical-model ADHC services, ACFs and assisted living facilities, hospice programs, and CCRCs. And, it includes various types of housing that offer social supports to residents, including affordable senior housing, Naturally Occurring Retirement Communities (NORCs) and Neighborhood NORCs, and market-rate retirement communities.

Medicaid is the de facto payer for LTC in New York State and pays for most of the care delivered by nursing homes and home care agencies, whereas Medicare is the primary payer for post-acute care. Medicaid pays for 72 percent of nursing home days in New York State, and Medicare covers 19 percent.[3] Similarly, 86 percent of licensed home care services agency (LHCSA) revenue is derived from Medicaid,[4] and Medicare accounts for 68 percent of certified home health agency revenue.[5] SSI Congregate Care Level 3 funds also pay for LTC for a small number of individuals receiving residential care in ACFs. With the overwhelming majority of their services reimbursed by public payers, LTC and post-acute care providers, unlike hospitals, have very little ability to raise rates charged to other payers in order to fill the gap when government reimbursement fails to cover costs.

It is worth noting that the Commission's analysis of utilization does not appear to appreciate the distinction between long-term and post-acute care utilization. Its slide 20 compares "LTSS utilization" in New York to selected states, but does not appear to focus on LTC exclusively, at least with regard to the nursing home sector. By focusing on the number of users or licensed beds, the slide appears to include post-acute utilization. Similarly, slide 23 seems to show more nursing home residents per relevant population than nationally, but also appears to focus on total residents rather than total long-term residents. And, on slide 20, the reference to long-term acute care hospitals (LTACHs) is misplaced – LTACHs are acute care facilities, not providers of LTSS.

II. Financing: The Foundational Challenge Facing New York's LTC System

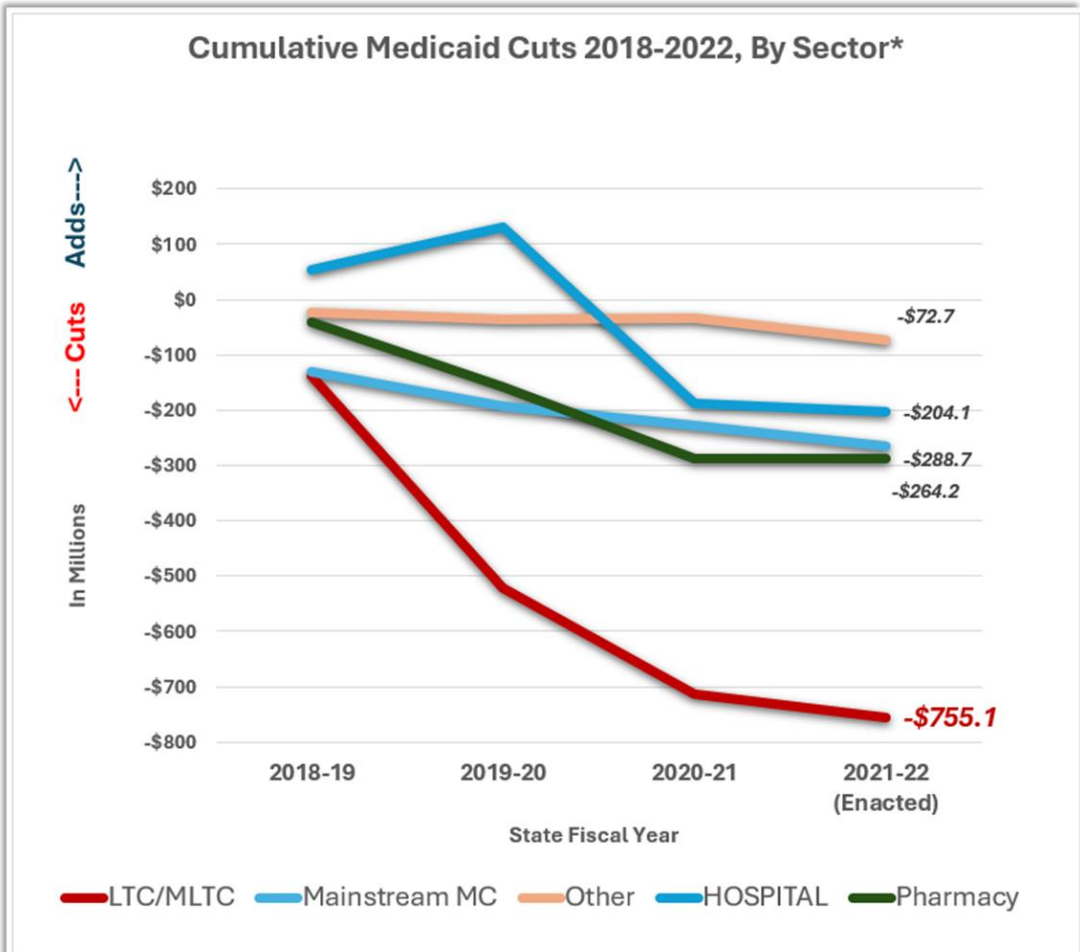
The Commission's slide deck enumerates 10 challenges (slide 16) which can be grouped into the following categories: (i) Capacity and Access; (ii) Quality and System Fragmentation; (iii) Financing and Sustainability; and (iv) Equity. At the core of all challenges is financing – without adequate reimbursement to cover high-quality care and support a well-compensated, properly sized workforce, there will not be adequate capacity or access, high quality, or equity. Further, in the absence of a major restructuring of the way we pay for LTC or a significant retrenchment in eligibility for Medicaid coverage of LTC, that reimbursement will have to come principally from Medicaid.

New York's Medicaid rates have, for a long time, failed to cover the costs of delivering care across the LTC continuum. The gap between rates and costs has widened over the past several years, in part due to

[3] LeadingAge New York analysis of 2022 Medicaid RHCF cost reports obtained from DOH.
[4] State of the Industry Annual Report 2024, Home Care Association of New York State, https://infogram.com/2024-state-of-the-industry-1h0r6rzle3q1l4e, accessed Aug. 5, 2024.
[5] Ibid.

workforce shortages and an increasingly competitive labor market. Due to their reliance on government reimbursement, LTC providers, unlike other employers, cannot raise their prices to cover rising costs and compete for staff. Nor can they cut costs by eliminating a shift. The only way to cover cost increases is through improved government rates.

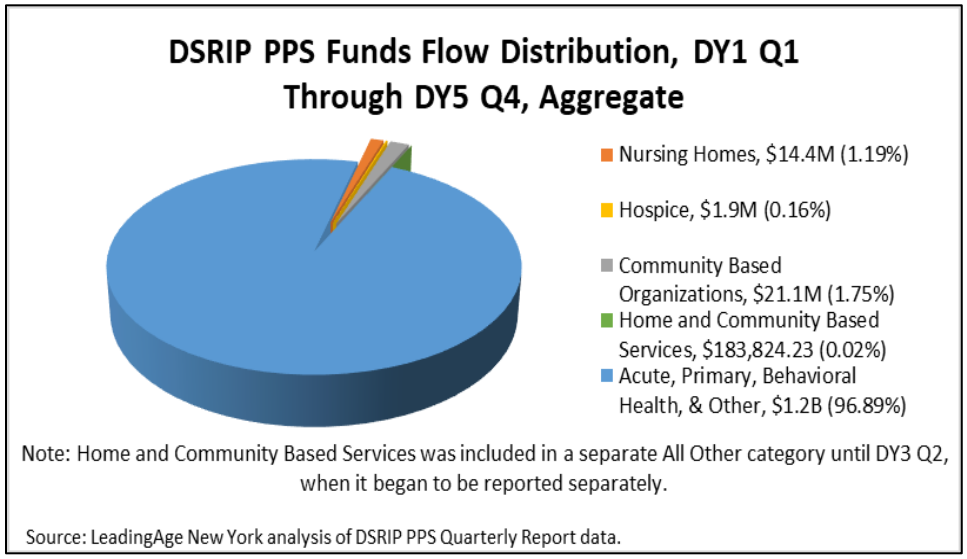
Unfortunately, the primary focus of New York's LTC policy for the past decade or more has been on constraining Medicaid spending for these services, despite our rapidly growing population of older adults and sharply rising costs. Inflation adjustments have been eliminated for 15 years or more. Between 2018 and 2022, the LTC sector experienced deeper Medicaid cuts than any other health care sector. Only since 2023 have there been meaningful increases in Medicaid funding for LTC, and even those investments have not come close to covering the rising costs of care. Costs have risen by 52 percent since 2007, according to the Consumer Price Index. Compensation costs, especially for nursing staff, have grown even more.



*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 proposed, retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due the pandemic not reflected, nor are savings actions that are not attributable to a specific health care sector.

New York has not only denied LTC providers regular Medicaid rate increases to cover rising costs; it has also neglected LTC when funds have been made available to other health care sectors through Medicaid waivers or grant programs. The State has appropriated funds for financially distressed nursing homes and hospitals through the Vital Access Provider Assurance Program (VAPAP) and the Financially Distressed Provider Pool. Although many of our members have applied for VAPAP funding, very few nursing homes have been funded, and only after lengthy waiting periods. In the 2024-25 budget, the Governor proposed, and the Legislature agreed, to cut the VAPAP program for nursing homes by $75 million, claiming that it had not been utilized. We are unaware of any funds distributed to nursing homes from the Financially Distressed Provider Pool. Home care agencies and ACFs are not eligible to apply for funding from either pool.

The greatest disappointment for the LTC sector was the 1115 New York Health Equity Reform (NYHER) Waiver, which will provide a $7.5 billion investment in our health system, including $2.2 billion for Medicaid-dependent safety net hospitals and $492 million for primary care, but nothing for LTC.[6] Inexplicably, the $646 million Career Pathways component of the waiver excludes job titles specific to LTC, such as certified nurse aide (CNA) and home health aide. The NYHER Waiver repeats the neglect of the LTC system exhibited by its predecessor – the Delivery System Reform Incentive Payment (DSRIP) Waiver. Under DSRIP, a mere 1.37 percent of funds was allocated to LTC providers. These policy decisions communicate that equity for older adults in need of LTC services is not a priority.



Today, the unsurprising results of policies that have focused exclusively on cutting rates are being felt throughout the health care continuum, as longstanding, high-quality providers are forced to close, sell to inferior providers, or at best reduce their admissions due to staffing constraints. The financial model is no longer viable.

A. Nursing Homes: Challenges and Recommendations

1. Challenges

The inadequacy of Medicaid rates and its effects can be seen most starkly in the nursing home sector, where detailed cost reports and staffing data reveal the gaping funding shortfall and the relationships

[6] It appears that the enhanced health-related social needs services under the waiver will not be generally available to dually eligible older adults and will not include many of the social supports beneficial to older adults.

among Medicaid days, staffing levels, and financial distress. New York's nursing home operating rate methodology is badly outdated with a 2007 cost base (discounted by 9 percent), no annual cost-of-living adjustment (COLA) since 2008, wage adjustments based on 15-year-old data, and an acuity adjustment system (Resource Utilization Group (RUG)-III) first implemented in 1998. The rates have been stagnant despite the mandate in Public Health Law to update them periodically to reflect changes in cost and labor market conditions.

Our analysis of 2021 nursing home cost reports shows a shortfall of over $1.6 billion between Medicaid rates and costs – an average of $80 per Medicaid day. This is confirmed by a federal 2023 Medicaid and CHIP Payment and Access Commission (MACPAC) report which concluded that New York's nursing home Medicaid rates were among the worst in the nation based on the gap between rates and costs. In 2022, 82 percent of not-for-profit nursing homes and 65 percent of for-profit homes lost money on operations. The median operating margin for not-for-profit homes in 2022 was *negative* 10.9 percent.[7]

Bargain-basement rates have not only impaired the ability of nursing homes to recruit and retain staff in an increasingly competitive labor market; they have also created a race to the bottom. Only those nursing homes that are willing to deliver care on a shoestring will be able to survive. The rest will have to close their doors or sell to a bargain-basement provider. This conclusion is borne out by nursing home cost reports which, together with Centers for Medicare and Medicaid Services (CMS) Payroll-Based Journal data, reveal that homes that staff better and pay higher wages are in more severe financial straits than others. In large part, these are not-for-profit and government-sponsored homes. **As the Commission considers quality, it must be recognized that rate adequacy and quality are intertwined, and that current state policy is driving quality providers out of business.**

This trend is also demonstrated by a shrinking number of available beds and rising closures and sales of not-for-profit and government-sponsored nursing homes. Since 2014, 33 nursing homes have closed their doors, 29 of them not-for-profit or government-sponsored. Unable to compete for staff due to inadequate rates, our members also report that they are limiting admissions in order to maintain appropriate staffing levels and improve their position in relation to mandated nurse/aide hours per resident day. Occupancy data combined with staffing data validate these reports, showing that homes with lower occupancy have better staffing ratios, even though low occupancy exacerbates their financial distress. As a result, 4,000 more beds are empty today than in 2019, and 1,600 beds have been permanently decertified since 2019. Given widespread reports of waitlists for quality nursing home beds and of hospital challenges with discharging patients to post-acute care, we do not believe this reduction is due to lack of demand.

The Commission's slides note that "there is room for improvement in nursing facility quality, notably upstate." We believe there is always room for improvement, and our members strive to excel. New York's approach to nursing home quality, however, does little to support improvements. It has been largely punitive, characterized by the imposition of onerous and ill-defined requirements and the submission of extensive reports and documentation, followed by penalties for non-compliance. Its staffing mandate imposes rigid, one-size-fits-all requirements that are impossible to meet for the overwhelming majority of nursing homes – 52 percent of not-for-profit and public nursing homes and 82 percent of for-profit homes

[7] The 7.5 percent increase in nursing home Medicaid rates enacted in 2023-24 and the $285 million investment appropriated in 2024-25 do not even begin to close the funding gap. These are offset by recent cuts in capital reimbursement and 15 years of inflationary increases in costs.

did not satisfy all three staffing requirements in Q1 of 2024 (the most current data available). Associated daily penalties, once imposed, will further deplete the resources available to facilities to hire staff.

The State's Nursing Home Quality Initiative (NHQI) – a quality pool that redistributes funds based on performance on pre-determined measures – represents a promising step. However, its funding is derived from facilities' below-cost Medicaid rates, not from funds added to the system. The initiative reduces the rates of lower-performing facilities and reallocates the proceeds to higher-performing facilities. A true quality initiative would provide additional funds and not deprive struggling facilities of funds needed for resident care.

It is important to recognize that quality measurement and improvement are complex and nuanced, especially in the LTC field. The CMS 5-Star Ratings for nursing homes offer a structured, data-driven, and well-defined starting point for examining nursing home quality. However, the overall ratings are heavily influenced by survey findings, which can be subjective and exhibit regional variation. Notably, the CMS Star Ratings are updated quarterly, yet the Commission's slide 24 appears to rely on 2022 data. Moreover, it is not surprising, as indicated on slide 24, that 40 percent of New York State facilities are rated below 3 stars because the star system is designed to allocate facilities into rough quintiles based on their scores in three domains. There can be some variation, however, in the distribution of overall ratings by state, based on interstate comparisons on the staffing and quality measure domains, which resulted in New York's 17th place ranking in 2022.

Finally, physical environment and care model are integral to the quality of care and quality of life experienced by residents. Our members would like to innovate and transform their facilities into state-of-the-art, person-centered models, like the Green House®. They would like to make their facilities more homelike and dementia friendly. However, existing reimbursement and rigid staffing requirements do not support innovative care models. Moreover, the State has repeatedly cut reimbursement of capital costs (by 15 percent over the past two years), jeopardizing homes' ability to cover existing debt service obligations and preventing them from making future improvements that promote quality of life and safety.

2. Recommendations

   a. **Engage with Stakeholders on a New Reimbursement Methodology and Ensure that It Includes Elements that Promote Quality and Desired Outcomes:** The Department of Health (DOH) has announced its intent to update its obsolete nursing home reimbursement acuity adjustment methodology, using an approach that resembles Medicare's Patient-Driven Payment Model (PDPM), with modifications to reflect the clinical needs and characteristics of Medicaid beneficiaries. This is a promising approach because PDPM, unlike the current system, connects payment to individual resident acuity, rather than the amount of therapy used. Importantly, the development of a new methodology presents an opportunity to update components of the methodology in addition to acuity. This effort should incorporate elements that incentivize quality and desired outcomes, support individuals with complex care needs, and enable innovation in care delivery. The Department should consult with the nursing home associations and other experts in New York's nursing home sector about the potential impacts and incentives (or disincentives) of various approaches.

b. **Update the Base Year for Nursing Home Rates:** In order to ensure that nursing home reimbursement appropriately reflects facility costs and incorporates desired incentives, New York must update the base year for the operating component of rates. Applying an updated acuity adjustment methodology (PDPM) to an operating base derived from 2007 discounted costs will undermine the accuracy of the adjustment, leading to incongruous and inequitable results.
c. **Incentivize Quality through the Rates and with Additional Funding:** The most effective way to promote quality is through a reimbursement methodology that covers the costs associated with higher quality and rewards desired actions or outcomes (e.g., enhanced staffing). In addition, the State should invest funds in the NHQI, rather than merely redistributing a portion of low-performing facilities' rates. DOH should also examine regional variations in survey findings, ensure consistency in training and approach among regional offices, and review reporting and documentation requirements to ensure that resident care is prioritized.
d. **Restore the Capital Reimbursement Cuts and Support Investment to Modernize Facilities:** To enable the creation of innovative, homelike facilities and models that support individuals with dementia, as well as more routine projects that promote quality and safety, the State should restore the cuts in capital reimbursement enacted in 2023 and 2024.

B. Adult Care/Assisted Living Facilities: Challenges and Recommendations

1. Challenges

ACFs serving low-income individuals are experiencing similar dynamics to those affecting nursing homes. State policies, both financial and regulatory, have constricted access to community-based residential settings for low-income older adults. According to AARP's 2023 State Scorecard, **New York State has the lowest assisted living supply** in the nation with **20 beds per 1,000 population age 75**+. With a growing population of older adults with dementia who require 24/7 care, but who can ambulate and engage in social activities, additional community-based residential capacity is needed.

Capacity for low-income adults on Medicaid and/or SSI in assisted living settings is shrinking. New assisted living development in New York is typically intended for affluent individuals who can afford the steep prices. Since 2017, 63 ACFs have closed voluntarily, and at least one of our members that serves a low-income population is currently in the process of closing. The driving force behind these closures is inadequate SSI Congregate Care rates for ACFs and inadequate Medicaid rates for ALPs.

ACFs are paid just **$45.50 per day** per resident by SSI and the State Supplement Program (SSP) (which has not been increased since 2007). This rate is entirely inadequate to provide residents with the services required by regulation, including housing, meals, personal care, assistance with medications, case management, and more. LeadingAge New York's analysis of 2019 ACF Financial Report data demonstrated that it costs ACFs twice the daily reimbursement per resident to provide the required services – and the gap between costs and reimbursement has grown significantly since then. There is no way to increase wages to compete for staff, given this reimbursement, nor to address the other rapidly rising costs of operations.

The Medicaid ALP is likewise under-reimbursed. Combining an ACF with a LHCSA, these residences offer housing, meals, and a range of nursing, home care, and therapy services to individuals who require a

nursing home level of care. Like nursing homes, ALPs have not received a standard trend factor increase since *2007*. While ALP rates were increased slightly in the last two state budgets, those increases did not make up for 15 years of underfunding, sharply rising costs, pandemic-related expenses, and costs associated with the recruitment and retention of staff in the current market.

Not only is the State forcing ALPs to close due to inadequate rates; it has also limited the number of ALP beds in the state since the program's inception. Under a 2018 law, DOH was directed to create a need-based application process for new ALP beds by 2023. The Department proposed an extension until 2025, which was enacted. Until that new process is established, there is no way to increase the number of ALP beds, despite a growing need.

Serving individuals who have specialized care needs related to dementia under the current ALP reimbursement is particularly difficult. Residents who present with intensive supervision needs and challenging behaviors simply cannot be supported safely with the staffing levels available at the current rate. For those who can no longer live in their own homes, nursing homes are often the only option. Yet, many Medicaid beneficiaries with dementia would be better served in an assisted living environment than in a nursing home. Existing reimbursement is denying them access to the most appropriate level of care.

Health equity demands that these more integrated, homelike settings be available, not only to affluent New Yorkers, but to low-income individuals as well.

2. Recommendations

   a. **Increase the ALP Medicaid Rate:** This rate must likewise be increased to meet current costs and enable Medicaid beneficiaries to access ALP services in lieu of nursing home care (see *A.7553-A (Paulin)/S.7248-A (Cooney)*).
   b. **Create a Dementia Adjustment for ALPs**: Like the existing dementia adjustment in nursing home rates, the ALP Medicaid rate for people with dementia should be adjusted to reflect the increased costs of serving them.
   c. **Increase the SSP for Congregate Care Level 3 Rate:** The SSP rate must be adjusted to meet current costs and ensure access to ACFs for individuals on SSI and/or Medicaid. Moving forward, a COLA must be applied to SSP, like the federal portion of the benefit, to keep pace with the cost of providing services.
   d. **Allow Additional ALP Capacity:** We are concerned that the April 1st deadline for a need-based process will once again be delayed, and that even if it is developed on schedule, DOH may not be ready to receive and review applications immediately. Given the time typically required to promulgate regulations, develop an application process, train agency staff and the field to implement it, and submit and secure approval of a certificate of need, the State may not see a single new ALP bed until 2027. To expedite additional capacity, at a minimum, the freeze on ALP expansion should be lifted to allow entities to apply for new ALP beds on April 1, 2025. In addition, pending the implementation of the new process, existing ALPs should be permitted to expand their beds by nine or fewer, as previously allowed under the 2018-19 budget. The State should also allow nursing homes to convert nursing home beds into new ALPs. These small steps could begin to create greater ALP capacity while a more comprehensive need methodology is implemented.

C. Adult Day Health Care Programs: Challenges and Recommendations

1. Challenges

ADHC programs, like nursing homes, ACFs, and ALPs, are closing their doors due to workforce shortages and inadequate rates. These programs were also disproportionately affected by the pandemic, and most have not recovered. ADHC programs offer participants skilled health care services, personal care, and social engagement opportunities. Their services include comprehensive nursing, medication management, and restorative and maintenance occupational, physical, and speech therapies, as well as personal care. While providing essential services to adults with complex conditions and disabilities, they also enable informal caregivers to work and manage other responsibilities.

Medicaid rates for ADHC programs are based on costs from 2009 or earlier and have not been updated for inflation. Like other providers, their first meaningful increase since 2009 was enacted in 2023. The survival of ADHC programs has been further compromised by the lingering effects of the pandemic, when they were closed by state policy for longer than any other health care provider. By the time they were allowed to reopen, most did not have the staff or a ready pool of participants to do so. Funds that were promised to support reopening were not distributed for two years and then were limited to programs that were already open. Today, less than half of the licensed ADHC programs have reopened. Only 23 counties have an open program; the Bronx, with approximately 200,000 residents over age 65, has just one operating program.

ADHC programs are critical resources for caregivers and consumers, enabling individuals with complex care needs to continue to live at home and in their communities. The State must make a concerted effort to return this valuable home and community-based service (HCBS) provider to viability. Individuals who qualify for ADHC, but are unable to access it, are likely to seek a higher level of care at a higher cost, either in a nursing home or ALP (if one is available).

2. Recommendations

   a. **Raise Medicaid Rates:** The Medicaid rate for ADHC programs should be set at 65 percent of their sponsoring nursing home rate to align with costs and enable them to reopen and remain open.

III. Workforce: Widespread Shortages and Resistance to Common-Sense Reforms

1. Challenges

Demographics, funding, labor market dynamics, and the effects of the COVID pandemic have combined to create an unprecedented workforce crisis in all LTC and post-acute care settings. LeadingAge New York's members are doing everything in their power to recruit and retain staff to enable them to continue to provide access to high-quality care. Yet, all report that they are unable to fill open positions, particularly in direct care. They cannot compete with other employers that have the luxury of raising prices to reflect labor market dynamics. Our members' extraordinary efforts to maintain high-quality staffing at appropriate levels, with inadequate reimbursement, are bankrupting them.

Despite these crisis conditions, New York has not only failed to pay Medicaid and SSI rates that cover the costs of recruiting and retaining a skilled and valued workforce; the State has also been unwilling or unable to make common-sense regulatory and statutory changes that would help providers to recruit and retain staff and deploy them more effectively. The Commission's slide 17 highlights the goal of "flexibly deploying workforce." The following recommendations would help to advance that goal. Admittedly, they would not eliminate the workforce challenges that providers face daily, but they would help to mitigate them. They would also expand opportunities for workers and increase access to care for consumers.

2. Recommendations

   a. **Allow Nurses to Practice Nursing in Assisted Living:** The average consumer is shocked to learn that the State does not permit most ACF/AL settings to provide nursing services, despite the fact that many of these settings employ nurses. The Enhanced Assisted Living Residence (EALR) – a private pay model – is the only ACF/AL setting where nurses are permitted to provide nursing services. In the context of a severe workforce shortage and an aging population, the State should allow nurses in any ACF/AL model to provide periodic services that would result in better health outcomes, prevent hospitalizations, support end-of-life care, and save Medicaid dollars. The State should enact legislation (*A.5670 (Solages)/S.5471 (Rivera)*) that would allow ACF/AL providers that employ nurses to provide nursing services, consistent with scope of practice laws and admission and retention standards.
   b. **Authorize Medication Aides in Nursing Homes:** Governor Hochul's Executive Budget included proposed legislation to authorize specially trained CNAs to serve as medication aides in nursing homes. We applaud this initiative, which was not enacted in the final budget, and we support similar legislation subsequently introduced in both houses (*A.8299 (Clark)/S.8635 (Cooney)*). Medication aides may administer routine medications to residents under the supervision of a registered nurse. Approximately 38 states authorize medication aides in nursing homes. New York's Office for People with Developmental Disabilities system similarly allows unlicensed personnel to administer medications in residential settings. These programs are safe and effective and help to support CNA recruitment and retention by offering new career opportunities.
   c. **Support Investment in Home Care and Hospice Workforce:** Home care and hospice agencies face increasing challenges in accepting a growing number of referrals of complex patients, due to lack of nursing and aide staff. This contributes to overall health system backups and a lack of access to care. Workforce funding is needed for financial incentives for frontline staff, nurse residency programs, nursing school collaborations, and to secure transportation to patients' homes (*A.7568 (Paulin)*).
   d. **Prioritize LTC for Workforce Development Programs:** All state workforce initiatives should prioritize and incentivize working in LTC settings. This should include expanding the 1115 Waiver's Career Pathways Program to include nurse aide and home health aide titles. It should also include eliminating barriers to licensed practical nurse and aide registered apprenticeship programs. In addition, the Nurses Across New York loan forgiveness program should be modified to recognize patients and residents of LTC services as underserved populations, regardless of where they are located geographically. Similarly, Doctors Across New York could incentivize physicians working in LTC settings. The State should also consider launching a campaign to increase public awareness of the rewarding careers available in the LTC continuum. In light of our aging population, it is imperative to expand the "pipeline" of qualified paid caregivers and medical professionals.

IV. Sources of Payment for LTC: Supporting Private Payment for LTC

1. Challenge

New York's comparatively generous financial and clinical eligibility criteria for Medicaid coverage of LTC services encourage individuals to count on Medicaid to cover their LTC needs. At the same time, the State does not create adequate opportunities for people who can afford it to share in the cost of their care and even discourages some private pay options. The following recommendations would facilitate greater private payment or partial payment for LTC services.

2. Recommendations

a. **Consolidate and Streamline Oversight of CCRCs:** CCRCs provide residents with a full range of services, as their needs change over time, through an upfront payment and monthly service fees. Covered services include independent housing, ACF/AL, and nursing home care. This innovative model encourages seniors to invest in their LTC and housing needs, rather than divest their assets to qualify for Medicaid-funded services. Studies have shown that CCRCs improve the overall wellness of their residents.

   Unfortunately, in New York State, multiple layers of regulatory oversight have become a barrier to development of new CCRCs and the efficient operation of existing ones. Under the Public Health Law, CCRCs in New York are regulated by DOH, the Department of Financial Services (DFS), in certain cases, by the Attorney General, and the CCRC Council. The time-consuming and duplicative oversight has added significantly to the cost of developing and operating CCRCs in New York. As a result, there are only 14 CCRCs in New York State, while the number in neighboring states is much larger: Pennsylvania has 197, New Jersey has 27, and Massachusetts has 31. New York's regulatory environment has not only inhibited the growth of the model; it has also limited the ability of existing CCRCs to be responsive to consumer preferences and market changes. New York should enact *A. 7742-A (Paulin)/S.7483-A (Cleare)* to consolidate oversight of CCRCs and support more efficient operation of CCRCs. This in turn would translate to expansion of this beneficial model.

b. **Expand Sliding Scale Aging Services:** Older adults and their informal caregivers are often willing and able to contribute to the cost of their home care, but are unable to afford the full cost of care. SOFA's Expanded In-Home Services for the Elderly Program (EISEP) and Community Services for the Elderly (CSE) program offer services with cost sharing on an income-based sliding scale. Additional funds should be allocated to expand these programs and address growing waiting lists. Expanding access to these programs may help to delay the use of Medicaid to pay for LTC while encouraging more New Yorkers to contribute to their LTC costs.

c. **Expand the SNALR Voucher Program:** The SNALR is designed to assist individuals with dementia or Alzheimer's disease residing in SNALRs who are at risk of requiring nursing home placement due to dwindling resources. The voucher program covers a portion of the cost of the resident's SNALR private pay rate. It can reduce unnecessary transitions to higher levels of care and delay reliance on Medicaid for LTC services. Current funding supports only 135-140 individuals. In July 2023, the

State paused the processing of applications for the voucher program due to funding constraints, and just reopened applications on Aug. 1, 2024.

V. Affordable Senior Housing: Resident Assistant Services Prolong Independence and Reduce Costs

1. Challenge

Subsidized, income-restricted, multifamily senior housing offers a critical foundation for enabling a growing population of low-income older adults to remain independent for as long as possible. In addition to age-appropriate design and accessibility features, multifamily senior housing offers residents the opportunity for socialization and engagement. Ideally, it is also a platform for connections with social activities, aging-related services, and resources in the community that can help them age safely in place and delay or prevent the need for higher, more costly levels of publicly funded care.

Most subsidized senior housing providers have little or no funding to maintain a staff person who could facilitate those much-needed connections. While the State has committed a total of $425 million in capital to developing affordable housing for low-income older adults in recent five-year spending plans for the Division of Housing and Community Renewal, no complementary operational funds have been invested in connecting the residents of the resulting properties with aging-related services and resources. And, although the State has invested heavily in the supportive housing model in recent years, most Medicaid-eligible older adults will not qualify for admission to a supportive housing program, as these typically require applicants to meet additional criteria such as being homeless, at risk of homelessness, unstably housed, or unnecessarily institutionalized.

2. Recommendation

The State should create a "Resident Assistant Program" in affordable independent senior housing. This program would offer a low-cost strategy to address the needs of older adults living independently before homelessness or entry into a higher level of LTC become inevitable. It would align well with the State's commitment to addressing health-related social needs of vulnerable populations. Resident Assistants would be available on-site and at resident request to provide information and referrals to supports in the community, assistance with accessing public benefits, and opportunities for social engagement and health-related programming for residents.

A rigorous New York-based study of the Selfhelp Active Services for Aging Model (SHASAM) found that the average Medicaid payment per person, per hospitalization was $3,937 less for Selfhelp residents as compared to older adults living in the same Queens ZIP codes without services, and Selfhelp residents were 68 percent less likely to be hospitalized overall. [8,9] Furthermore, with the SHASAM Resident Assistant

[8] Kaplan, S. C., M.B.A., Lynn, E., Ed. M., & Mishra, M., CASP, LMSW (2018). *Healthy Housing: An Evaluation of Selfhelp Active Services for Aging Model (SHASAM)*. Selfhelp. https://selfhelp.net/wp-content/uploads/2022/02/Selfhelps-Healthy-Housing-White-Paper.pdf.

[9] 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.

program in place, less than 2 percent of Selfhelp's residents are transferred to a nursing home in any given year.[10]

Based on these data, we anticipate that a $10 million investment in state funds over five years could support Resident Assistants in at least 16, 100-unit affordable senior housing buildings, which would serve 1,600 or more low-income older adults and generate a state-share Medicaid savings of at least $6.5 million per year, with net state-share Medicaid savings (after the $2 million investment) of at least $4.5 million annually.

VI. Integrated Managed Long Term Care: Promising Models, Not Platforms for Spending Cuts

1. Challenge

The Commission's slide 16 highlights the disjunction between LTSS and other health care coverage. This is driven in part by the bifurcation of the dominant payers for individuals receiving LTC and other health care (e.g., primary, specialty, acute, post-acute, pharmacy) services – i.e., Medicaid for LTC and Medicare for everything else. The Medicare-Medicaid divide at best creates perverse incentives and at worst can lead to cost shifting and lack of accountability for delivering comprehensive care in the most appropriate setting.

2. Recommendation

Integrated MLTC plans, such as New York's Medicaid Advantage Plus (MAP) plans and PACE, that combine the Medicaid-funded LTC benefits with the Medicare-funded health care benefits show promise in bridging the divide between Medicare and Medicaid. They have been associated with reductions in nursing home and hospital use and improving longevity.[11] Member satisfaction with these models is high, as they can offer a coordinated and customized approach to comprehensive services through care management and/or an interdisciplinary team. In particular, the plans sponsored by the not-for-profit LTC providers in LeadingAge New York's membership play a special role that combines a mission orientation with strong connections to the LTC system and a wealth of experience in meeting the needs of older adults and Medicaid beneficiaries.

Despite these positive attributes, however, enrollment in integrated MLTC overall has been comparatively low, due to a number of factors, including the federal prohibition on mandatory enrollment of Medicare beneficiaries in Medicare managed care plans and provider concerns related to payment adequacy.

New York should promote these models as a vehicle for improving the well-being of their enrollees. However, it should not use them as vehicles to reduce LTC spending or provider rates. Absent adequate

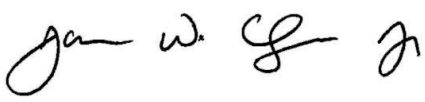
[10] The New York Housing Conference. Spotlight: A Conversation with Mohini Mishra, Selfhelp Realty Group. July 2021.
[11] *See, e.g.,* Micah Segelman, MA, Jill Szydlowski, Bruce Kinosian, MD, Matthew McNabney, MD, Donna B. Raziano, MD, MBA, Catherine Eng, MD, Christine van Reenen, PhD, and Helena Temkin–Greener, PhD, "Hospitalizations in the Program of All-Inclusive Care for the Elderly," Journal *of the American Geriatrics Society*, (Feb. 2014) 62(2):320–324. Darryl Wieland, Rebecca Boland, Judith Baskins and Bruce Kinosian, "Five-Year Survival in a Program of All-Inclusive Care For Elderly Compared With Alternative Institutional and Home- and Community-Based Care," *J Gerontol A Biol Sci Med Sci* (Mar. 2010) 65A (7): 721-726. Susan M. Friedman, MD, MPH, Donald M. Steinwachs, PhD, Helena Temkin-Greener, PhD, and Dana B. Mukamel, PhD, "Informal Caregivers and the Risk of Nursing Home Admission Among Individuals Enrolled in the Program of All-Inclusive Care for the Elderly," *The Gerontologist* (2006) 46 (4): 456-463.

funding, these models will not contribute to positive outcomes for consumers or the stability of the system. Moreover, low rates will discourage providers from participating in plan networks, which will in turn deter enrollment.

Conclusion

In order to carry out the Governor's commitment to health equity and aging with dignity in one's preferred place for people of all income levels, New York must be prepared to pay for it. With a growing population of older adults, the State cannot continue on its current path. A robust, financially viable continuum of LTC that enables older adults to thrive will require investment by the state and federal governments, additional cost sharing by consumers who can afford it, and new approaches to workforce development and regulation of LTC settings. We would welcome the opportunity to provide the Commission with additional details on our recommendations and work with the Commission to develop a path forward.

Sincerely yours,



James W. Clyne, Jr.
President and CEO

cc: Angela Profeta