2021-22 Health/Medicaid Testimony

Provided by

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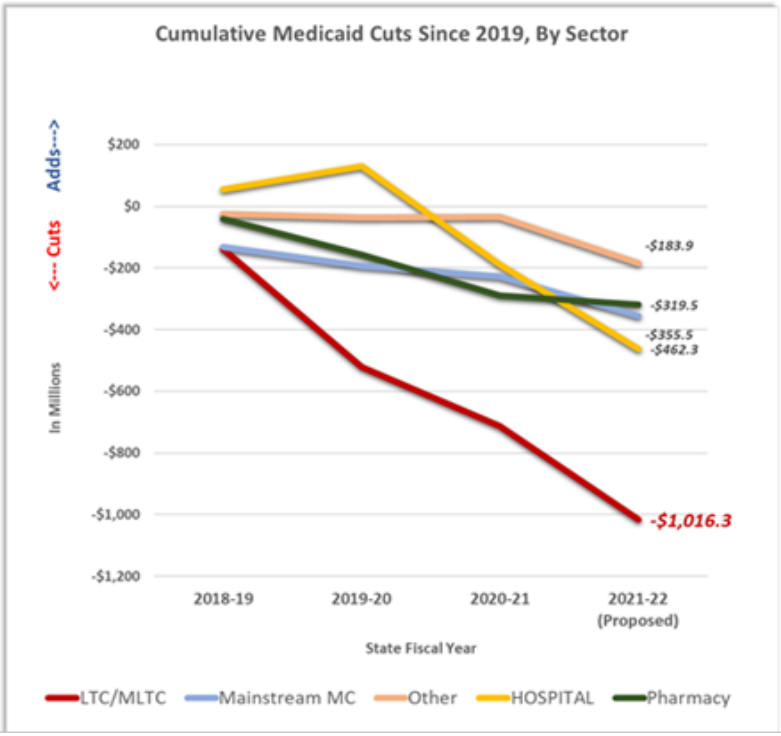
INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the aspects of the SFY 2021-22 Executive Budget impacting long-term care and post-acute care (LTC) providers[1] and older adults. LeadingAge New York represents over 400 not-for-profit and public providers of LTC, aging services, and senior housing, as well as provider-sponsored Managed Long Term Care (MLTC) plans. This testimony addresses the Executive Budget proposals that apply across the continuum of LTC, aging, and MLTC services, as well as those that would affect specific types of providers and managed care plans.

The COVID pandemic has destabilized an LTC system already shaken by year-over-year cuts in funding that have far exceeded the cuts imposed on other health care sectors. When the pandemic hit, and LTC providers were pummeled with extraordinary costs for personal protective equipment (PPE), staffing, and testing, New York did not offer meaningful support. Instead, it carried out a 1.5 percent across-the-board Medicaid cut. At the same time, 23 states and the District of Columbia raised their nursing home Medicaid rates or increased nursing home funding to support COVID response.[2] Today, the Governor's budget proposes even deeper **cuts of more than $1 billion** in Medicaid funding for LTC, plus additional cuts in other programs that support LTC services.



Note: Figures are based on state calculated impacts of new Medicaid budget actions since 2018-19 as well as cuts proposed for SFY 2021-22. More than $1.5 billion in proposed, retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due the pandemic are not reflected, nor are most savings actions that are not attributed to a specific health care sector. ATB cuts are apportioned based on Global Cap proportions.

[1] The term LTC providers is used throughout this testimony to refer to providers that deliver long-term and/or post-acute care. These providers include home care agencies, nursing homes, hospice programs, adult day health care programs, and adult care/assisted living facilities.

2 As of mid-June, the states that raised reimbursement were: Alabama, California, Connecticut, Colorado, District of Columbia, Indiana, Georgia, Kansas, Kentucky, Massachusetts, Louisiana, Minnesota, Maine, Montana, New Mexico, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Rhode Island, Virginia, and Washington. (LeadingAge, "States Leverage Medicaid to Provide Nursing Homes a Lifeline through COVID-19," https://www.leadingage.org/node/63186.)

As you negotiate the SFY 2021-22 budget, we ask you to keep at the forefront the needs of older adults and people with disabilities who need LTC services. The system that serves them is in crisis, and this budget will determine whether they will have access to high-quality LTC services in the future.

To understand the impact of the Executive Budget proposals, it is critical to understand the impact of COVID-19 on LTC, as well as the distressed condition the sector was in before the pandemic due to underfunding, cuts, and workforce shortages. It is only through this lens that one can fully comprehend the devastating impact the budget will have on current and future LTC and aging services and the people who rely on them, and the urgent need for additional financial relief.

THE IMPACT OF COVID-19 ON LEADINGAGE NEW YORK MEMBERS AND THE PEOPLE THEY SERVE

Our members are mission-driven, not-for-profit organizations – they are not an industry; they are caregivers. They grieve for the residents and staff who lost their lives to COVID. They ache for the older adults they serve who have declined due to isolation and loneliness. Our members are communities and families, and every life is precious. They are acutely aware of the solemn trust placed in them by residents, patients, and families, and they accept that trust with unwavering dedication. But they have been operating under crisis conditions for 12 months, are financially depleted, facing unprecedented operational challenges, and in need of your support.

While we are in a far better place now with regard to an understanding of COVID, and fully utilizing every tool to combat it, it is important to remember the difficult path that has led to this place. It was well-known from the beginning that the people served by LTC providers are the most vulnerable to negative outcomes from COVID. Yet, the efforts of providers to protect residents, consumers, and staff were undermined by a lack of access to PPE and testing to support infection control during the first months of the pandemic. Government agencies did not prioritize LTC providers for PPE distributions or testing for weeks after the pandemic began. These factors, together with an insufficient knowledge of how the virus manifested itself in older adults, how easily it was transmitted, and how many infected people were asymptomatic, all contributed to the rapid spread of the virus in nursing homes and adult care/assisted living (ACF/AL) facilities with devastating and heartbreaking results.

The Unprecedented Costs of Fighting COVID

Today, we have greater knowledge and more tools to fight the spread of COVID. Testing is available, albeit at an extraordinary and unreimbursed cost. PPE is also generally available, although there are still intermittent shortages, and it is only available at inflated prices. As a result of greater knowledge about the mode of transmission and greater availability of testing and PPE, as well as the vaccination efforts, we will see better results. But combating infection requires the daily vigilance of every LTC and aging services provider, and it requires enormous resources, both financial and human – resources these providers do not have.

Testing: Mandatory weekly or twice-weekly staff testing costs are among the largest unbudgeted and unreimbursed costs for both nursing homes and ACF/AL facilities. The State has made it clear that providers are responsible for covering staff testing costs when insurance coverage is unavailable, and most health insurers have made it clear that COVID testing for employment purposes is not covered. Overall staff testing costs vary widely based on the size of the facility, the types of tests used, and lab charges. To provide an order of magnitude, we have received reports from members of monthly testing costs ranging from approximately $50,000 to more than $250,000. Most providers have

reported costs averaging $100 per week for each staff member tested. Although some rapid antigen test kits are being distributed by government agencies, these tests require a substantial investment in staffing to analyze, record, and report results and often require confirmation via more reliable and expensive polymerase chain reaction (PCR) tests.

PPE: The volume of PPE needed by LTC providers is staggering and continues to require a major investment of resources among nursing homes, ACF/AL facilities, hospice programs, and home care agencies. For example, based on median facility use rates reported to the Department of Health (DOH), nursing homes statewide used the following volume of PPE in April:

- 870,000 N-95 masks
- 4.7 million surgical masks
- 2 million gowns
- 27 million gloves[3]

The expense associated with these supplies was not budgeted for, nor is it reimbursed in any provider rates. One downstate nursing home reported spending an additional $800,000 on PPE over five months. Although providers received some PPE allotments from the State and local governments, the amounts provided were inconsequential in comparison with what was and continues to be needed.

Staffing: LTC providers struggled with staffing shortages before the pandemic, attempting to compete with hospitals and other providers for similar personnel, in the context of much lower reimbursement from Medicaid. The situation has grown dramatically worse as a result of COVID. COVID-related absences due to illness, family demands, positive test results, and exposures have strained an already limited workforce. Extensive absences have generated additional costs to ensure adequate staffing through hazard pay, overtime, and staffing agencies, as well as paid sick leave.[4] At the same time, COVID has necessitated additional staffing for cohorting, cleaning, in-room dining, virtual and in-person visitation, and socially-distanced activities. State and federal requirements related to the management of the pandemic have added significant, labor-intensive administrative responsibilities – daily and weekly state and federal reporting; administering, tracking, and recording staff screening, testing, and furloughs; and monitoring, analyzing, and complying with federal, state, and local guidance that is rapidly evolving on matters ranging from infection control to travel advisories to sick leave.

Declining Census and Shrinking Revenues

Along with extraordinary cost increases, nursing homes, ACF/AL facilities, and home care providers are experiencing dramatic drops in patient/resident census and, for nursing homes and certified home health agencies (CHHAs), significant reductions in Medicare revenue from post-surgery rehabilitation services, creating growing budget shortfalls. Occupancy in AL facilities is down by more than 6 percent, while the statewide median nursing home occupancy remains nearly 15 percent lower than in January 2020. Statewide median figures mask the even more precipitous decline in nursing home occupancy in the downstate region, where nursing homes that typically operated at 90 to 95 percent occupancy are still recovering from occupancy rates that had dipped as low as 75 percent. As a result, it is not uncommon for our nursing home members to report COVID-related impacts from increased costs and

[3] LeadingAge NY analysis of DOH compilation of nursing home data reported April 2020.

[4] While the State created a COVID staffing portal in the early months of the pandemic, it was designed for hospitals and did not yield much relief for LTC providers. Individuals who registered for the portal were seeking higher-paying jobs and generally were not prepared for or interested in working in LTC settings. The portal was recently reopened with some modifications to support recruitment of LTC staff, but we have not heard of any successful hires.

revenue losses in the millions of dollars. Notably, while rising vacancies in nursing homes are causing financial distress for facilities, they are also driving Medicaid savings for the State. We estimate that reductions in nursing home Medicaid days in 2020 resulted in State-share Medicaid savings exceeding **$40 million per month.**

Losses That Far Exceed Federal Provider Relief

Most health care providers, including nursing homes, home care agencies, and ACF/AL facilities, received federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Funding (PRF). While this funding represented a critical financial lifeline, for most providers it covered just a fraction of the significant, unanticipated expenses and lost revenue caused by the pandemic. For many nursing homes and AL facilities, the costs of mandatory staff testing alone have exceeded any relief funding they may have received.

To get a more accurate picture of our members' experience, in mid-2020 we surveyed both our nursing home and AL members about the financial impact of the pandemic on their organizations. A typical AL facility experiencing losses of about $700,000 over 12 months would receive PRF funds that cover only 11 percent of those losses. General distribution PRF funds covered only about 38 percent of a typical nursing home's COVID losses. While targeted PRF has provided additional funding to nursing homes and AL providers, such relief represents less than $4 of every $10 in new COVID-related financial impact.

CHRONIC UNDERFUNDING AND FINANCIAL DISTRESS BEFORE COVID

The COVID-19 pandemic has exposed and exacerbated the chronic underfunding of LTC in New York State and nationwide. Not only has New York repeatedly imposed deeper cuts on LTC providers than other health care sectors, it has also failed to invest an equitable share of capital and federal Delivery System Reform Incentive Payment (DSRIP) funds in LTC, despite a growing aged population and rising costs. These failures have contributed to the current crisis.

Deep Cuts Year After Year Have Led to Negative Margins and Closures

Most Medicaid providers have not received inflation adjustments in 12 years, despite rising wage and benefit costs,[5] increased utility and food costs, and new regulatory requirements related to information technology, nursing assessments, care planning, reporting, compliance, infection control, and labor laws.[6] On top of the elimination of a trend factor, rates and other funding have been cut year after year, and almost all Medicaid providers are currently experiencing an additional 1.5 percent payment cut. This cut has already reduced Medicaid payments for LTC services by **approximately $50 million** in the first three months of CY 2020 and, along with reducing MLTC rates to the bottom of the allowable rate range, is set to slash **another $300 million** from Medicaid MLTC, nursing home, home care, and

[5] Although minimum wage increases may have been beneficial overall, policymakers should be aware of the additional challenges that the policy poses for providers. Not only have these increases made it more difficult to attract staff because the compensation difference between traditionally better-paying health care jobs and other jobs is now smaller, but providers have also had to adjust their pay scale across the board to adjust for compression. These adjustments are not discretionary; any employer will recognize that it is not optional if one is to maintain morale and retain staff.

[6] The medical Consumer Price Index (CPI) alone increased by 38 percent between 2008 and 2019. This does not take into account rising costs as a result of rising acuity or programmatic requirements. U.S. Bureau of Labor Statistics, Consumer Price Index: Medical Care in U.S. City Average, All Urban Consumers [CPIMEDSL], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/CPIMEDSL, September 18, 2019.

Medicaid AL payments in SFY 2020-21.[7] On top of last year's across-the-board cut, the Executive Budget includes **another 1 percent payment reduction**.

The cumulative effect of repeated reductions in public funding has been negative margins across all LTC provider types:

- Two-thirds of public and non-profit nursing homes had negative operating margins in 2018, the most recent year for which cost report data is available. The median operating margin for these homes was -2.1 percent.[8]
- 67 percent of CHHAs have negative operating margins, with a median margin of -14.78 percent.[9]
- 74 percent of hospice programs have negative margins, with a median margin of -16.57 percent.[10]
- The ACF Supplemental Security Income (SSI) daily rate is $42.02 per day, less than half of the average cost per day.

Fiscal pressures are leading to closures and sales of not-for-profit nursing homes, ACFs, adult day health care (ADHC) programs, and provider-sponsored MLTC plans:

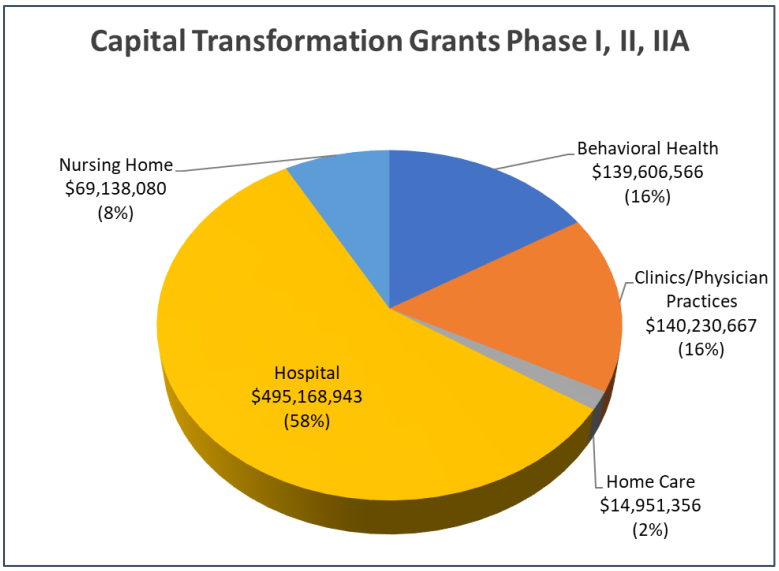
- Since 2014, 13 nursing homes have closed – one was public, one was for-profit, and the rest were not-for-profit. Nearly 50 public and not-for-profit homes have been sold.
- Between 2017 and 2019, 16 medical model ADHC programs closed. Since the pandemic, another 12 have closed.
- Since 2017, 30 ACFs have closed voluntarily statewide. Others are on the brink of closure.
- In 2019, three MLTC plans closed, forcing the transfer of thousands of beneficiaries to new plans and disrupting relationships with aides and care managers.

Each closure displaces vulnerable New Yorkers from a home or program that has provided them with necessary care and separates them from familiar caregivers and/or settings that offer comfort and knowledge of their needs and preferences. Each closure causes havoc and stress in the families that help older adults to navigate systems of care and adds to the administrative costs of the system.

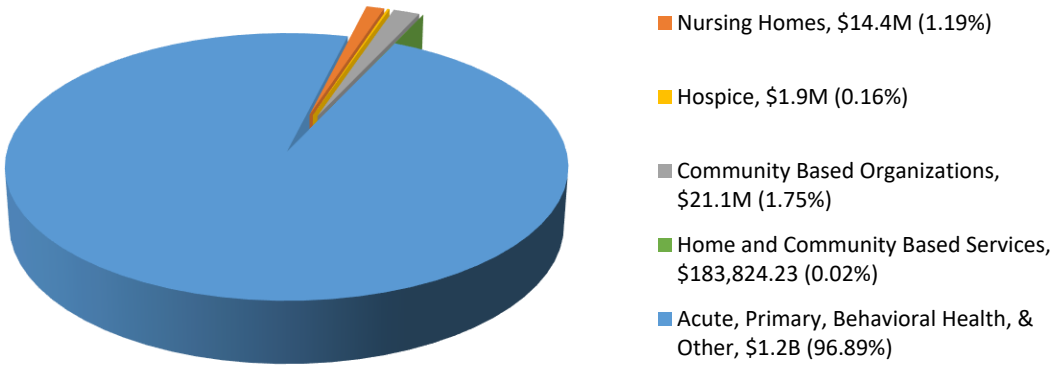
[7] The magnitude of these cuts can be seen in the impact on a typical nursing home. The median daily nursing home rate in April 2020 was $227, $9 per resident day lower than 2019. If this year's Executive Budget proposal is enacted, the rate would drop to $221.36. For a typical 200-bed nursing home, this translates to a $1.1 million reduction over last year – for one facility.
[8] LeadingAge New York analysis of 2018 RHCF Cost Reports.
[9] "State of the Industry 2020," Home Care Association of NYS, February 2020, accessed at https://hca-nys.org/wp-content/uploads/2020/02/HCA-State-of-the-Industry-Report-2020.pdf.
[10] *Ibid.*

Infrastructure and System Reform Investments Have Overlooked LTC

While LTC providers have taken more than their fair share of cuts, they have not gotten their fair share of capital investments or funding from the DSRIP program. Only about 2 percent of DSRIP funds and 10 percent of Statewide Health Care Facility Transformation Program funds have been allocated to LTC providers. As a result, LTC providers have not received sufficient State financial support for the critical infrastructure necessary to operate efficiently and effectively in today's changing delivery system. And, now more than ever, facility-based providers need capital funding to upgrade their physical plants and ventilation systems to prevent the spread of infection and enable safe visitation and socialization.



DSRIP PPS Funds Flow Distribution, DY1 Q1 Through DY5 Q4, Aggregate



Note: Home and Community Based Services was included in a separate All Other category until DY3 Q2, when it began to be reported separately.

Source: LeadingAge New York analysis of DSRIP PPS Quarterly Report data. February 2021

Workforce Investments Are Critical

The pandemic has also exacerbated the longstanding shortages in the LTC workforce statewide at all levels. Even before the pandemic, the Center for Health Workforce Studies found that 59 percent of home care agencies reported difficulty hiring full-time workers. Similarly, 69 percent of nursing homes reported difficulty hiring workers for evening, night, and weekend shifts.[11] These shortages extend to both aides and nurses. LeadingAge New York has developed a package of regulatory reforms and workforce initiatives that would support recruitment and retention of LTC staff, and we look forward to working with the Legislature and Executive on these issues.

Individuals who work in LTC deserve our deepest appreciation for their work on the front lines, in crisis mode for nearly a year. They have made tremendous sacrifices, and they need support. We need to retain this dedicated workforce and help them heal from this experience, while recruiting new people to the field. Given the aging demographics of New York State, we must build the LTC workforce and identify ways to use a shrinking pool of workers more efficiently and effectively. Yet, at a time when we need it most, the Executive Budget proposes to *reduce* workforce recruitment and retention funding by $45 million, hurting home health, hospice, and MLTC plans.

GENERAL RECOMMENDATIONS TO PRESERVE AND STRENGTHEN THE LTC SYSTEM AS A WHOLE

These general recommendations would help to support the financial viability of the LTC system, while improving quality of care and strengthening our workforce. They are followed by an analysis of setting- or service-specific proposals and recommendations.

- *Reject the Medicaid across-the-board cuts and other cuts to LTC providers in the Executive Budget.*
- *Prioritize LTC and senior services providers for allocations from the Governor's proposed COVID-19 Extraordinary Relief Fund and for any additional federal funding the State receives to help address the costs associated with the pandemic.*
- *Prioritize LTC providers for allotments from the Statewide Health Care Facility Transformation Program. A short deadline should be set for solicitation of applications for the next round and distribution of funds. The Assisted Living Program (ALP) awards should be announced immediately.*
- *Ensure that the extension and renewal of the Medicaid 1115 waiver recognizes and operationalizes LTC as a "high priority area" and clearly dedicates funds to these providers to support transformation.*
- *Support LTC workforce development:*
    - *Reject the $45 million workforce recruitment and retention funding cut. Implement workforce development programs that bring new workers into LTC and adopt reforms that enable optimal use of a limited workforce;*
    - *Authorize the use of medication technicians in nursing homes; and*
    - *Authorize nurses to practice nursing in AL facilities, and authorize them to provide influenza, pneumococcal, and COVID-19 immunizations to residents and staff.*

[11] Martiniano R, Krohmal R, Boyd L, Liu Y, Harun N, Harasta E, Wang S, Moore J. *The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; March 2018.

As we move into the next phase of the pandemic, the State and LTC providers must work together to strike a proper balance between infection prevention and the quality of life of older adults receiving LTC services. We are in the eleventh month of the lockdown of nursing homes and ACFs and the closure of ADHCs and other programs for seniors. As many seniors are being vaccinated, and we are in a better infection prevention position, we need to consider the negative health and mental health effects of social isolation on older adults. It is one thing to close down a facility or a program for a month or two, but to prevent visitors, communal dining, social activities, and religious services for a year or more, when the residents and participants by definition have limited life expectancy, may cause more harm than good.

Similarly, the Legislature and DOH must weigh the impact of new requirements, audits, and surveys on patient and resident care. State and federal requirements related to the pandemic are rigorous. The cost of even minor non-compliance is great, and the State has been unforgiving in its response to even minor violations – being minutes late in submission of a daily survey that providers have completed every day since last March triggers a violation notice and a fine. The array of existing requirements necessarily divert facility staff and resources from the delivery of direct care and maintaining connections to residents' loved ones. Before any new requirements are imposed, including the increased fines proposed in the 30-day amendments, policymakers should consider the broader context and whether their value outweighs the diversion of resources from direct care.

SERVICE- AND SETTING-SPECIFIC RECOMMENDATIONS

I. Nursing Homes

LeadingAge New York's nursing home members are committed to providing high-quality care while helping residents achieve the highest quality of life possible. These providers and their dedicated staff have been at the forefront of the fight to protect the state's most vulnerable residents while at the same time seeking to minimize the effects of prolonged social isolation and separation from loved ones. The lessons from the pandemic should inspire policymakers to allocate appropriate resources to ensure that the State's LTC system is able to continue to deliver high-quality care and able to withstand future challenges.

Nursing homes serve the most medically complex individuals on the LTC continuum who are at grave risk of contracting and succumbing to COVID-19 even in the context of perfectly-executed infection control and care. Eighty-five percent of nursing home residents in New York are over age 65, and 38 percent are over age 85. Ninety-seven percent of nursing home residents in New York require assistance with toileting, and 40 percent require two people to assist with sitting up or turning in bed.[12] Over half of all nursing home residents have diagnoses of Alzheimer's disease or other forms of dementia, which pose unique challenges in curbing COVID transmission, including wandering behaviors, fear of mask usage, and inability to practice social distancing. Despite the desire of most people to age in place, nursing home care will continue to fill a critical need for people who need short-term rehabilitation, who lack appropriate housing or informal supports to remain in the community, who have complex conditions that require long-term skilled care, or who simply cannot find aides and nurses to provide home care on a 24/7 basis.

[12] CMS MDS National Repository, MDS 3.0 Frequency Report for 4th Quarter of 2019.

Our nursing home members have strived to meet the demands of pandemic response with Medicaid rates that are based on 2007 costs with no inflation adjustments, resulting in a *pre*-pandemic shortfall of $64 per Medicaid resident day.[13] The 1.5 percent Medicaid cut imposed in the midst of the pandemic further exacerbated their financial condition, which will only grow more dire if the Executive Budget proposals are enacted. Nursing homes cannot continue to provide high-quality care and absorb the extraordinary costs associated with COVID with rates that cover only a fraction of their expenses. Instead of imposing more cuts, the State should use the lessons of the pandemic as an opportunity to examine potential service gaps in residential care, invest in capital improvements, address shortages of qualified staff, and review rate setting methodologies to ensure appropriate reimbursement that recognizes quality practices and outcomes.

a. Federal COVID-19 Support, COVID-19 Extraordinary Relief, and Distressed Facility Funds

As noted above, nursing homes and other LTC providers should be prioritized for a fair share of the COVID-19 Extraordinary Relief Fund and any enhanced federal funding that the State receives for pandemic response. In addition, the State should utilize the funding generated through the Distressed Facility program created in the SFY 2020-21 budget to stabilize quality providers at risk of sale or closure.

Recommendation: *Provide additional funding for pandemic response and ensure that prompt financial assistance is available for high-quality providers facing financial distress.*

b. Direct Resident Care Ratio Proposal and Executive Salary Limits

Amendments to the Executive Budget propose that specified percentages of nursing home revenue be spent on direct resident care and resident-facing staff and would limit margins to 5 percent. Facilities that fail to meet the spending thresholds in a given year would be required to spend the "excess revenue" on direct care or remit the funds to DOH. The amendments would also limit executive salaries and cap expenses on executive and managerial salaries at 15 percent of total annual expenses.

While well-intentioned, these requirements fail to take into account real-world demands on providers, the needs of residents, and diverse provider cost structures. And, the ratio proposal threatens to disincentivize, if not preclude, payments for PPE, staff testing, physician services, staff recruitment and training, and critical investments in nursing home physical plants and operations to support infection prevention and the quality of life of residents. Moreover, the legislation is over-broad in its scope, affecting pediatric and hospital-based facilities and continuing care retirement community (CCRC) nursing homes that have different cost and financing structures.

Recommendation: *Reject direct care ratios and executive salary limitations.*

c. Medication Technicians

To support the most effective deployment of available staff, the State should authorize the use of medication technicians in nursing homes. Specially trained certified nurse aides could provide routine medication passes in nursing homes, freeing nurses to provide other care while creating a career ladder

[13] Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care," November 2018. New York's $64 per day shortfall represents the largest shortfall of the 28 states the report analyzes.

for aides option. This approach is already in use in several states. In New York State, the Office for People with Developmental Disabilities is already doing this and has created a program that allows direct care aides to pass medication under the supervision of a nurse. A similar approach should be authorized in nursing homes.

Recommendation: *Enact legislation allowing nursing homes statewide to utilize medication technicians.*

d. E-Prescribing

The Executive Budget proposes to curtail the availability of e-prescribing waivers. Since the State implemented the requirement that physicians use electronic prescribing in 2017, certain health care settings have been granted waivers of the requirement. Recognizing that the requirement may impede access to prescription medications for nursing home residents, the Commissioner of Health has waived the provision in annual increments, most recently in November 2020, with an expiration date of Oct. 31, 2021. In granting the waiver, the Commissioner acknowledges that while many nursing homes have adopted electronic prescribing, the practice is not possible in some facilities due to exceptional circumstances. While the proposed budget legislation would maintain the Commissioner's authority to issue waivers for extraordinary circumstances, it is time to move away from annual waivers and align e-prescribing policies for nursing homes with those applicable to hospitals. This will help ensure that residents receive medications without interruption and conform the requirements with how physicians care for nursing home residents.

Recommendation: *Enact legislation to align the e-prescribing policy applicable to nursing homes with the policy applicable to hospitals.*

e. Benchmark Rates

The legislative requirement that Medicaid MLTC plans pay their network nursing homes Medicaid fee-for-service rates in the absence of a mutually agreed-upon alternative payment arrangement expired on Dec. 31, 2020. While the transition of most long-stay nursing home residents enrolled in MLTC plans back to fee-for-service Medicaid has significantly reduced the volume of nursing home days paid through MLTC, adequate rates should be maintained to ensure consumer choice. The requirement to use benchmark rates is permanent for out-of-network arrangements, and in-network arrangements should be treated consistently to avoid creating an intrinsic disincentive for network participation. Robust networks increase consumer choice and foster closer relationships between plans and providers that benefit enrollees and facilitate value-based payment arrangements.

Recommendation: *Pass legislation to extend nursing home benchmark rates.*

f. Quality Pool Expansion

The Executive Budget Briefing Book signals that DOH intends to expand the existing Nursing Home Quality Pool with an emphasis on rewarding quality based on provider staffing practices. We wholeheartedly support quality payments and ask that any expansion should represent new investment, not just a redistribution of already inadequate Medicaid reimbursement. Moreover, it is imperative that quality pool payments be based on accurate and complete measures and be calculated and paid in a timely way. They should be based on the numerous federal and state nursing home quality measures that are already being calculated and reported to allow homes to effectively focus their quality

improvement efforts and to avoid confusing consumers with competing measures. If new measures are to be based on staffing, they must be considered in a comprehensive way (e.g., inclusion of nurse practitioners) to ensure accuracy and appropriate incentives.

Recommendation: *Expand the quality pool by allocating new funding rather than redistributing existing reimbursement, ensure that staffing is considered comprehensively, and structure the measures so as to facilitate timely calculations.*

II. Managed Long Term Care

MLTC plans manage and pay for the LTC services provided to more than 270,000 older adults and people with disabilities eligible for Medicaid in New York. MLTC plans and Programs of All-Inclusive Care for the Elderly (PACE) sponsored by not-for-profit LTC providers have helped to strengthen the LTC system by providing care management and facilitating access to an array of community-based services for Medicaid beneficiaries, while bending the Medicaid cost curve. During the COVID-19 emergency, plans have stepped up their care management activities and telehealth and telephonic connections to beneficiaries to ensure that homebound seniors are receiving the home care services they need, as home care aides have struggled with illness and family demands.

These plans have been the target of significant Medicaid rate reductions during recent years. The State has already adopted a rate setting methodology that reduces MLTC rates to the lowest possible level, just short of violating requirements for actuarial soundness. In addition, plans are subject to additional withholds that, while possible to earn back, exacerbate cash flow challenges.

a. Quality Pool

The Executive Budget proposes to eliminate the MLTC Quality Pool, which has already been reduced by 25 percent in the 2020-21 State spending plan. This cut disproportionately affects high-quality plans and the high-quality providers that receive incentives through MLTC plans' quality pool distributions. As this pool is self-funded through MLTC rates, the cut is effectively a rate cut that further threatens the financial viability of the community-based LTC system, jeopardizes value-based payment models, and drives the elimination of health promotion programs for older adults.

Recommendation: *Restore the $103.5 million cut to the MLTC Quality Pool.*

b. Rate Changes

MLTC plans have endured deep cuts over the past three years while being required to maintain the same or greater levels of services and complying with ever-increasing administrative requirements. Plans are forced to pass many of these cuts to providers, which further destabilizes an already vulnerable LTC system. Several large Medicaid Redesign Team (MRT) II initiatives that may have an MLTC rate impact are still under development. At the same time, the Executive Budget assumes a $400 million retroactive rate reduction in 2020-21 rates to account for reduced utilization during the COVID-19 pandemic.

Recommendation: *Ensure that any prospective MLTC rate cuts are associated with programmatic changes that drive savings. Ensure that any retroactive reduction does not threaten actuarial soundness*

and is allocated fairly among plans and implemented incrementally to avoid cash flow shortfalls that will destabilize plans and the providers they reimburse.

c. Integrated Care

While the majority of individuals who are served through MLTC are members of partially capitated MLTC plans, which focus on Medicaid services, the State is implementing strategies to increase enrollment in managed care plans that cover both Medicare services and Medicaid LTC services. LeadingAge New York's members have been active participants in integrated managed care models, including Medicaid Advantage Plus (MAP) and PACE. These programs help to reduce the cost-shifting between Medicaid and Medicare that drives inefficiencies, clinical fragmentation, and sub-optimal outcomes.

However, the State's initiative to promote integrated care relies heavily on default enrollment from Mainstream Medicaid managed care organizations and threatens to drive enrollment from PACE and other provider-based integrated plans specializing in LTC that do not operate a mainstream Medicaid managed care plan. MLTC plans sponsored by non-profit LTC providers can play a key role in strengthening these initiatives given their unique expertise in the issues faced by older adults and the services they utilize. Through close personal contact with members and their caregivers and geographic proximity, these plans are able to make informed care management decisions and create strong linkages with health and social services providers in their members' communities.

At the same time, to promote integrated care, the State has indicated that it may scale back the partially capitated MLTC program, which accounts for 88 percent of current MLTC membership statewide. This would potentially shift those unable or unwilling to join a Medicare managed care plan from smaller plans focused on LTC to large mainstream Medicaid plans whose enrollment is primarily younger populations. Consumers who choose not to enroll in a Medicare managed care plan should not lose access to plans specializing in LTC.

As the State pursues integration, it should leverage the expertise of plans that specialize in providing LTC services so as not to leave the responsibility for these vulnerable populations to organizations that primarily serve younger and healthier populations.

Recommendation: *Support LTC provider-sponsored plan participation in integrated managed care programs. Ensure that partially capitated plans specializing in LTC remain an option for consumers who do not or cannot participate in integrated plans.*

d. Reimbursement of Enrollee Assessments

MLTC plans develop individualized care plans to meet each member's unique needs based on comprehensive assessments typically performed by plan nurses. As a result of the SFY 2020-21 budget, DOH is contracting out these assessments to Maximus. Most plans will nevertheless continue to conduct their own assessments to ensure that care plans are appropriate and will bear additional costs of coordinating the multi-step assessment process with Maximus and beneficiaries. It is unclear whether DOH will continue to include the costs associated with plan-based assessments in plan rates and whether other costs will be recognized.

Recommendation: *Ensure appropriate and transparent reimbursement for assessments. Rates must continue to reflect expenses associated with this function.*

III. Home and Community-Based Services

A majority of older adults want to age at home and in their communities. Home and community-based services (HCBS) providers, including CHHAs, licensed home care services agencies (LHCSAs), hospice, and other aging services providers, deliver critical services and supports that enable seniors and individuals with disabilities to live in the community.

HCBS providers play three significant roles in the services they provide. They play a primary role in the LTC sector by providing personal care and other services and supports, including assistance with activities of daily living, to those aging in place at home. They also play a significant role in delivering post-acute care following hospital and short-term rehabilitation that helps avoid higher levels of care and prevents hospital admissions, readmissions, and nursing home placement. Further, they provide services and supports to the elderly and disabled that are preventive in nature and address social determinants of health, such as ensuring a safe home, access to healthy food, care coordination, transportation to doctor's appointments, and social activities.

While much of the COVID-19 spotlight has been on LTC facilities, the pandemic has also had significant operational and financial impacts on HCBS providers. It has also highlighted how important these services are to those most vulnerable in our communities. HCBS providers have struggled from the beginning of the pandemic to access the PPE they need to protect patients and workers. Agencies continue to experience increased costs of PPE, hazard pay, staff testing, and sick pay with shrinking revenues. Home care agency patient census numbers and their associated revenue took a significant financial hit early in the pandemic as elective surgeries were halted and patients refused care in the home. Now, with many seeking HCBS instead of congregate care, agencies are faced with referrals they cannot staff. Home care and hospice agencies continue to have staffing difficulties, and the pandemic has made this challenge even more vexing due to lack of available hires, a halt in in-person aide training, difficulties onboarding new staff, and staff absences caused by illness, exposure, fear of infection, and lack of child care.

With these challenges in mind, and with the cost savings and efficiencies that HCBS providers provide, we urge the State to end the constant cutting of these critical cost-saving services and invest in and recognize the potential of this health care sector.

a. Medicaid Cuts, Elimination of Trend Factors

As noted above, the Governor's proposed budget continues the elimination of Medicaid trend factors for home care and hospice and would impose an additional across-the-board cut. Again, this is on top of unsustainable reimbursement rates for home care providers. Inadequate reimbursement for home care services results in a lack of access to home and community-based care. This not only affects the older adult waiting to be discharged from the hospital or nursing home and his or her family, but it also has a ripple effect across the LTC continuum, the broader health care system, and the community. Without adequate access to home care, hospital and nursing home beds remain occupied by individuals waiting for discharge and are unavailable to those who require admission. Individuals who are living in the community without needed home care may experience avoidable exacerbations of chronic conditions, functional decline, falls, and ultimately nursing home admissions. These outcomes add to the State's Medicaid spending and place a strain on the health system and our communities.

Recommendation: *Restore Medicaid cuts, including trend factors, for HCBS providers.*

b. HCBS Workforce Funding

As home care and hospice agencies continue to face workforce shortages, the Executive proposes cutting Worker Recruitment and Retention funds by another 50 percent on top of cuts made last year. Agencies are seeing increasing referrals of patients due to a preference to age in place, as highlighted by the pandemic, yet they lack the staff to serve those new patients. The home care sector values its workforce and seeks innovative ways to recruit and retain its staff. This funding is critical and allows providers to compete with other employers that are paying the State's minimum wage.

Recommendation: *Restore Worker Recruitment and Retention funding.*

c. Telehealth

LeadingAge New York commends the Executive for its proposed expansion of telehealth services. HCBS providers are ideal providers of telehealth services as part of the post-acute care team ensuring fewer hospitalizations and readmissions. A record number of agencies ramped up their telehealth services during COVID-19. Agencies deserve parity with other providers for reimbursement and insurance coverage of these services. Flexibility for telehealth-based remote patient monitoring, education, patient assessment, socialization, and more will help LTC providers as they face significant workforce shortages and serve those who are geographically remote.

Recommendation: *Support telehealth initiatives with proper reimbursement for providers.*

d. Expanded In-Home Services for the Elderly Program

LeadingAge New York supports additional funding beyond the current $65 million for the Expanded In-Home Services for the Elderly Program (EISEP), which funds non-medical, in-home services; case management; non-institutional respite care; and ancillary services for functionally impaired older adults. Area Agencies on Aging report that there continues to be 10,000+ individuals on the waiting lists for these and additional services. This program serves individuals who are not eligible for Medicaid and who pay on a sliding scale for services.

Recommendation: *Support increased funding for EISEP.*

IV. Adult Day Health Care

Medical model ADHC programs were instructed to temporarily close on March 17, 2020 and have not been permitted to reopen. Since then, ADHC registrants across the state have gone without personal care, therapies, and skilled nursing services – needed services that cannot be adequately provided through telehealth services. This has resulted in a spike in *preventable* hospitalizations, nursing home admissions, and overall decompensation of registrant health and hygiene. In addition, ADHC programs serve a large population of individuals diagnosed with severe and chronic mental illness, one of the populations most at risk for physical and mental health complications due to prolonged isolation.

ADHC registrants are reporting extreme loneliness and often call their program pleading to return. While the State has suggested that telehealth is a tool to assist during this pandemic, it is not a replacement

for human interaction for those who need it most. ADHC registrants require necessary nursing services and therapies, as well as companionship and purpose.
For registrants who have been fortunate to have help from family or caregivers during the last year, those family members and caregivers are returning to work and are unable to find alternative arrangements. In many parts of the state, there are simply not enough home health aides or private duty nurses to care for individuals in their homes. ADHC has been lauded as a solution to the chronic workforce shortage, but ongoing closures, especially in rural areas, have exacerbated the issue. ADHC must reopen to lessen the strain on home health and so that caregivers may return to work. Families deserve to know when their ADHC program will reopen.

A large percentage of ADHC staff have received their first or second dose of vaccine. Unfortunately, due to insufficient and inconsistent supply, ADHC registrants are getting vaccinated at very low rates. Approximately 8,000 New Yorkers attend ADHC programs. If open, ADHC registrants could get vaccinated at the sponsoring nursing home during their ADHC visit. This approach would be much easier for the registrant – they would not have to schedule an appointment in the community, wait in line for hours, and then go back three weeks later. It would also save the State money because Medicaid would not have to pay *twice* for an aide and transportation to the community vaccination site. If ADHC programs were allowed to reopen, thousands of New Yorkers could get vaccinated as soon as vaccine shipments arrived in nursing homes.

Finally, the Adult Day Health Care Council (ADHCC) wrote and submitted recommendations to DOH in May 2020 on how ADHC programs would prevent the spread of COVID-19 and safely care for ADHC registrants. The proposal to reopen programs was pragmatic and cautious, and it followed Centers for Disease Control and Prevention (CDC) and DOH policies such as infection control and social distancing. Even though the State agreed with the tenets of the proposal, there is still no timeline to reopen ADHC. Furthermore, there has been no communication from DOH to ADHC providers since March 17, 2020. **At least 12 programs have permanently closed since the pandemic started**. Without a reopening date, the State should expect many more to permanently close. The State will then see even more hospitalizations and nursing home placements as registrants of these programs decompensate.

Recommendation: *Reopen medical model ADHC programs. ADHC remains the only health care setting unable to provide in-person services.*

a. Medicaid Cuts to ADHC

The Governor's proposed budget eliminates positive Medicaid inflation trend factors for another two years. Again, this is compounded by stagnant reimbursement rates that have not changed for ADHC providers since 2009.

Recommendations: *Restore the 1 percent across-the-board reduction to Medicaid payments and reinstitute cost of living adjustments (COLAs) to ADHC rates.*

b. Telehealth

ADHCC commends the Executive for its proposed expansion of telehealth delivery of services. ADHC providers are ideal providers of telehealth services as part of the post-acute care team ensuring fewer hospitalizations and readmissions. Many ADHC providers developed telehealth programs during COVID-

19 and will continue to provide telehealth when in-person services resume. ADHC providers deserve parity with other providers for reimbursement and insurance coverage of these services.

Recommendation: *Support the expansion and adequate reimbursement of telehealth.*

V. Adult Care Facilities and the Assisted Living Program

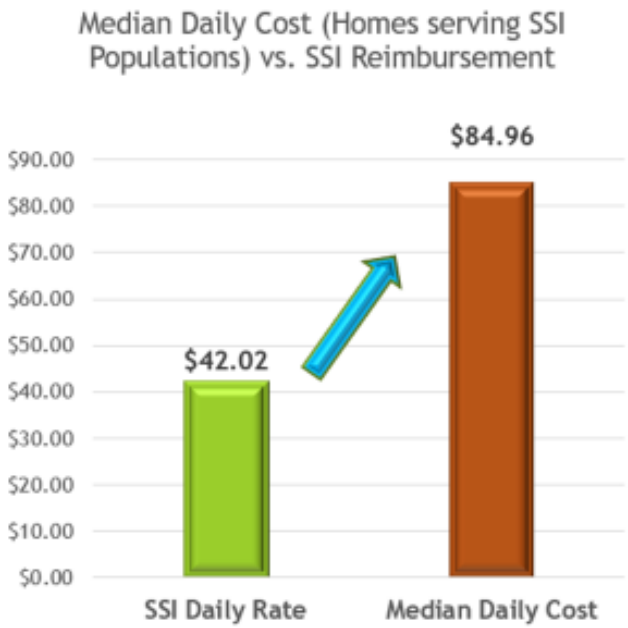
ACF/AL facilities provide residents with a comprehensive package of services, housing, and meals in a home-like setting. The model provides necessary supports such as personal care, case management, and assistance with medications, but also promotes independence and integration with the community. ACF/AL settings make efficient use of a scarce workforce – a true asset in communities where the workforce cannot support 24-hour in-home care for seniors with functional limitations.

As discussed above, ACF/AL settings have been hit hard by COVID-19 with enormous unbudgeted and largely unreimbursed costs related, including PPE, weekly staff COVID testing, increased staffing costs, intensive cleaning and sanitizing, and education. The Federal Emergency Management Agency (FEMA) Public Assistance program does not recognize most ACFs as meeting the eligibility criteria for funding. ACF/AL settings are also experiencing a reduction in revenue due to decreased census, as well as the provision of private rooms and cohorting for infection control purposes.

Yet, the Executive Budget proposes cuts in both Medicaid for ALPs and other funding for ACF/AL facilities that serve low-income seniors. It is unclear whether the Governor's proposed restoration of cuts, predicated on receipt of federal relief, would cover critical *non*-Medicaid funding that ACFs rely on each year – including funding that was secured in last year's budget but never released. Nonetheless, the restoration of such cuts is wholly insufficient to meet the growing needs of ACFs. These providers need additional financial relief to get through this pandemic and be a viable option in the future.

The State's ongoing lack of support for ACF/AL facilities that serve low-income seniors is causing a major reduction in access to services in the least restrictive setting. ACFs are closing at an alarming rate – **30 have closed voluntarily since 2017**, and there will be more in the months to come. When low-income seniors cannot access AL, they go to nursing homes, on Medicaid, at a greater cost to the State. This lack of planning and investment creates an endless loop of driving up Medicaid costs, which triggers Medicaid cuts, which make it increasingly challenging to provide high-quality care and recruit and retain skilled, compassionate staff, which leads to additional facility closures.

ACFs That Serve SSI Recipients



Unfortunately, ACF/AL facilities that rely on public funds are struggling to survive. The Congregate Care Level 3 SSI rate of **$42.02** per day falls far short of what it costs to provide the services that ACFs are, by regulation, required to provide. As the chart to the right shows, the median daily cost of providing care in ACFs is over twice the level of reimbursement – before the pandemic. The resulting consistent financial losses are unsustainable. The last increase to the State supplement was implemented in 2007; before that, it was 17 years.

a. EQUAL

The Enhancing the Quality of Adult Living (EQUAL) program supports quality of life initiatives for residents of ACFs that serve SSI recipients. Last year, EQUAL funding was bifurcated into two programs funded at $3.26 million each, for capital and programmatic funding. **That funding was never distributed to providers.** The Executive Budget eliminates EQUAL funding for SFY 2021-22. Given the inadequacy of the SSI rate, ACFs that serve SSI recipients do not have extra resources to dedicate to the types of initiatives that EQUAL funding supports. Residents of ACFs have come to expect and depend upon this funding to support projects they have deemed as critical.

Recommendation: *Restore the $3.26 million for EQUAL programmatic funding and $3.26 million for EQUAL capital program funding, and ensure that funding for the current fiscal year is reappropriated and distributed expeditiously.*

b. Enriched Housing Subsidy

The Enriched Housing Subsidy has historically paid $115 per month per SSI recipient to operators of not-for-profit certified enriched housing programs and was funded at $380,000 last year. Given the inadequacy of the SSI rate, enriched housing providers rely on this funding to survive. In fact, they budgeted for this funding in the current fiscal year, and yet none has been paid out to date, putting some of these programs in a financial crisis. The Executive Budget eliminates the program for the next fiscal year.

Recommendation: *Restore the Enriched Housing Subsidy at $380,000 and ensure that funding for the current fiscal year is also reappropriated and distributed expeditiously.*

c. SSI

ACFs that serve SSI beneficiaries cannot survive on $42.02 per day and are closing. Because their residents are Medicaid-eligible and cannot live in independent housing, most will go to nursing homes at

a greater cost to the State. One rural county has had three recent ACF closures related to the inadequacy of the SSI rate. As a result of just one of those closures, approximately one-third of the residents had to be placed in a nursing home, where the State is now paying several times more *in Medicaid dollars for these former ACF residents*. Clearly, this makes no financial sense and is contrary to State and federal policy to support individuals in the most integrated setting appropriate to their needs. LeadingAge New York estimates that for every 45 low-income ACF residents who can continue living in their ACF or are diverted from nursing home placement, **the State saves $1 million in Medicaid spending.**

Recommendation: *Help ACFs that serve low-income seniors in the most integrated setting possible by supporting an increase of at least $20 per day in the State supplement to the Congregate Care Level 3 SSI rate, and include an annual COLA thereafter.*

d. Assisted Living Program

The ALP is the only Medicaid AL option in New York, serving seniors who require a nursing home level of care but do not need ongoing skilled services. The ALP Medicaid reimbursement is approximately half of the nursing home rate. The ALP rate has not had a standard trend factor increase since *2007* and was cut by 1 percent on Jan. 1, 2020, and then again by .5 percent on April 2, 2020. While other states have *increased* provider rates during the pandemic, the Executive Budget proposal would again cut the ALP rate by 1 percent. The ALP cannot sustain further cuts – rather, the rate should be updated to a more recent base year to reflect current costs. If ALP residents are displaced due to closures, they will go to a nursing home at twice the Medicaid cost.

Recommendation: *Restore the 1 percent ALP Medicaid rate cut and reinstitute a trend factor to recognize rising costs.*

e. Capital Transformation Grants

ACFs and ALPs were made newly eligible for Statewide Health Care Facility Transformation Program funds in the SFY 2020-21 budget, but applications have yet to be issued for Phase III, and awards have not been made for the ALP expansion initiative in Phase II. This funding can generate savings for the State by supporting the delivery of care in the most integrated setting appropriate, at a lower cost than a nursing home.

Recommendation: *Ensure that applications for Statewide Health Care Facility Transformation Program funds are issued expeditiously, with LTC providers, including previously ineligible entities such as ACFs and ALPs, prioritized for funding. The State should award the ALP expansion Request for Applications (RFA), which was to be awarded over a year ago, immediately.*

f. Allow Nurses to Provide Nursing in ACFs

The pandemic has highlighted the importance of our health care workforce, and nurses play a critical role in LTC and aging services. Nurses work in ACF/AL settings across the state, and they have been invaluable during this pandemic in guiding infection control and education efforts, but most are not permitted to provide nursing services directly due to restrictions on the duties nurses can perform in these settings. The Enhanced Assisted Living Residence (EALR) is the only ACF/AL setting that permits these professionals to provide nursing services. Particularly during a pandemic, we should be utilizing

nurses in ACFs to provide periodic services, including immunizations, that would result in better health outcomes, prevent hospitalizations, support end-of-life care, and save Medicaid dollars.

Recommendation: *Pass legislation [S.1593 (Rivera)] that would permit nurses working in ACFs to practice nursing services. This is a no-cost reform to maximize resources and achieve savings.*

VI. Affordable Independent Senior Housing Assistance Program

LeadingAge New York was delighted with the State's historic commitment of $125 million in capital appropriations for the construction and rehabilitation of affordable senior housing over the course of five years and is grateful to the Legislature for the role it played in securing this funding. That investment should be paired with an appropriation of $10 million over five years to provide resident assistant services in affordable senior housing. This model generates Medicaid and Medicare savings by providing low-income seniors with "light-touch" services that help them to prolong their independence and improve their quality of life. Rigorous studies have shown that affordable senior housing with supportive services reduces Medicare and Medicaid spending.[14]

Providing low-income seniors with access to affordable housing with support services can have a significant impact on their ability to live independently in the community and may delay or prevent them from entering more costly levels of care, creating significant savings for the State's Medicaid program. Furthermore, a housing with services model would be an extremely cost-effective tool for promoting health equity amongst one of New York's most vulnerable populations.

LeadingAge New York, along with a coalition of senior housing providers and associations, has called for the creation of the Affordable Independent Senior Housing Assistance Program, to be administered by DOH, and the appropriation of $10 million over five years to fund resident assistants in 41 senior housing properties around the state. We propose that grants of approximately $45,000 per property be made available to congregate senior housing operators to work with seniors and that those assistants specifically focus on linking residents to the services they need to remain healthy in their communities. If each resident assistant works with approximately 150 individuals, 6,150 low-income seniors would be served by this program. Based on the national average for Medicaid-eligible individuals living in Department of Housing and Urban Development (HUD)-assisted housing, 3,813 of the 6,150 seniors served would be Medicaid-eligible. If a resident assistant can keep two people out of a nursing home for one year, the savings covers the cost of the grant. If an assistant works with approximately 93 Medicaid-eligible individuals, emphasizing health education, wellness programming, more effective use of primary care, reduced use of emergency departments, and better management of chronic health conditions, the savings potential is enormous.

Evidence of these savings has been demonstrated in recent studies conducted in Oregon and New York. In 2016, the Center for Outcomes, Research & Education issued a report on a study conducted in Oregon that showed a decline in Medicaid costs of 16 percent one year after seniors moved into affordable

[14] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* October 2018. 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. *Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.

housing with resident assistants.[15] Their analysis included 1,625 individuals, 431 of whom lived in properties that serve older adults and individuals with disabilities.

Additionally, a three-year research study that was recently conducted by Dr. Michael Gusmano of Rutgers University focused on the health care savings and utilization of Selfhelp Community Services residents living in Queens compared to older adults from the same zip codes based on New York State Medicaid claims data. Selfhelp provides affordable housing complemented by an array of services. Among the key findings in this study is that the average Medicaid payment per person, per hospitalization for Selfhelp residents was $1,778 versus $5,715 for the comparison group. Additionally, the odds of Selfhelp residents being hospitalized were approximately 68 percent lower than for the comparison group, and the odds of visiting the emergency room were 53 percent lower than for the comparison. These findings have vast implications for health care savings if more affordable housing for seniors can be developed in conjunction with a successful resident assistant model.

Recommendation: *A $10 million, five-year strategic investment to bolster the $125 million in senior housing capital funding is a cost-effective strategy to optimize the independence, health, and quality of life for New York's growing senior population, while reducing Medicaid spending. Moreover, the Affordable Independent Senior Housing Assistance Program aligns directly with the goal of Homes and Community Renewal's (HCR) Senior Housing Plan to develop rental housing that has healthy aging programming that affords seniors the option to age in their own homes and communities.*

CONCLUSION

LeadingAge New York's not-for-profit members are committed to providing high-quality care to their patients and residents. They are also committed to direct care workers, who are the heroes in their organizations. They are struggling to meet the extraordinary demands of protecting residents from COVID, while providing high-quality care, in the context of a shrinking workforce and shrinking government support.

Looking to the future, we can expect that a significant portion of seniors will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs. Medicaid currently pays for nearly three-quarters of nursing home days and 87 percent of home care services in New York State. These percentages are not likely to shrink as the later Baby Boomers age and retire without the substantial savings and generous pensions that their predecessors enjoyed. State and federal policymakers, along with stakeholders, need to intensify efforts to develop alternative strategies to fund LTC services. We must be willing to innovate and invest now to create more efficient models, slow the growth in spending, build capacity, and secure resources for the future.

Our members cannot continue to carry out their mission without adequate reimbursement. As this testimony illustrates, New York must act now to ensure that LTC providers have the tools they need to see the people they serve through this pandemic and beyond.

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-

[15] Li, G., Vartanian, K., Weller, M., & Wright, B. (2016). *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education.

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 plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.