2023-24 Health/Medicaid Testimony

Provided by

James W. Clyne Jr.
President/CEO
LeadingAge New York

Feb. 28, 2023

INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the aspects of the State Fiscal Year (SFY) 2023-24 Executive Budget impacting long-term and post-acute care (LTC) providers,[1] aging services, 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 and Programs of All-Inclusive Care for the Elderly (PACE). This testimony addresses the Executive Budget proposals that apply across the continuum of LTC, aging, and MLTC/PACE services, as well as those that would affect specific types of providers and managed care plans.

New York's population is aging rapidly – between 2015 and 2040, the number of adults over 85 will double.[2] This growth will drive a corresponding increase in the number of New Yorkers who need LTC services. Approximately 70 percent of adults who live beyond age 65 will need LTC at some point in their lifetime.[3] Alarmingly, while the percentage of our population over age 65 is growing, the percentage of working-age adults to care for them is shrinking.

New Yorkers rely overwhelmingly on Medicaid to cover their LTC needs. Medicaid pays for over 70 percent of nursing home days and over 80 percent of home care services in New York. Yet, New York's Medicaid reimbursement for LTC has failed miserably to keep pace with rising costs. Rates paid to nursing homes, assisted living programs (ALPs), and adult day health care (ADHC), for example, have not been increased for inflation in **15 years** – a period in which costs have risen by more than **40 percent** due to inflation alone.

When Medicaid rates fail to cover costs and do not allow LTC providers to pay competitive wages for their staff, the entire system constricts and withers. This is happening today, and its ripple effects are being felt by consumers and providers across the health care delivery system.

New Yorkers rely overwhelmingly on Medicaid to cover their LTC needs. Medicaid pays for over 70 percent of nursing home days and over 80 percent of home care services in New York.

Inadequate rates, a highly competitive labor market, and mandatory staffing ratios are forcing nursing homes to close beds and units, if not close their facilities entirely. Home care agencies are likewise turning away patients in need of care due to lack of available staff. Vulnerable hospital patients who are waiting for discharge are experiencing prolonged hospital stays because they cannot find appropriate post-discharge care. This leads to shortages of available hospital beds, which in turn results in overcrowded emergency departments and ambulances backed up in hospital parking lots. Access to care is limited and emergency services response time is delayed for everyone in the community. While hospital patients wait for a nursing home

[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] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/; accessed Jan. 4, 2019.

[3] Johnson, R.W. "What is the Lifetime Risk of Needing Long-Term Services and Supports?" ASPE Research Brief. Apr. 2019.

bed and acutely ill patients wait in overcrowded emergency rooms, the State has failed to distribute the funds appropriated over the past two fiscal years to help nursing homes to staff their beds – $187 million in 2022-23 and $128 million in 2021-22 (all funds).

This year, the Governor proposes a 5 percent Medicaid increase for nursing homes, ALPs, and ADHC. While it is a step in the right direction, it is far from adequate given rising costs. A Medicaid rate increase of *20 percent* is needed for these providers to stabilize and continue to provide care to vulnerable New Yorkers. Other states have raised Medicaid rates during the pandemic (when New York cut rates) and have found the funds for ongoing Medicaid LTC reimbursement that approaches costs. New York can do better.

Rates paid to nursing homes, ALPs, and ADHCs have not been increased for inflation in 15 years – a period in which costs have risen by more than 40 percent due to inflation alone.

Today, New Yorkers in need of LTC face limited options in terms of setting, services, and provider, and those choices are shrinking rapidly. We urge you to join us in creating an LTC system that provides older adults at all income levels and in all regions with choice and an array of high-quality services and settings, aligned with their acuity levels, needs, and lifestyle preferences. Our testimony elaborates on the challenges facing LTC providers reaching this goal, LTC funding needs, and policy recommendations to revitalize New York's LTC system.

The testimony is organized in four parts, as follows:

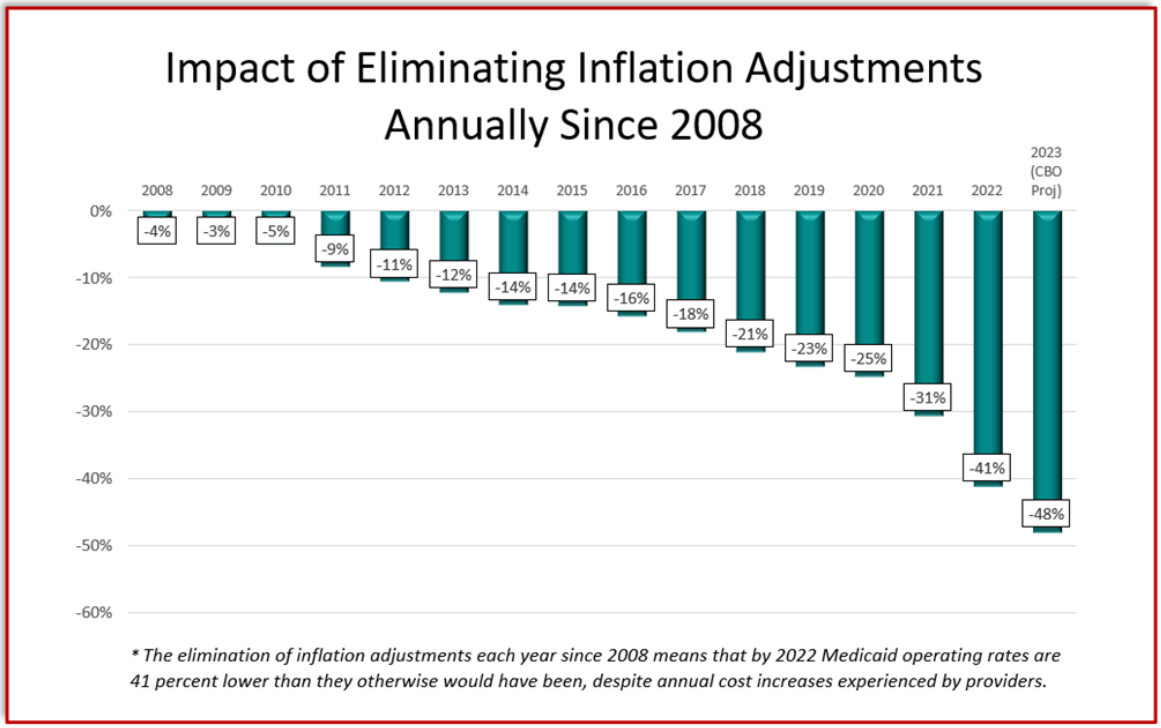
I. Financial Condition of New York's LTC Providers
II. The LTC Workforce Crisis
III. General Recommendations
IV. Service- and Setting-Specific Recommendations
    a. Nursing Homes
    b. Assisted Living Facilities
    c. Home and Community-Based Services
    d. Senior Housing

I. FINANCIAL CONDITION OF NEW YORK'S LTC PROVIDERS

a. Historic Underfunding Exacerbated by the Pandemic

As the primary payer for LTC services in New York and nationwide, Medicaid bears significant responsibility for access to high-quality LTC services, the financial viability of the LTC sector, and its capacity to compensate staff appropriately for the difficult and essential services they deliver. Despite the rapidly growing population of older adults in New York State and a workforce crisis that has been looming for years, New York's principal focus for LTC policy for the past several years has been to reduce Medicaid spending on these services. Most LTC provider rates have not even been adjusted for inflation since 2008.

Today, the gap between Medicaid rates and costs, exacerbated by the pandemic, has brought the State's LTC providers to a precipice. Costs are skyrocketing for staffing, food, supplies, and energy, while unreimbursed COVID-related expenses continue to accrue. Providers have spent millions on hazard pay, overtime, bonuses, and extortionate staffing agency fees to recruit and retain workers. COVID expenses, including additional personal protective equipment (PPE) and 60-day PPE stockpiles, warehouse space for stockpiles, COVID sick pay, and new COVID-related testing, reporting, and recordkeeping requirements, were not contemplated when nursing home Medicaid rates were last updated in 2007.



Source: US Bureau of Labor Statsitics, CPI for All Urban Consumers (CPI-U)

b. Comparison with Other States: New York State Nursing Home Rates Among Worst in Nation

Over the course of the pandemic, most states raised Medicaid rates for LTC, whereas New York cut rates across –the board in 2020.[4] It finally restored the cut and increased rates by only 1.5 percent in SFY 2022-23. According to national studies, New York continues to have among the largest shortfalls in the nation between the cost of care and its Medicaid nursing home rates.[5] The federal Medicaid and CHIP Payment and Access Commission (MACPAC) concluded that the

[4] Musameci, M, State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19. Kaiser Family Fdn, Aug. 2020, available at https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/; see also 2021 update available at https://files.kff.org/attachment/Tables-States-Respond-to-COVID-19-Challenges.pdf

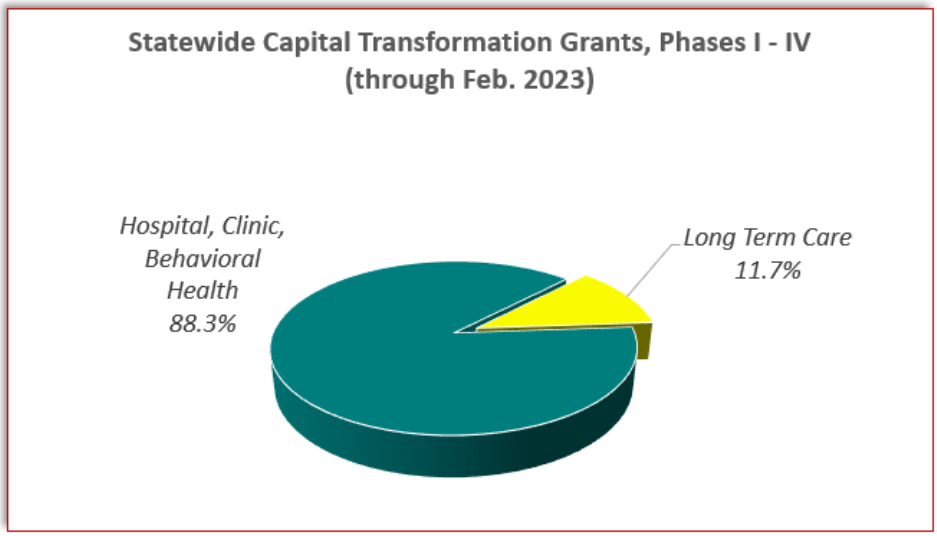
[5] "Estimates of Medicaid Nursing Facility Payments Relative to Costs." Medicaid and CHIP Payment and Access Commission. Jan. 2023, available at https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/. See also Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care – 2018 Update."

shortfall between New York's 2019 nursing home Medicaid rates and costs was among the largest in the country. **Based on MACPAC's analysis, New York's Medicaid rates covered only 76 percent of Medicaid costs,** resulting in an average shortfall of $74 per resident day. That gap has only grown since 2019 due to inflation, COVID costs, and staffing costs.

The five states that competed with New York for the largest shortfall in 2019, according to MACPAC, have all increased rates materially since then. These include Nebraska (15 percent increase); South Dakota (20.3 percent one-year increase with 6 percent continuing); Florida (7.8 percent increase); New Jersey (10 percent increase); and Wisconsin (12 percent increase and a commitment to increase rates to cover 91 percent of costs starting in 2023, up from 77 percent in 2022). Although not in the bottom five due to sizeable supplemental payments it provides to nursing homes, Pennsylvania also increased rates by 17 percent.

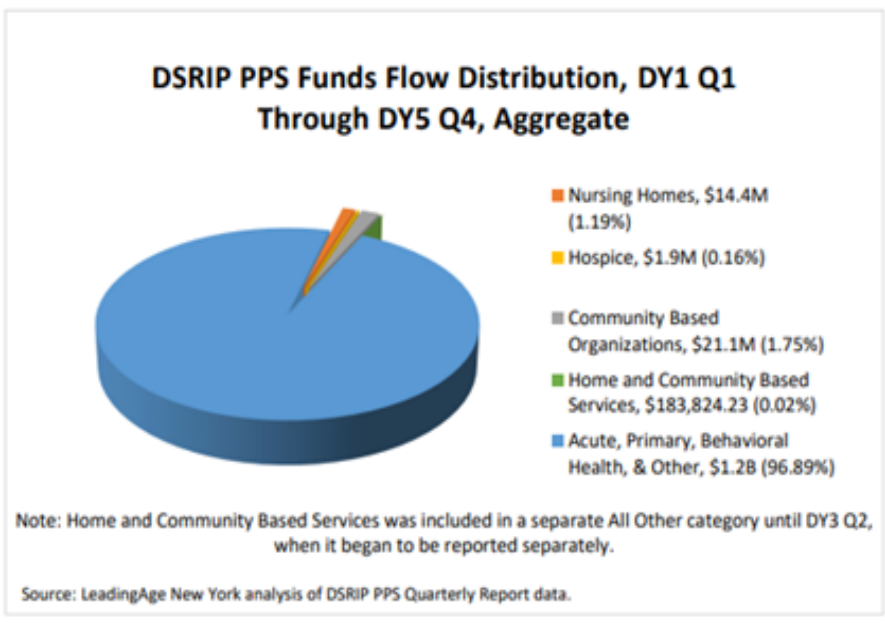
c. Lack of Investment Through Capital Grants and Waiver Funding

LTC providers have not only been denied adequate Medicaid rates – they have also been denied a fair share of capital investments and waiver funds. Only 11.7 percent of Statewide Health Care Facility Transformation Program (SHCFTP) funds have been allocated to LTC providers. Our LTC system today offers consumers a shrinking array of choices, with nursing home services predominantly in outdated, institutional facilities, rather than innovative, homelike environments, and limited access to telehealth or advanced technology solutions across the LTC continuum.



Source: LeadingAge NY review of DOH awardee lists

Similarly, even though New York's LTC providers sought to make meaningful contributions to the Medicaid Redesign Team (MRT) Waiver's Delivery System Reform Incentive Payment (DSRIP) program, only about 2 percent of DSRIP funds went to this sector (see chart below). The State's plan for a new 1115 Waiver outlined in the recent concept paper threatens similar paltry results, as LTC is barely mentioned in that plan.



d. Widespread Financial Distress

Years of operating with inadequate rates and little new investment has depleted our LTC providers. The financial position of many providers, especially not-for-profit providers, was shaky before COVID, and the situation is now dire. Costs have skyrocketed, and revenues have plummeted.

Over 40 percent of all nursing homes in the state were facing operating losses before the pandemic, a figure that increased to 55 percent in 2020. The State's not-for-profit and public homes are struggling even more, with 72 percent reporting operating losses in 2020. A recent LeadingAge New York/Greater New York Hospital Association joint financial survey of members found that the median operating loss for not-for-profit and public homes in 2022 was -18.6 percent, down from a median of -3.8 in 2019. During 2020 and 2021, even when COVID relief and other one-time-revenue was factored in, median operating margins were at -10 percent each year. Even more troubling, the majority of respondents projected increasing costs along with decreasing revenue for 2023, and 74 percent reported having delayed or cancelled a capital project due to financial concerns. Nearly all (99 percent) of survey participants highlighted inadequate Medicaid rates as contributing to their financial stress. **More than 75 public and not-for-profit homes have closed or been sold to for-profit operators since 2014,** a trend that is likely to accelerate if Medicaid underfunding is not addressed.

The condition of home care providers is also depleted. According to a report by the Home Care Association of New York State, 61 percent of all home care agencies are estimated to have had a negative operating margin in 2021, including an estimated 75 percent of certified home health agencies (CHHAs) and 50 percent of licensed home care services agencies (LHCSAs).

Like nursing homes, adult care facilities (ACFs) that serve Medicaid beneficiaries have also been struggling to survive with inadequate public funding. Their Supplemental Security Income (SSI) Congregate Care Level 3 rate of **$44.94 per day** covers less than half of the cost of State-mandated services. Every year, ACFs that serve low-income seniors close. Since 2017, 48 ACFs have closed voluntarily, and others are in the process.

e. Loss of Providers and Services for Medicaid Beneficiaries

Rising costs and stagnant, inadequate rates have placed LTC providers in an unsustainable financial position, even with a 5 percent Medicaid rate adjustment. As discussed in more detail in the workforce section below, nursing homes are bankrupting themselves in order to comply with the State's staffing mandates. While we appreciate the investments proposed in the Executive Budget, more must be done to enable LTC providers to cover the costs of delivering high-quality care during a pandemic.

The inadequacy of the State's Medicaid rates is forcing providers that want to deliver high-quality care to leave the market. Since 2014, approximately **25 nursing homes have consolidated or closed, and approximately 50 public and not-for-profit nursing homes have been sold to for-profit entities**. During the pandemic, this trend has accelerated, with eight closures, several not-for-profit homes sold or in sale negotiations, and additional quality providers planning to substantially reduce their available beds. We fully expect these numbers to grow.

II. LTC WORKFORCE CRISIS

Demographics, funding, labor market dynamics, and the effects of COVID have combined to create an unprecedented workforce crisis in the field. LTC and aging services providers and the people they serve have been disproportionately affected by the pandemic. The personal toll has been even greater than the financial – our mission-driven, not-for-profit providers are exhausted and demoralized. Repeatedly, they are faced with seemingly impossible tasks and regulatory requirements, and this is driving people out of the field. We are seeing unprecedented turnover at every level. The State needs to shift its focus to find ways to attract and incentivize people to join in this important work.

Our members are doing everything in their power to recruit and retain staff. They are raising wages, paying signing and retention bonuses, offering shift differentials and shift completion incentives, providing funding for college courses and advanced training, creating high school apprenticeship programs, and even opening on-site day care centers. Yet, all report that they are unable to fill open direct care positions. They cannot compete with other employers that have the luxury of raising prices to reflect labor market dynamics. They are forced to retain staffing agencies, at exorbitant rates, to fill empty shifts and ensure that residents and patients receive the care they need. Their extraordinary efforts to maintain high-quality staffing at appropriate levels, with inadequate reimbursement, are bankrupting them.

These efforts are reflected in national data. According to the federal Bureau of Labor Statistics (BLS), New York State has the highest hourly mean wage for "nursing assistants" (the occupational classification that includes nurse aides) among the states with the "highest employment level" of nursing assistants.[6] Further, according to the Centers for Medicare and Medicaid Services (CMS), New York's nursing home workforce turnover rate is approximately 6 percent lower (i.e., better) than the national average.[7]

a. COVID Impacts and End of COVID Workforce Waivers

While workforce shortages are growing, COVID has necessitated additional staff and caused higher absenteeism. 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 and visitor screening and testing, vaccinations, and furloughs; and monitoring, analyzing, and complying with federal, State, and local guidance that is continually evolving. Moreover, staffing shortages are further exacerbated by the termination of COVID staffing waivers that allowed nurse aide trainees to work for longer periods without certification and that suspended periodic in-service training requirements.

b. Impacts of Recently Enacted State Nursing Home Policies

Recently enacted State policies are contributing to the staffing challenges and financial decline in nursing homes. In the context of our health care workforce emergency, the minimum nurse and aide hours requirements are infeasible for the vast majority of nursing homes – nearly 75 percent of all New York State nursing homes fall short of at least one of the three minimum hours requirements (registered nurse (RN), licensed practical nurse (LPN), and aide), according to the most recent publicly available Payroll-Based Journal (PBJ) data from CMS (second quarter of 2022). Some of those "non-compliant" homes serve higher-acuity residents and actually exceed staffing levels for RNs, but are below required levels for certified nurse aides (CNAs). Other "non-compliant" homes serve a large percentage of residents with cognitive deficits who need less nursing care, but more activities and supervision. Unfortunately, the law does not take into account the needs of higher-acuity residents and does not count activities or therapy staff in measuring staffing levels.

These homes are threatened with steep penalties (up to $2,000 daily) if they fail to meet all three staffing requirements. If forced to pay these penalties, they will have even less funding to recruit and retain staff. Beginning in June, nursing homes will also face harsh penalties for

[6] See U.S. Bureau of Labor Statistics, Occupational Employment and Wages, May 20202021 31-1131 Nursing Assistants, available at https://www.bls.gov/oes/current/oes311131.htm#st.
[7] See CMS, Payroll Based Journal Daily Nurse Staffing, available at https://data.cms.gov/quality-of-care/payroll-basedjournal-daily-nurse-staffing/data.

mandating nurse overtime, under legislation enacted this year. It seems that, no matter what they do, nursing homes face heavy fines.

Without candidates for open nurse and aide positions, nursing homes are doing what they can to comply with the staffing mandate – serving fewer residents is often their only option. In order to improve their staffing compliance posture, many nursing homes are closing beds and units, even if they have sufficient staff to meet their residents' needs. They are forced to turn away individuals seeking care and maintain waitlists for beds. Statewide, there are approximately **6,000 more empty nursing home beds** today than there were in 2019. This is contributing to the hospital backups discussed above and forcing many older adults to seek care in facilities far from loved ones. The reduced occupancy not only limits access to care, but also weakens the financial viability of nursing homes – with empty beds and units, they have even less revenue to cover fixed costs and achieve economies of scale.

The Way Forward

Battered by mounting, unreimbursed costs and workforce shortages, our LTC system is facing a future in which choice of setting and provider is severely limited and high-quality care is accessible only to the affluent. New York must take bold action now to revitalize its LTC system. In the short run, a significant infusion of Medicaid dollars is needed, along with aggressive efforts on multiple fronts, to expand the workforce through modest changes in scope of practice, as well as new training opportunities and supports for LTC staff. In the longer term, the State's Master Plan for Aging provides an opportunity to consider the entire continuum of aging services, and the integral role of these services in the health care delivery system, as highlighted by the pandemic. The work of the Master Plan for Aging, the Task Force on LTC established in legislation, and the 1115 Medicaid Waiver development should all be connected. LTC and aging services should be a priority in all discussions of health and human services, not an afterthought. LeadingAge New York is eager to be a part of these discussions.

With this as context, we offer the following recommendations for the Legislature to consider for the 2023-24 State Budget.

III. GENERAL RECOMMENDATIONS TO STRENGTHEN THE LTC SYSTEM

a. Capital Transformation and Distressed Provider Funds

- ***Dedicate financially distressed provider funding to LTC, and ensure quick access for those facing financial crisis.***

Vulnerable nursing home residents and their families should not have their lives disrupted because their high-quality provider of LTC must close due to inadequate funding. Yet, an increasing number of New Yorkers are facing this prospect, as their nursing homes struggle to survive with increasingly inadequate reimbursement. We are seeing an acceleration of closures and sales of not-for-profit homes, some of which might have been saved with temporary, but

immediate, financial assistance. It is imperative that the State assist high-quality providers in surviving the persistent financial turbulence of the pandemic with rapid and equitable distribution of distressed facility funding.

Last year's State Budget included residential health care facilities among the recipients of Vital Access Provider Assurance Program (VAPAP) funding and earmarked an amount specifically for nursing homes. We appreciate that the Department of Health (DOH) implemented an application process quickly, but are concerned about the pace and transparency of the awards process. While some applicants have been notified of awards, many are uncertain as to the fate of their application or the timing of announcements – a difficult position for a provider facing financial crisis.

Consistent with the SFY 2022-23 Enacted State Budget Medicaid Scorecard, nursing home VAPAP funding for SFY 2022-23 and SFY 2023-24 should be made available promptly, applicants should be apprised of the status of their application as soon as possible, and a similar portion of VAPAP funding should be reserved for nursing homes on an ongoing basis. In addition, the funding accumulated in the Distressed Provider Assistance Account for grants to safety net hospitals and nursing homes, as well as Vital Access Provider (VAP) funding, should be awarded rapidly and equitably by eligible provider type to ensure that LTC is appropriately reflected.

- ***Enact the Executive's health care capital proposal, with assurance of appropriate allocation to LTC and deadlines for distribution.***

We support the Executive's proposal for a $1 billion SHCFTP V and are pleased that desperately needed capital dollars will be made available. The legislation should earmark a proportional amount of the overall capital allocation to LTC, which has been marginalized in previous funding initiatives and is again shortchanged in the most recent Transformation Grant award announced earlier this month, with LTC projects representing only 13 percent of the funding. Specifically, a percentage of Round V funding should be dedicated, by statute, as follows:

- Technology/Telehealth capital pool: a minimum of 25 percent for LTC, including nursing homes, ADHCs, ACFs, home care, hospice, and PACE programs;
- Other capital pool: a minimum of 30 percent for nursing homes, ADHCs, ACFs, PACE programs, home care, and hospice.

To prevent long delays, deadlines must be imposed for awards of grants, which should be made on a prompt and predictable schedule to help facilitate planning.

b. Workforce

- ***Authorize medication aides in nursing homes.***

LeadingAge New York wholeheartedly supports the Governor's proposal to authorize specially trained CNAs to work as medication aides in nursing homes, administering routine medications

to residents under the supervision of an RN. This proposal would help to address the nursing shortage in nursing homes, while providing new opportunities for CNAs and preserving quality and safety. Approximately 25 states already authorize medication aides to perform these tasks in nursing homes. Likewise, in New York State, the Office for People with Developmental Disabilities (OPWDD) already allows unlicensed direct care staff to administer medications.

The proposal would provide several benefits to nursing home residents and the people who care for them. It would allow RNs and LPNs to focus on higher-level tasks that make their jobs more rewarding and enable them to devote added attention to residents with more complex clinical needs. It would also provide another step on the career ladder for CNAs, providing them with additional training and compensation and a path to explore the possibility of a nursing degree. Unlike many workforce development proposals that require years to provide a measurable impact, this initiative could be implemented and begin to make a difference relatively quickly.

A 2011 review of the academic literature by the National Council of State Boards of Nursing concluded that "medication aides are capable of safely administering oral, topical, and some parenteral medications; that is, no evidence suggests that medication aides have higher error rates than licensed nurses." Studies also show that the use of medication aides improves job satisfaction among nurses and medication aides.[8] Given the severe nursing shortages we are experiencing across the state, we cannot afford to forgo this win-win strategy.

- ***Modify the Nurses Across New York proposal to specifically identify LTC as an underserved population.***

This student loan repayment program, enacted last year, provides financial incentives for nurses to work in underserved areas and with underserved populations in New York. Although the Nurses Across New York advisory group met several times, we are unaware of any awards under this program. Going forward, we urge the Legislature to modify the legislation supporting this program to explicitly identify LTC as an underserved population and prioritize the benefit to those who work in these settings and services. Due to heavy reliance on Medicaid and inadequate reimbursement, LTC providers face greater challenges in recruiting and retaining nurses than most primary and acute care settings.

- ***Support the Interstate Nurse and Physician Licensure Compacts, career ladder, and regulatory flexibility.***

We support the Governor's proposed investments in our health care workforce and proposed reforms that support career ladders for certified personnel and regulatory flexibility for professionals. In particular, we support the proposal to join the Interstate Nurse and Physician Licensure Compacts. We also appreciate proposals to make permanent some of the flexibilities

[8] Walker, M. "Effects of the Medication Nursing Assistant Role on Nurse Job Satisfaction and Stress in Long-Term Care," *Nursing Administration Quarterly*, Oct. 2008. Report on New Mexico Trial Program for Medication Aides in Licensed Nursing Facilities, Oct. 2004.

utilized during the pandemic, including flexibility with ordering and specimen collection of COVID tests and administration of vaccines.

c. Reducing Low-Value Administrative Requirements

- ***Reduce unnecessary and duplicative reporting, surveys, audits, and other requirements.***

The pandemic has led to the imposition of an overwhelming array of new administrative requirements without any recognition of the additional personnel they require, their impact on residents and patients, and the costs they impose. Nursing homes and ACFs, in particular, are staggering under the stresses of a mind-boggling assortment of growing and ever-changing administrative requirements, in the midst of a staffing crisis.

For nursing homes, the daily and weekly Health Emergency Response Data System (HERDS) surveys; weekly National Healthcare Safety Network (NHSN) surveys; oversight, recordkeeping, and reporting of staff and visitor COVID testing; offering, administering, and documenting staff and resident COVID vaccinations; and numerous mandated postings and notices of various laws, ratings, and contractual relationships are just a few examples of recent administrative mandates. Many of these requirements (e.g., posting a summary of *every* contract for goods or services, notifying DOH of every contract, satisfying State audit checklists) duplicate federal requirements or offer little, if any, value in terms of quality or safety. Yet, they divert precious staffing resources from resident care to low-value administrative tasks. They contribute to worker burnout and drive people out of the field.

Legislators and regulators should consider the impact on residents and staff of any new administrative requirements. One simple step the Legislature can take to support providers is to urge DOH and the Governor to eliminate the daily HERDS reporting, which has been a requirement for nursing homes and ACFs for nearly **three years** and requires collection and reporting of data elements that are now obsolete or irrelevant. The most salient data regarding COVID can be collected in less onerous ways, including data already being collected on a national level for nursing homes.

IV. SERVICE- AND SETTING-SPECIFIC RECOMMENDATIONS

a. Nursing Homes

- ***Provide a 20 percent Medicaid rate increase.***

A 20 percent Medicaid rate increase is needed to mitigate the impact of 15 years of rising costs and stabilize our nursing homes. With 70 percent of days paid for by Medicaid, nursing homes have nowhere else to turn for funding. A 5 percent rate increase for nursing homes, while a step in the right direction, is simply not enough. Medicaid rates for nursing home care in New York are **based on 2007 costs (discounted by 9 percent)** and have not been updated or

increased for inflation in over 15 years. Since nursing home Medicaid rates were last adjusted for inflation, the costs of delivering care have risen by **more than 40 percent**.

As noted above, the federal MACPAC has found that New York's shortfall between costs and rates was among the biggest in the nation in 2019. That gap has only grown, and New York's competitors for worst rates have since increased rates substantially. Nebraska increased rates by 15 percent, South Dakota by 20.3 percent in the first year with a 6 percent continuing increase, Florida by 7.8 percent; New Jersey by 10 percent, and Wisconsin by 12 percent with a commitment to increase rates to cover 91 percent of costs starting in 2023. Although not in the bottom five of the MACPAC analysis, Pennsylvania increased nursing home Medicaid rates by 17.5 percent in 2022.

New York's inadequate rates are preventing nursing homes from recruiting and retaining staff and forcing them to close units and beds, creating backups in hospitals. As a result of staffing shortages, there are 6,700 fewer nursing home beds open today than there were in 2019. A 20 percent increase is needed to enable high-quality nursing homes to reopen beds and remain viable.

- ***Add titles to minimum staffing level provisions.***

The minimum nurse staffing law enacted in 2021 (in the wake of the minimum direct care spending law discussed below) sets inflexible staffing requirements that the vast majority of homes (nearly 75 percent in quarter 2 of 2022) have found impossible to meet during this unprecedented staffing crisis. As a result, the law will trigger penalties on most nursing homes, further depleting the resources they need to recruit and retain staff.

The staffing requirements are based solely on nurses and aides, excluding the care provided by other hands-on staff who serve the overall needs of nursing home residents on a daily basis. Failing to recognize the time provided by these caregivers, or requiring that their time be replaced by aide hours, does little to improve the quality of life for residents. The law should be amended to take into consideration the hours worked by rehabilitation therapy staff, nurse practitioners, nurse managers and directors who deliver direct care (consistent with federal standards), recreation and activities staff, aide trainees, and feeding assistants.

- ***Eliminate barriers to capital improvements imposed by direct care spending requirements.***

As currently structured, the nursing home minimum spending requirements penalize facilities that make capital investments necessary to address infection prevention and improve quality of life for residents. While last year's enacted budget excluded capital reimbursement under limited circumstances, most capital reimbursement for most facilities will continue to be included in countable revenues for purposes of the minimum spending calculation. As a result, capital improvements that benefit residents may trigger revenue seizures under the direct care

spending law. These provisions must be amended to exclude capital reimbursement in order to encourage, rather than thwart, innovation and badly needed capital improvements.

b. PACE and MLTC

- ***Block enrollment minimums and competitive procurement of MLTC plans.***

MLTC plans and PACE programs manage and pay for the LTC services provided to more than 300,000 older adults and people with disabilities eligible for Medicaid in New York – the vast majority of community-based LTC delivered in our state. The Governor's budget would require MLTC plans to have a minimum of 20,000 enrollees and/or 5,000 enrollees in an integrated Medicare-Medicaid product by Oct. 1, 2024 in order to continue to participate in the MLTC program. If an "insufficient" number of plans meets these and other requirements, DOH would conduct a competitive procurement of MLTC plans.

This proposal seems destined to result in a heavy reliance on large insurers that focus on *non*-elderly, *non*-disabled populations, abandoning the specialized expertise and commitment of our MLTC plans sponsored by not-for-profit LTC providers. The enrollment thresholds required by the Governor's proposal would eliminate many of the MLTC plans operated by not-for-profit LTC providers. In the event of a procurement, those MLTC plans that are sponsored by LTC providers would be disadvantaged by the proposal's procurement criteria, which prefer statewide plans that offer insurance products geared to children and non-elderly adults.

By reducing the number of plans eligible to serve older adults and people with disabilities, this proposal would limit choices available to Medicaid beneficiaries and cause widespread disruption in consumers' established relationships with providers. It would also shift the State's managed care contracts to large national or statewide insurers that do not specialize in high-needs populations. By contrast, MLTC plans sponsored by not-for-profit LTC providers are uniquely equipped to provide person-centered care management, enabling members to maintain independence. The State should seek to maximize consumer choice and preserve access to these specialized plans.

- ***Reject the proposed elimination of the MLTC Quality Pool.***

The Governor's budget would cut funding to MLTC plans, including PACE programs, by $103.5 million (all funds) by eliminating the MLTC Quality Pool. The MLTC Quality Pool incentivizes the delivery of high-quality LTC services and supports value-based payment (VBP) initiatives with LTC providers. This cut would disproportionately affect high-quality plans and the high-quality providers that may receive incentives through MLTC plans' Quality Pool distributions. Notably, current Quality Pool funding already reflects a 25 percent reduction enacted in the 2020-21 State Budget. The Legislature should not only reject the proposed elimination of the Pool – it should also allocate $17.25 million (State share) to restore the 25 percent cut. Last year's enacted budget restored this cut, but only for SFY 2022-23.

c. Home and Community-Based Services

Home and community-based services (HCBS) providers continue to confront daunting financial and workforce challenges. While demand for community-based care is soaring due to changing preferences and our growing population of older adults, inadequate Medicaid rates and pandemic-related stresses have led to unprecedented workforce shortages. HCBS providers are being forced to limit patient admissions because they are unable to find sufficient staff. This has ripple effects on the entire health care system, delaying hospital and nursing home discharges to the community due to insufficient home care capacity. Medicaid's failure to pay LTC providers rates that cover the costs of competitive wages is resulting in diminished access to care and long waiting lists.

- ***Support investments in home health and hospice.***

CHHAs and hospice programs are receiving growing numbers of referrals of complex patients from hospitals. Like nursing homes, amidst a severe nursing shortage, they are increasingly unable to admit patients from hospitals. One LeadingAge New York member – a large metropolitan home health agency – was unable to provide home health care to more than 11,600 hospital patients in 2022 because of lack of capacity.

Agencies of all sizes are unable to admit patients due to lack of nursing and aide staff. Hospice is struggling with similar staffing issues, and New York is 50th in the nation in hospice use. These dynamics are creating backups in hospitals and delaying or blocking access to care across the health care continuum. The problem is worse in "home health and hospice deserts," communities already hit hard by health disparities.

HCBS providers play an increasingly significant role in the broader health care system and need support. We urge the State to include $35 million ($70 million with federal match) for the Home Health and Hospice Access Fund to help agencies tackle the workforce crisis by targeting financial incentives for frontline staff, nurse residency programs, and nursing school collaborations, and to secure transportation to patients' homes.

- ***Ensure that wage mandates are fully funded.***

Last year, the Legislature enacted a home care minimum wage, establishing a $3 increase above the minimum wage for home care aides. This was a helpful step in promoting equitable wages for home care aides.

LeadingAge New York supports the payment of appropriate compensation to home care aides and other direct care staff delivering LTC services. We recognize that an increase in wages for all LTC workers is well-deserved and must be part of the solution to the workforce crisis. However, a wage mandate is a blunt instrument that can have unintended consequences, particularly in a health care sector that is heavily dependent on public payers and struggling

with the impacts of the pandemic and under-reimbursement. We are concerned that a new home care wage mandate will threaten the stability of the agencies that deliver this care and disrupt services for the individuals who rely on it.

With the current home care minimum wage mandate in place and a corresponding increase in reimbursement only for minimum wage hours reimbursed by Medicaid, agencies have to find funds to cover the increase in costs associated with compression effects and hours reimbursed by non-Medicaid payers such as Medicare, Medicare Advantage, the Expanded In-Home Services for the Elderly Program (EISEP), commercial payers, and consumers themselves. As the State considers measures to increase compensation for aides, we ask for a careful analysis of options and of broader market impacts of those options.

- ***Support funding for aging services programs.***

LeadingAge New York fully supports the Executive's additional funding for EISEP and the Private Pay program to deliver personal care services and everyday supports to aging New Yorkers. This funding includes additional monies to address the continuing unmet needs of older adults that have been exacerbated by the historic decline in workforce caused by the pandemic.

We also support continued funding for both traditional and Neighborhood Naturally Occurring Retirement Communities (N/NORCs), including a restoration of $1 million in supplemental funding for nursing services provided as part of the N/NORC program and another $1.5 million to expand the definition of Neighborhood NORC so that more communities can utilize this valuable program.

Social isolation has been a significant issue for older New Yorkers during the pandemic and is an important social determinant of health. LeadingAge New York is pleased to see new and continued funding in the Executive Budget for virtual socialization programs and transportation services geared toward older adults. We support reimbursement of social and adult day care programs that offer virtual socialization services to their participants.

- ***Support the Governor's proposal to modify the advanced home health aide supervision requirements.***

The statute and regulations for the advanced home health aide (AHHA) role established in 2016 have rendered the model unworkable. The Executive Budget's proposed changes would help allow some providers to implement this model. The budget should also address Medicaid reimbursement for the AHHA role and nursing supervision visits.

- ***Fund Resident Assistants in affordable senior housing.***

LeadingAge New York, along with a coalition of senior housing providers, associations, and affordable housing advocates, is calling for the commitment of $25 million over five years to support Resident Assistant positions in subsidized and income-restricted independent rental

housing for low-income seniors. We propose that grants be made directly to senior housing operators to establish the systems they need to hire Resident Assistants, who would work to identify residents' unmet needs and link them with the existing community programs and resources that can help them remain healthy and independent.

The older New Yorkers living in these settings are generally income-eligible for Medicaid, but often struggle to navigate the network of health and social supports that could help them age safely in place. Resident Assistants available on-site and at resident request can help address this need by providing information and referrals to supports in the community; education regarding Medicaid and other benefits; and assistance with accessing public benefits, services, and preventative and social programming.

We estimate that this investment would generate **net savings of $6.6 million** (State share) to the State annually, based on our analysis of a rigorous New York-based study of the Selfhelp Active Services for Aging Model (SHASAM) Resident Assistant program. The study 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.[9] Furthermore, with the SHASAM program in place, less than 2 percent of Selfhelp's residents are transferred to a nursing home in any given year. However, without State operational support, most providers have little or no avenue outside of charitable donations to maintain a much-needed Resident Assistant staff person.

d. Assisted Living and ACFs

Assisted living (AL) and ACF providers offer support and assistance in a home-like setting for nearly 54,000 New Yorkers. The average resident is 85 years of age, requires assistance with at least three activities of daily living, and has multiple comorbidities. These settings are a popular option with consumers, and we anticipate the demand for these services will only grow in the years to come. Some AL providers offer aging in place services or memory care, and the Medicaid ALP is the only Medicaid-funded AL option in the state.

Over the past three years, ACF/AL providers have faced extraordinary challenges, including the strain of COVID, workforce shortages, rapidly increasing costs, and growing administrative requirements. New York's senior living providers have incurred hundreds of millions of dollars in unbudgeted expenses for staff testing, procurement of PPE and other infection control supplies, extraordinary recruitment and retention efforts, and overtime pay. Providers have had to adhere to countless mandates, many of which still continue today. Unlike the arts and entertainment sectors that have received financial support from the State, ACF/AL providers have received *no State financial relief* throughout the pandemic.

[9] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. Health Affairs. Oct. 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.

At the same time, funding initiatives such as the health care worker bonus program largely overlooked this sector; staff in approximately 400 of the 541 ACF/AL settings were ineligible. Similarly, the home care minimum wage increase supported the increase in wage for aides working in Medicaid-funded home care, but not aides working in other settings.

The Executive Budget includes some positive steps with a modest Medicaid rate increase and workforce initiatives, but after years of increasing mandates and no investments, it is insufficient. Like other LTC providers, ACF/AL providers face challenges that predate the pandemic, but have worsened over the past three years. After 15 years of underfunding, with growing mandates and severe workforce shortages, we are truly at a tipping point. Given the growing aging population and the consumer preference for this model, the State must do more now to ensure access to needed services. We urge the Legislature to take the following steps to provide much-needed financial relief and targeted support to ensure the availability of ACF and AL services, particularly for low-income older adults.

- ***Increase the ALP Medicaid rate by 20 percent, and update the base year to address the longstanding underinvestment and rapidly growing costs.***

The ALP serves Medicaid-eligible seniors who require a nursing home level of care, but do not need ongoing skilled services, at approximately half of the nursing home Medicaid rate. The ALP Medicaid rate has not had a standard trend factor increase since *2007*, and in the middle of the pandemic, when other states *increased* provider Medicaid rates, the rate was cut by 1.5 percent. The restoration of that cut and the 1 percent rate increase last year was appreciated, but has done almost nothing to address 15 years of increased costs, COVID-related costs, workforce shortages, and skyrocketing inflation. The State must increase the rate by 20 percent to recognize these growing costs over 15 years. Moving forward, we must update the base year for the ALP Medicaid rate to ensure that it reflects current costs.

- ***Modify the Assisted Living Residence quality reporting initiative to require provider association input and more time to ensure meaningful information for the consumer.***

The Executive Budget proposal includes an ambitious proposal to develop quality measures for Assisted Living Residences (ALRs), Enhanced Assisted Living Residences (EALRs), and Special Needs Assisted Living Residences (SNALRs) and begin reporting by January 2024. The proposal would also require public posting of information including the monthly service rates, fees, and staffing information.

With significant variation in the services offered, acuity of residents, and subsequent staffing of the different AL models, this is a complex task. To date, DOH has not begun to work on this initiative with the provider community. The State must engage provider representatives such as LeadingAge New York on the development of quality measures, as well as parameters for public reporting, to ensure success. Providers will then need time to develop data collection methods before reporting begins. Careful thought is necessary to ensure that meaningful information is

available to the consumer, reported in a way that enables valid comparison, which will require more time.

Additionally, public reporting standards must be flexible enough to recognize the differences in licensure, services offered, and populations served. For example, continuing care retirement communities (CCRCs) have a different pricing structure that is based not just on the ALR service, but also on a commitment to service at any level of care the individual needs over the course of their lifetime. These nuances must be captured in any reporting to ensure that the consumer has useful information.

To sum, the language must be modified to provide ample time to develop meaningful measurements, and to solicit provider input and collect data, and the language must be flexible enough to acknowledge the variation in the different models, including the different pricing structure of the CCRC. Failing to do so risks giving the consumer confusing or misleading information.

- ***Consolidate EQUAL funding.***

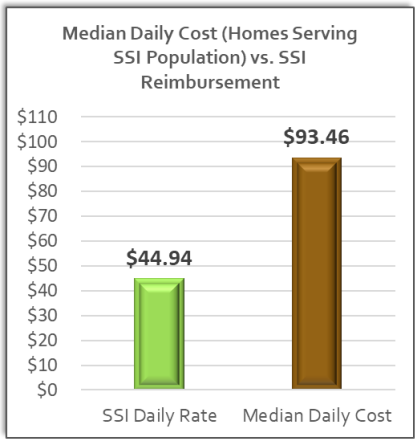
The Enhancing the Quality of Adult Living (EQUAL) program supports quality of life initiatives for low-income residents of ACFs. Changes to the program in 2020 to split it into two separate components (capital and aid to localities) have made it difficult to utilize the funds in the most impactful ways. We recommend consolidating the funding as it was prior to 2020 and ensuring that it is distributed through an objective methodology so that funds can be directed as the program intended, consistent with residents' wishes.

- ***Modify the respite care in ACFs proposal.***

We support the Executive's initiative to appropriate $7.2 million to relieve high-need family caregivers through respite care in ACFs; however, we recommend a modification in the language of this proposal to allow for flexibility in allocating 120 days of respite per person. Allowing variation in usage for shorter stays, with a *maximum* of 120 days per person, would enable the State to extend the benefit to more than 300 individuals.

- ***Increase the State portion of the SSI rate for ACF residents by at least $20 per day, and build in an annual cost-of-living adjustment thereafter.***

ACFs that serve low-income older adults are in particular financial distress given the aforementioned challenges. They are even less able to find ways to increase wages or compensation incentives to compete for staff in this current environment. SSI, together with the State Supplement Program (SSP), pays ACFs **$44.94** per day, which is entirely inadequate for ACFs to provide residents with regulatorily required services including housing, meals, personal care, case management, and more. There has not been an increase to the SSP since 2007. Approximately 12,000 ACF residents rely on SSI statewide. LeadingAge New York's analysis of 2019 pre-pandemic ACF Financial Report data of ACFs that serve this population demonstrated that it costs ACFs more than *twice* the daily reimbursement per resident to provide their services – and the gap between costs and reimbursement has grown significantly since then.



Since 2017, there have been *48 ACFs that have closed* voluntarily, and others are in the process. If SSI/Medicaid-eligible seniors cannot access ACFs in their communities, they will go to nursing homes at a significantly higher cost to the State. LeadingAge New York estimates that *for every 45 low-income ACF residents who can remain in their ACF or are diverted from nursing home placement, the State saves $1 million in Medicaid spending annually*. We urge the Legislature to increase the Congregate Care Level 3 SSP rate by at least $20 per day and build in an annual cost-of-living adjustment thereafter.

- ***Allow nurses to provide nursing services in ACF settings.***

The Legislature could implement a no-cost workforce solution by enabling nurses working in ACF/AL settings to provide nursing services. Nurses working in these settings across the state have been invaluable during the 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 EALR is the only ACF/AL setting that permits these professionals to provide nursing services. During this workforce shortage, we should be maximizing resources and utilizing nurses in ACFs to provide periodic services that would result in better health outcomes, prevent hospitalizations, support end of life care, and save Medicaid dollars.

e. Adult Day Health Care

- ***Support the viability of medical model ADHC programs.***

ADHC programs are cost-effective, community-based programs that provide skilled nursing care and therapies to individuals in a congregate day setting. ADHC programs reduce emergency room visits, reduce hospital admissions, reduce falls, and delay nursing home placement. In March 2020, all 116 ADHC programs were instructed to close their programs due to COVID, one of the only provider settings to be instructed to do so. Although ADHC programs were authorized to reopen in March 2021, to date only 50 ADHC programs have been able to reopen. Others are trying to reopen and are struggling to do so as a result of funding and workforce constraints. Over 26 counties have lost access to ADHC care, and less than half of the licensed programs in New York City have reopened. The Bronx, for example, no longer has a single open ADHC program.

The State should dedicate the necessary resources to commit to a full return to operational status for ADHC programs. ADHC programs provide nursing home-level care to individuals who live in the community, and it is critical that these resources are re-established as quickly as possible.

- ***Increase Medicaid reimbursement for ADHC programs*.**

We urge the State to increase the ADHC Medicaid reimbursement rate by 20 percent to reflect current costs of care, associated operating expenses, and adequate compensation of staff. The Governor's proposed nursing home rate increase of 5 percent (which includes ADHC) is a good starting point, but is still inadequate. Like their sponsoring nursing homes, ADHC programs are operating at 2008 Medicaid rates despite the fact that the cost of skilled care has risen 42 percent since that time. Programs must be able to offer the increased salaries and wages necessary to attract staff and deliver services, or they will not be sustainable.

- ***Increase Medicaid reimbursement for ADHC transportation*.**

Another serious challenge facing ADHC programs is the cost of transportation to and from the program. ADHC Medicaid transportation rates are substantially lower than any other health care transportation rate and do not cover the increased costs of gas, insurance, and driver wages, and the purchase and maintenance of vehicles. Programs struggle to find transportation vendors that will accept the State's 2008 Medicaid rates and must subsidize vendors with funds intended for other program services to bring their registrants to their sites. We have seen several reputable transportation vendors close their businesses due to these challenges.

This dynamic is causing significant barriers to accessing ADHC programs across the state. It is unconscionable for programs to be in the position of denying admission to low-income individuals with disabilities and complex medical conditions because of a lack of Medicaid transportation.

CONCLUSION

In order to revitalize our LTC and aging services in the wake of the pandemic and ensure that accessible, high-quality services are available to older adults and people with disabilities in the future, we need to make significant investments now. We must strive to ensure access across the continuum of LTC consistent with consumers' needs and preferences. Adequate public funding must be the foundation of this revitalized LTC system. Looking to the future, we can expect that a significant portion of older adults will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs. In addition, we will need a multi-pronged, intergovernmental effort and private and public sector engagement in workforce development for the LTC continuum. We look forward to working with the Legislature to ensure that LTC is a top priority in the State Budget for SFY 2023-24.

Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven, and public continuing care, including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs, and Managed Long Term Care plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.