2024-25 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 State Fiscal Year (SFY) 2024-25 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.

This year's Executive Budget is devastating for older adults and people with disabilities who need LTC services.

Although the Governor acknowledges New York's growing older adult population and the rising need for LTC, her budget fails to make any investment to address the dire need. Not only does the budget proposal fail to invest desperately needed funds to ensure access to services for older adults, but it also imposes significant cuts. Even worse, *only* older adults and others who need LTC are targeted with deep cuts under the Governor's budget; in other areas where needs are acute, the Governor has found funding to address them.

The Executive Budget demands that older adults with LTC needs bear the brunt of Medicaid cuts. In fact, the Executive Budget's Medicaid Scorecard shows a $633.7M State share reduction in Medicaid funding for LTC services, as compared to a net $112.2M State share reduction for all other Medicaid services outside of LTC. In other words, **services for older adults and others in need of LTC are bearing nearly six times more cuts than the rest of the health care system**.

As we will discuss in more detail below, LTC services in New York are already in a precarious position due to chronic underfunding, sharply rising costs, and a rapidly growing aging population. These conditions have already created serious access issues across the state – not only for older adults, but also for the health care system as a whole. It is also a crisis for those who are trying to care for their loved ones, but find themselves unable to meet their needs alone. This, too, will have broad societal impact not unlike the child care challenges we saw throughout the pandemic and their impact on the workforce. If enacted, the Governor's budget will push the LTC system to the brink along with the people who rely on it, and the ripples will be felt throughout.

New Yorkers rely overwhelmingly on Medicaid to cover their LTC needs, and New York's Medicaid program bears substantial responsibility for ensuring that New Yorkers have access to high-quality LTC. New York prides itself on being a leader in so many ways. Yet, the state is an

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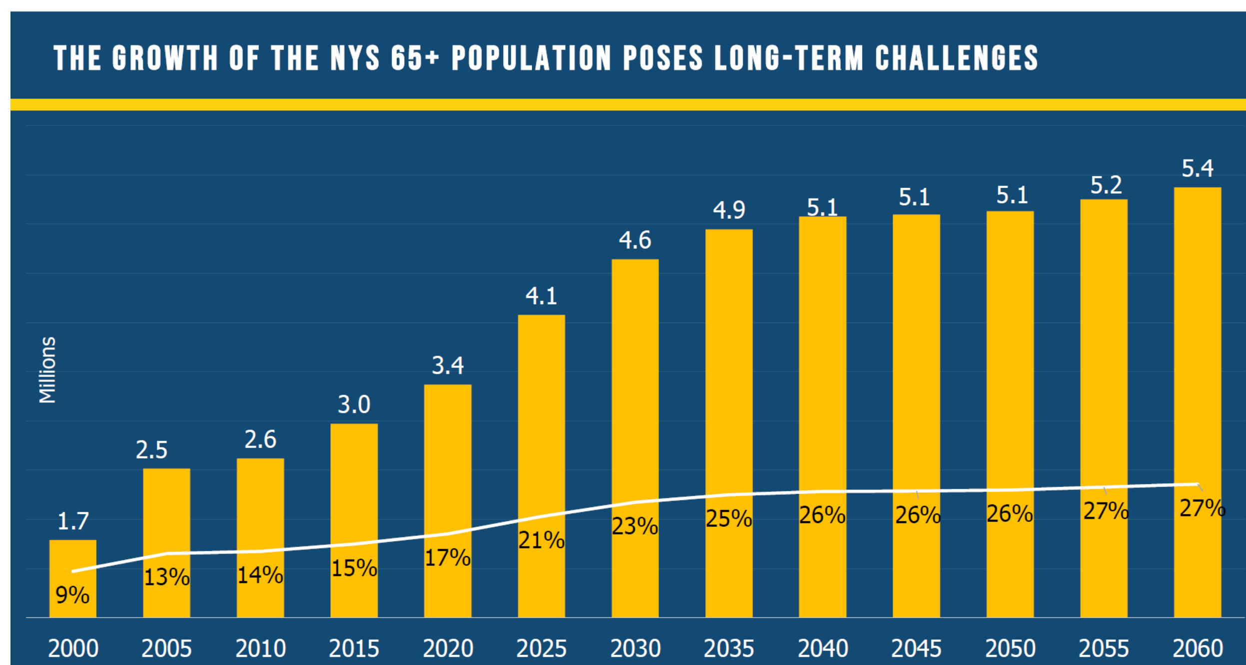
[1] The term LTC providers is used throughout this testimony to refer to providers that deliver long-term and/or post-acute care. These providers include home care agencies, nursing homes, hospice programs, adult day health care programs, and adult care/assisted living facilities.

outlier when it comes to funding LTC. While New York proposes cuts to inadequate rates, other states have been making significant investments in LTC services.

The availability of LTC services is an issue that *all New Yorkers* should care about; approximately 70 percent of adults who live beyond age 65 will need LTC at some point in their lifetime.[2] Remarkably, the State has not taken a thoughtful approach to the development of LTC policy and funding, despite what we know about the demographics. Between 2015 and 2040, the number of adults over 85 will double in New York.[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.



NYS Division of Budget, presentation, Jan. 16, 2024, accessed at https://www.budget.ny.gov/pubs/archive/fy25/ex/fy25-director-presentation.pdf.

Despite the predictability of growing need and costs associated with a rapidly rising population that is largely reliant on Medicaid, New York is somehow caught unprepared. The needs of older adults and others who need LTC services are once again ignored in the recently approved 1115 waiver, while capital investment and funding for safety net providers has been targeted primarily at hospitals.

The Master Plan for Aging (MPA) may, in the future, provide an aspirational blueprint for older adults living in New York, but its future-oriented focus turns a blind eye to current pressing needs. The MPA process should not be an excuse for delaying needed actions to preserve and improve our LTC system today. New York's failure to provide investment and solutions in the

[2] Johnson, R.W. "What is the Lifetime Risk of Needing Long-Term Services and Supports?" ASPE Research Brief. April 2019.
[3] Cornell University Program on Applied Demographics New York State Population Projections; http://pad.human.cornell.edu/; accessed Jan. 4, 2019.

short term threatens the demise of high-quality, innovative providers that could implement that blueprint in the future.

It is difficult to understand or justify the inequitable targeting of older adults in need of LTC for the deepest cuts in the proposed Health Budget. It is difficult to discern a reasonable explanation for the repeated neglect of older adults and LTC services in major health initiatives like the 1115 waiver. We ask the Legislature to break from this pattern and respond to the needs of older adults by replacing the Governor's cuts with investments.

If New York is truly committed to health equity and aging with dignity in one's preferred place for people of all income levels and in all regions of the state, it must be prepared to pay for it. *Significant investment is needed in LTC to have a system in New York that will meet the needs of older adults today and tomorrow.* We ask you to raise Medicaid rates for LTC providers to cover the cost of delivering care. For nursing homes, this means a $510M (State share) increase to preserve access to high-quality care pending a more comprehensive update to the methodology to align rates with costs and accommodate federal changes.

Our testimony elaborates on the challenges facing LTC providers, LTC funding needs, and policy recommendations to do better for older New Yorkers.

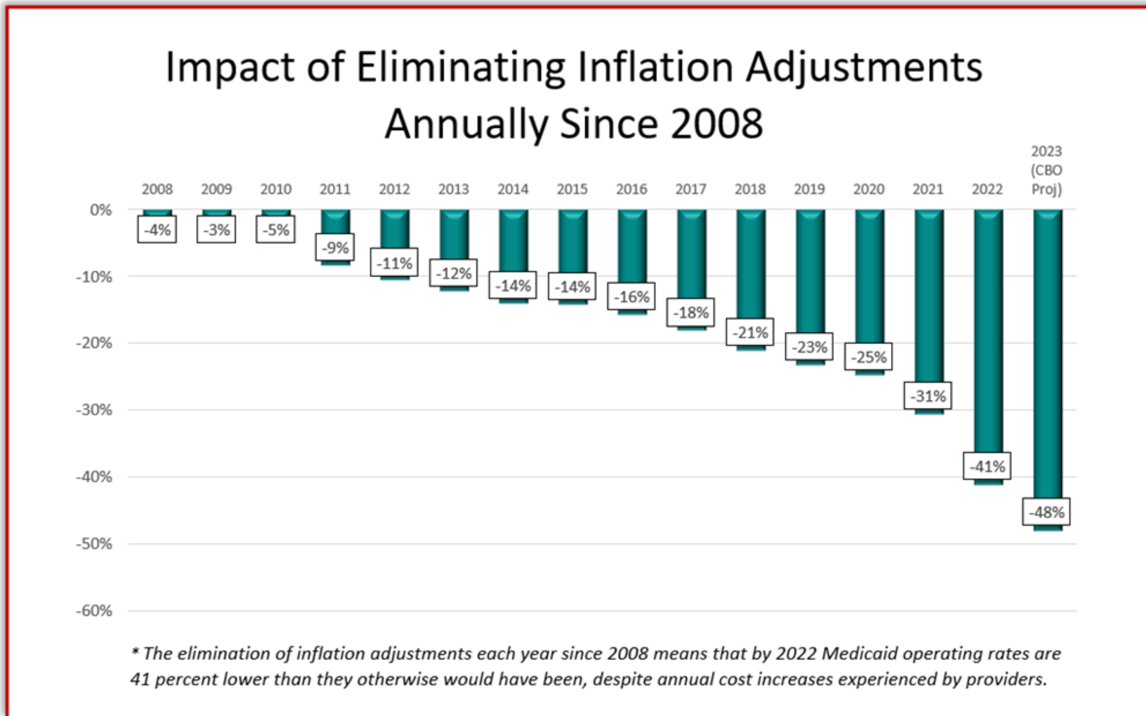
The testimony is organized in four parts, as follows:

I. Financial Condition of New York's LTC Providers
II. The LTC Workforce Crisis
III. Service-Line Specific Recommendations to Ensure Access to LTC Services
   a. Nursing Homes
   b. Managed Long Term Care and Programs of All-Inclusive Care for the Elderly
   c. Home and Community-Based Services
   d. Adult Care Facilities and Assisted Living
   e. Continuing Care Retirement Communities
IV. Workforce Recommendations

I. FINANCIAL CONDITION OF NEW YORK'S LTC PROVIDERS

Years of inadequate Medicaid rates and little new investment have depleted our LTC providers. The financial position of many providers, especially not-for-profit providers, was shaky before COVID and the intensification of the staffing crisis. The situation is now dire. Since the pandemic, costs have skyrocketed, revenues have plummeted, and many providers are closing their doors.

New Yorkers rely overwhelmingly on Medicaid to cover their LTC needs. Medicaid pays for over 72 percent of nursing home days and over 80 percent of home care services in New York.



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

a. Inadequate Medicaid Rates Causing Widespread Financial Distress and Loss of Services

Medicaid pays for 72 percent of nursing home days and over 80 percent of personal care services in New York. As the primary payer for LTC services in New York, 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.

Until 2022, when Medicaid rates were increased by 1 percent, rates paid to nursing homes, assisted living programs (ALPs), and adult day health care (ADHC), for example, had not been increased for inflation in 15 years – a period in which inflation drove up costs by more than 40 percent. Unfortunately, last year's 6.5 percent rate increase for ADHCs and ALPs and "up to 7.5 percent" for nursing homes did not even meet the inflationary cost increases *in that year alone*. The sector experienced an 8 percent inflation rate for the 12-month period ending April 2022, an additional 5 percent inflation rate for the year ending April 2023, as well as significant wage increases in recent collective bargaining agreements.[4]

As a result, nursing home Medicaid rates, for example, fall short of costs by at least 25 percent on average, according to our comprehensive analysis of 2021 allowable costs relative to 2021 rates – a shortfall that has likely widened since. Staffing levels are a leading predictor of the size

[4] Bureau of Labor Statistics Inflation Calculator, accessed at www.bls.gov/data/inflation_calculator.htm.

of the Medicaid shortfall on a facility level: **the average Medicaid shortfall for homes meeting State staffing requirements was about $150 per resident per day**.

The financial distress is widespread and growing. Over 40 percent of all nursing homes in the state were facing operating losses before the pandemic, a figure that in 2021 was nearly 50 percent. The state's not-for-profit and public homes are struggling even more – 62 percent reported operating losses in 2021, with more recent data pointing to an increase in financial stress in the past two years. Financial surveys of LeadingAge New York members in 2022 and 2023 found that the median operating margin for not-for-profit and public homes is now near -20.0 percent, compared to -3.8 percent in 2019.

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 and home care agencies, adult care facilities (ACFs) that serve Medicaid beneficiaries have been struggling to survive with inadequate public funding. Their Supplemental Security Income (SSI) Congregate Care Level 3 rate of **$45.50 per day** covers less than half of the cost of State-mandated services.

The financial distress is forcing high-quality providers to close or sell and constricting access to care. **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 quickly. Of those not-for-profit closures, nine occurred just in the past four years. Another 15 not-for-profit homes are currently in the sale process.

Similarly, since 2017, 59 ACFs have closed voluntarily. After prolonged closure during the pandemic, only 55 of the 115 licensed ADHC programs have reopened to date.

Financial challenges and workforce shortages are also forcing providers to limit admissions. Nursing homes are closing beds and units in an effort to improve their compliance with staffing ratios because they cannot find the staff necessary to meet the requirements at a higher occupancy. As a result, there are 5,600 fewer nursing home beds available today than there were in 2019. Home care agencies are likewise turning away patients in need of care due to lack of available staff.

The shrinkage of LTC capacity is creating backups in hospitals and ripple effects throughout the health care system. Vulnerable hospital patients who are waiting for discharge cannot find appropriate post-discharge care close to home. The inability to find needed services is devastating for those who need it and for their caregivers. But it does not end there – lack of access to LTC services leads to shortages of available hospital beds. This dynamic is distressing for patients who must wait in an ambulance for available space in the hospital emergency department, or spend long days in overcrowded emergency departments waiting for hospital

beds to open up, and it is financially damaging to hospitals. As a result of reduced LTC capacity, access to care is limited, and emergency services response time is delayed, for everyone in the community.

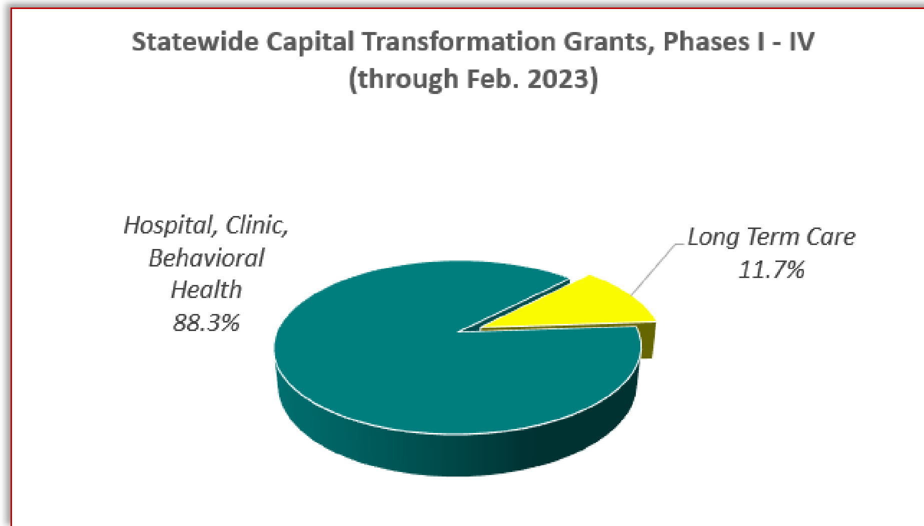
b. Older Adults and LTC Providers Forsaken by 1115 Medicaid Waiver and Capital Grants

Despite years of flat Medicaid rates and deepening financial distress among LTC providers, the State has repeatedly failed to invest in the LTC sector even when capital grants or federal Medicaid funds are made available. This pattern is repeated in the Governor's budget, which would invest $451M of State funds into several initiatives recently approved under the 1115 waiver (i.e., hospital global budget initiative, primary care, substance use disorder (SUD) services, continuous eligibility for young children, and additional State Medicaid match). Tragically, none of these funds will support older adults in need of LTC. The State once again turned its back on older adults and people with disabilities in need of LTC when developing the 1115 waiver.

For example, the waiver invests $3.2B over three years in Health-Related Social Needs (HRSN) services to be targeted to Medicaid high utilizers: individuals experiencing SUD, serious mental illness, intellectual and developmental disabilities, or homelessness; pregnant and postpartum persons; criminal justice- and juvenile justice-involved populations; and children. It does not appear to enable the delivery of HRSN to older adults with LTC needs, unless they also meet the above criteria. Moreover, it is unclear whether individuals dually eligible for Medicare and Medicaid (i.e., the vast majority of older adults on Medicaid) will be able to qualify for these services.

Likewise, the waiver's investment in Career Pathways Training (CPT) for allied health care workers *does not* appear to provide support for training the "frontline" staff who work in LTC settings. The CPT program will not train home health aides, personal care aides, or certified nurse aides (CNAs). Instead, the waiver's CPT for frontline staff is limited to community health workers and patient care managers/coordinators.

Similarly, LTC providers have been denied a fair share of State capital grants. Only 11.7 percent of Statewide Health Care Facility Transformation Program (SHCFTP) funds has 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. Capital investments are sorely needed.



Source: LeadingAge NY review of DOH awardee lists

II. THE LTC WORKFORCE CRISIS

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

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. More than a year after staffing level requirements went into effect, 74 percent of all New York State nursing homes are still unable to meet one or more of the minimum hours requirements, according to the most recent publicly available Payroll-Based Journal (PBJ) data from the Centers for Medicare and Medicaid Services (CMS) (second quarter of 2023).

These homes are threatened with steep penalties (up to $2,000 daily) if they fail to meet all three staffing requirements. At the same time, under recently enacted legislation, they are faced with penalties if they mandate that nurses work overtime in order to meet staffing requirements. If homes are forced to pay all of these penalties, they will have even less funding to recruit and retain staff. Unfortunately, the few homes that are able to meet staffing requirements are those at greatest risk of sale or closure – as noted above, compliance with mandated staffing ratios creates an average Medicaid shortfall of about $150 per resident per day.

The demanding nature of LTC work, the training and skill required, and inadequate reimbursement are driving people from the field. The State needs to shift its focus to find ways to attract and incentivize people to join in these important and meaningful careers.

III. SERVICE-LINE SPECIFIC RECOMMENDATIONS TO ENSURE ACCESS TO LTC SERVICES

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. The State must deliver on its promise of a Medicaid program that ensures access to high-quality LTC for all New Yorkers. It cannot achieve its goal of health equity by balancing the Medicaid budget on the backs of older New Yorkers and people with disabilities who need LTC services.

As an initial matter, the Legislature must **reject** the unspecified $200M cut in Medicaid spending on LTC services. Further, the additional unspecified $200M in Medicaid savings must not be achieved through cuts to LTC services, whether or not community-based. And, the Legislature and Executive must agree to sizeable investments to align Medicaid reimbursement for LTC with the cost of providing high-quality care.

With this as context, we offer the following recommendations for the Legislature to consider for the 2024-25 State Budget.

a. Nursing Homes

- ***Reject cuts and instead update the reimbursement methodology while increasing nursing home Medicaid rates by $510M. Commit to update and rationalize rate methodology by 2025.***

We urge the Legislature to invest $510M in the 2024-25 budget to narrow the current funding gap that exceeds 25 percent. In addition, we ask the Legislature to enact a plan to update and rationalize the rate methodology by 2025 to promote quality, efficiency, and provider viability in line with the state’s demographic realities.

For the reasons described above, many nursing homes are on the brink of failure. Due to Medicaid underfunding, the current financial model is unsustainable. Wages and benefits, primarily for nursing staff, represent the bulk of nursing home costs. The competitive labor market requires 5 to 7 percent wage increases annually to retain and attract quality staff. It is impossible to continue to operate, much less meet staffing ratios, with rates based on 2007 costs. **By eliminating inflation adjustments annually for more than a decade, the State has cut payments to nursing homes by a cumulative amount exceeding $15B since 2012 alone.** The State must reinvest some of the savings achieved through years of Medicaid underpayments back into nursing home funding.

While claims of high per-capita Medicaid costs are common excuses for proposing cuts, it is critical to note that not only is New York's shortfall between nursing home costs and rates among the largest in the nation,[5] but many lower-cost states, including Maine, Maryland, Minnesota, Washington, Delaware, and even Kentucky, West Virginia, and North Dakota, have average Medicaid rates that exceed New York's nursing home average rate.

The human cost of this underfunding is well documented. Many high-quality homes have waitlists of people seeking care. This has forced older adults to seek care far away from their loved ones, often at great inconvenience and cost to quality of life. We cannot abandon older adults with the highest care needs – those who require 24/7 care, skilled nursing, continuous medical oversight, and/or extensive assistance with activities of daily living. Our efforts to promote care in the most integrated setting should not deny those who need nursing home care access to the best possible quality of care and quality of life in close proximity to their loved ones.

- ***Ensure appropriate capital reimbursement: reject proposed 10 percent cut, restore existing 5 percent cut, and waive imputed capital provision.***

With 72 percent of nursing home resident days paid for by Medicaid, it is not surprising that Medicaid capital reimbursement is a key concern not only for providers and consumers, but also for lenders that help finance nursing home renovations that improve quality of life and safety for nursing home residents. Medicaid reimburses the Medicaid proportion of pre-approved capital expenses incurred by a nursing home. Most financing arrangements are based on the understanding that Medicaid will meet its promise to reimburse the percentage of approved capital expenses corresponding with Medicaid utilization. Current and proposed reductions to capital reimbursement threaten nursing home access to needed capital funding and the improvements to nursing home space that make facilities more homelike and enable better infection control.

The Executive Budget proposal seeks to impose a cut of 10 percent on nursing home capital reimbursement, on top of a 5 percent cut that took effect in April 2020. We urge the Legislature to reject this new cut and restore the prior cut.

In addition, we ask the Legislature to enact legislation to waive the capital reimbursement penalty on facilities with occupancy below 90 percent. Through this penalty, the State has quietly denied these facilities full reimbursement of their approved capital costs, jeopardizing their viability and generating savings of more than $50M in each of the prior two years. The impact falls disproportionately on those homes that have been forced to limit admissions in the face of staffing shortages to ensure compliance with State-required staffing levels.

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[5] In January 2023, the federal Medicaid and CHIP Payment and Access Commission (MACPAC) concluded that the shortfall between New York's nursing home Medicaid rates and costs was among the largest in the country. "Estimates of Medicaid Nursing Facility Payments Relative to Costs," MACPAC, available at https://www.macpac.gov/publication/estimates-of-medicaid-nursing-facility-payments-relative-to-costs/.

- ***Restore proposed $75M cut to Nursing Home VAPAP funding.***

The Nursing Home Vital Access Provider Assurance Program (VAPAP) is a suballocation within the larger VAPAP program that primarily supports hospitals. The Nursing Home VAPAP is intended to provide $100M annually to support nursing homes that are in severe financial distress. Until Medicaid rates are increased and the rate methodology is updated, the program is critical in helping those homes that are facing the most severe financial challenges to survive. We urge the Legislature to reject the proposed $75M cut and ensure that this lifeline funding is available. Given the emergency nature of this program, we also ask that the Legislature ensure that all of the allocated funding is distributed without delay.

- ***Add titles to minimum staffing level provisions and allow nurses to satisfy aide hours.***

The minimum nurse staffing law enacted in 2021 sets inflexible staffing requirements that the vast majority of homes (nearly 75 percent in quarter 2 of 2023) have found impossible to meet during this unprecedented staffing crisis. In fact, Department of Health (DOH) Commissioner Dr. McDonald issued a determination of an acute labor supply shortage of nurse aides, CNAs, licensed practical nurses (LPNs), and registered nurses (RNs) statewide on June 22, 2023. Nonetheless, the State is in the process of imposing penalties for non-compliance with the minimum staffing mandate, further depleting the resources nursing homes need to recruit and retain staff.

The staffing requirements are based solely on nurses and aides, and require specified minimum hours for each, regardless of the needs of residents. For example, some of those "non-compliant" homes serve higher-acuity residents and actually exceed staffing levels for RNs and overall, but face penalties because they are below required levels for 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.

Further, the law fails to recognize the time provided by other hands-on staff who serve the needs of residents daily. Denying the hours of care 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. We thank Assemblyman Hevesi for introducing *A.2800*, which would recognize the essential care provided by therapists as well as therapy assistants and aides. We urge the Legislature to enact and expand upon this legislation.

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

LeadingAge New York appreciates the Governor's proposal to authorize specially trained CNAs to work in nursing homes as certified medication aides (CMAs) administering routine medications to residents under the supervision of an RN. This general proposal, or that set forth in *A.8299 (Clark)*, would help to address the nursing shortage in nursing homes, while providing new career ladder opportunities for CNAs and preserving quality and safety. Approximately 38 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. Given that this is being used in other states, a curriculum can be built using what nursing homes in other states use. 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 – without cost to the State.

Given the severe nursing shortages we are experiencing across the state, we cannot afford to forgo this win-win strategy.

b. Managed Long Term Care and Programs of All-Inclusive Care for the Elderly

- ***Block competitive procurement of MLTC plans.***

MLTC plans manage and pay for the LTC services provided to more than 320,000 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 a "competitive bid" process for MLTC plans in order to qualify to serve individuals eligible for Medicaid. This "competitive bid" process would be exempt from Comptroller oversight and other standards required by the State Finance Law to ensure the integrity of State procurements.

This proposal seems destined to result in a heavy reliance on large national or statewide insurers that focus on *non*-elderly, *non*-disabled populations, abandoning the specialized expertise and commitment of the MLTC plans sponsored by not-for-profit LTC providers. The budget legislation would require consideration of a series of criteria in order to select "qualified managed long term care plans." Many of these criteria have no bearing on MLTC quality and appear to create a preference for plans that offer products geared toward the general population. For example, the legislation requires consideration of the number and type of products offered by the MLTC plan bidder, including mainstream managed care, Child Health Plus, and the Essential Plan products. MLTC plans sponsored by not-for-profit LTC providers do

not offer these products because their mission is to serve older adults and people with disabilities. They are uniquely equipped to provide person-centered care management, enabling members to maintain independence.

Moreover, 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. The State should seek to maximize consumer choice and preserve access to these specialized plans.

Some policymakers and advocates have supported the elimination of partially capitated MLTC plans (those covering the Medicaid benefits and not Medicare benefits) entirely and replacing them with a health home-driven managed fee-for-service system. LeadingAge New York is opposed to this proposal. It would disrupt a system of care that currently serves over 250,000. It would presumably rely on local social services districts or DOH to develop care plans, approve hours of home care, adopt updated reimbursement rates, and work to promote adequate provider capacity. We question whether state and local governments have the resources to perform these tasks and whether the transfer of these responsibilities would, in fact, drive savings as the proponents suggest, much less improve access to care.

- ***Reject 1 percent cut in MLTC/PACE rates and the proposed elimination of the MLTC Quality Pool.***

The Governor's budget would cut funding to MLTC plans by 1 percent, resulting in a reimbursement reduction of approximately $150M (all funds). It would also reduce funding by $103.6M (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 $17.25M (State share) to restore the 25 percent cut.

- ***Reject transfer of dental benefits to Medicare Advantage D-SNP supplemental benefits.***

While this proposal may seem like a simple effort to shift State Medicaid costs to Medicare within the State's Medicaid Advantage Plus (MAP) product, it is not. The proposal may actually compromise the actuarial soundness of the plan premium and the adequacy of funding for dental care and other benefits. Under CMS regulations, the costs of Dual-Eligible Special Needs Plan (D-SNP) supplemental benefits are generally paid through "rebate dollars" – the amount the D-SNP receives if its bid to provide Medicare Part A and B benefits is below the benchmark for its service area. As a result, the Medicare portion of the premium may not be adequate to support dental benefits along with the regular benefit package.

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 and create waiting lists 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.

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

CHHAs and hospice programs are receiving growing numbers of referrals of complex patients and face challenges in admitting and serving them. Staffing shortages, payment challenges, and other policy barriers leave New York at *50th in the nation in hospice utilization*. Similarly, LHCSAs are unable to admit patients due to lack of nursing and aide staff. The problem is worse in communities already hit hard by health disparities. Like nursing homes, amidst a severe nursing shortage, home care agencies and hospice programs are increasingly unable to admit patients from hospitals, resulting in overall system backups and a lack of patient access to care.

HCBS providers play an increasingly significant role in the broader health care system and need support. We urge the State to provide significant funding for LHCSAs, CHHAs, and hospice providers to help agencies tackle the workforce crisis. Funding is needed for financial incentives for frontline staff, nurse residency programs, nursing school collaborations, and to secure transportation to patients' homes.

- ***Increase Medicaid reimbursement for adult day health care.***

ADHC programs were ordered by the State to be closed during the height of the pandemic, with no sense of when they would be able to reopen. This created great uncertainty and loss of critical support for the registrants. The programs were finally authorized to reopen in late March 2021, but by that time were depleted of staff and revenue. Sadly, *only 55 of the 115 licensed ADHC programs are open to date*. Many are struggling to stay open as they deal with staffing shortages and reimbursement challenges. Others are unable to reopen and operate with their current Medicaid rates. Many regions now lack ADHC programs altogether.

The State has voiced its commitment to making HCBS options available so that individuals can age in place and in their communities. ADHC programs are such an option, providing registrants with skilled nursing care, personal care, socialization, recreation, and meals in a day program with an integrated care team. ADHC programs defer nursing home placement, prevent hospitalization, and allow registrants to return home at the end of the day. This provides a greater quality of life for registrants, as well as Medicaid savings for the State.

The Adult Day Health Care Council (ADHCC), an affiliate of LeadingAge New York, respectfully requests that the State provide a significant Medicaid increase to allow ADHC programs to fully reopen and rebuild.

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

LeadingAge New York recommends the development of a funding program to support Resident Assistant positions in subsidized and income-restricted independent rental housing for low-income seniors. With a commitment of $10M over five years, grants could 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. This low-cost approach could result in significant return on investment in Medicaid savings, keep people living in the community, and reduce pressure on more expensive staff-intensive services.

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 could 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 a State-share Medicaid **savings of at least $2.25 for every dollar invested**, 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.[6] 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.

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

LeadingAge New York fully supports increasing funding for the State Office for the Aging's Expanded In-home Services for the Elderly (EISEP) and Community Services for the Elderly (CSE) programs to deliver personal care services and everyday supports to aging New Yorkers. Additional monies should be added to address increases in the home care minimum wage and waiting lists that continue to occur due to historic underfunding and workforce challenges exacerbated by the pandemic.

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[6] 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.

We also support continued funding for both traditional and Neighborhood Naturally Occurring Retirement Communities (N/NORCs), as well as efforts to grow the program upstate and expand the definition of Neighborhood NORC so that more communities can utilize this valuable program.

d. Adult Care Facilities and Assisted Living

Assisted living (AL) and ACF providers offer support and assistance in a homelike setting for approximately 36,000 New Yorkers, 55 percent of whom are over the age of 80. Given the homelike nature of these settings, they are a popular option with consumers, and we anticipate that the demand for these services will only grow in the years to come. Notably, according to AARP's 2023 State Scorecard Report, New York is the *worst in the nation* on the AL supply metric.[7]

ACF/AL providers face the same workforce shortages plaguing other parts of LTC and are still recovering from the strain of the pandemic. New York's senior living providers have incurred hundreds of millions of dollars in unbudgeted pandemic-related expenses, some of which still continue today. Sharply rising costs further exacerbate these challenges, and this sector was largely overlooked with recent years' budget investments. While other sectors received State pandemic relief funding, ACF/AL providers received none. Staff in approximately 400 of the 541 ACF/AL settings were ineligible for the health care worker bonus, nor were they eligible for funding to adjust to rising minimum wages.

With this as a backdrop, it is alarming that rather than investing in this critical LTC option, the Executive Budget proposes cuts in longstanding programs that serve low-income older adults and does nothing to support the growing need for these 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/AL services, particularly for low-income older adults.

- ***Invest in and grow the ALP, rather than impose Medicaid cuts.***

The ALP is the only Medicaid-funded AL option in the state. It serves people who require a nursing home level of care, but do not need ongoing skilled services, at approximately half of the nursing home Medicaid rate. Like other LTC Medicaid providers, the ALP Medicaid rate had not had a standard trend factor increase for 15 years and even had a rate cut during the pandemic. While the 6.5 percent rate increase in last year's budget was helpful, it did not make up for the chronic underfunding, sharply rising costs, pandemic-related expenses, and costs associated with the recruitment and retention of workers.

The need for ALP services is only growing, particularly as nursing homes close or take beds offline and individuals in need of 24/7 services seek more homelike alternatives to nursing

[7]AARP 2023 State Scorecard Report, available at https://ltsschoices.aarp.org/scorecard-report/2023/states/new-york.

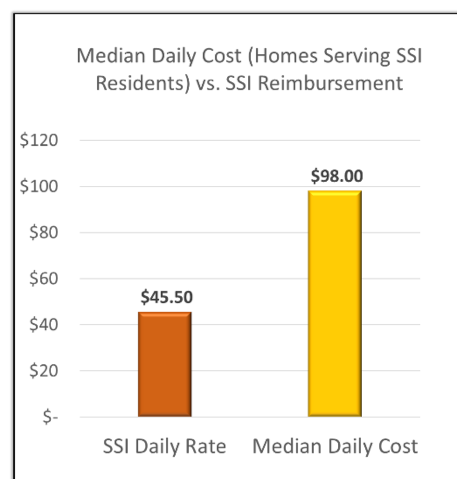
homes. While we await the State's development of a needs-based application process for any new ALP beds by 2025, there is currently no way to increase the number of beds in the state. A simple step the State can take in this year's budget is to provide existing ALPs an expedited process to expand their beds by nine or fewer if they can do so without requiring construction, as had been done in the 2018-19 budget.

Additionally, the Legislature must reject any cuts to the ALP Medicaid rate. Rather, the rate must be *increased* to recognize these growing costs over 15 years, and the base year for the ALP Medicaid rate must be updated to ensure that it reflects current costs moving forward, as outlined in *A.7553 (Paulin)/S.7248 (Cooney)*.

- ***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. Approximately 12,000 ACF residents rely on SSI statewide. SSI, together with the State Supplement Program (SSP), pays ACFs **$45.50** per resident 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 in the SSP since 2007. There is no way to increase wages or compensation incentives to compete for staff in this current environment on such inadequate reimbursement. 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.

This chronic underpayment threatens access to this level of care for low-income adults. Since 2017, 59 ACFs 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 at least $1M 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.

- ***Restore and consolidate EQUAL funding.***

The Governor's proposal cuts the Enhancing the Quality of Adult Living (EQUAL) program, historically funded at $6.5M. EQUAL supports quality of life initiatives for low-income residents

of ACFs. As discussed above, these ACFs are woefully underpaid for the services they provide and are struggling to keep their doors open.

The Legislature must restore the EQUAL program and funding at $6.5M and restore it to a consolidated pool of funds. Changes to the program in 2020 that 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 EQUAL 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 ALR 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 2025. 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. More time is needed to ensure careful thought to craft measures that yield meaningful information for the consumer, reported in a way that enables valid comparison. Engagement with provider representatives such as LeadingAge New York on this effort, as outlined in *A.5790-A (Paulin)*, is also essential. Providers will then need more time to develop data collection methods before reporting begins.

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. As such, we recommend modifications to this proposal.

- ***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, as outlined in *A.5670 (Solages)/S.5471 (Rivera).* The EALR is the only ACF/AL setting that is permitted by the State to allow 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.

- ***Accept the Governor's proposal to make the SNALR Voucher Program permanent, and expand it.***

We support the Governor's proposal to make the Special Needs Assisted Living Voucher Demonstration Program for Persons with Dementia permanent. This program is designed to financially assist individuals with dementia or Alzheimer's disease residing in SNALRs for at least one year who are at risk of requiring nursing home placement due to dwindling resources. The program provides stability and continuity of care by preventing an unnecessary transfer. In addition, the program is designed to provide support *before* someone becomes Medicaid-eligible. Currently, the program can support up to 200 vouchers to support eligible residents by subsidizing up to 75 percent of their monthly payments. Since July, no new applicants have been accepted into the program, and there is a waiting list. Meanwhile, we anticipate the number of people with Alzheimer's disease to climb. Thus, in addition to making the program permanent, it should be expanded to address the waiting list and meet future demand. This program can prevent the need for someone to transition to a nursing home and become reliant on Medicaid.

e. Continuing Care Retirement Communities

The Executive Budget misses a no-cost opportunity to promote CCRCs, an innovative model that encourages seniors to invest their resources in their care and housing needs rather than divest their assets to qualify for Medicaid-funded services. CCRCs are economic drivers in their communities, and the model encourages people with resources to stay in the state.

CCRCs provide a full range of services including independent housing, ACF/AL, and nursing home care to residents in a campus setting as their needs change. Despite the benefits of this model, State oversight has actually become a barrier to the efficient operation of CCRCs, as well as the expansion and development of new CCRCs. To date, there are only 14 CCRCs in New York State, as compared to neighboring states: Pennsylvania (197), New Jersey (27), and Massachusetts (31).

A.7742 (Paulin)/S.7483 (Cleare) would address these problems, while maintaining vital resident protections. By consolidating oversight of CCRCs into a single State agency, DOH, it would expedite some of the oversight functions, enabling CCRCs to operate more nimbly and be responsive to consumer needs and preferences. It would also change the CCRC Council to an advisory role, consistent with nearly all other councils in the health space. This council has consistently had difficulty filling open seats and achieving a quorum, which is necessary to approve establishments and most operational changes. In its current state, it threatens to bring critical projects to a standstill.

Including the language in *A.7742 (Paulin)/S.7483 (Cleare)* in this year's budget is a no-cost way to promote the success of this model, to the benefit of current and future CCRC residents, as well as to the State.

IV. WORKFORCE RECOMMENDATIONS

In addition to the workforce initiative proposals noted above, we recommend the following to support preservation and further development of the LTC workforce:

- ***Support the Interstate Nurse and Physician Licensure Compact proposals.***

We need to make it easier for more professionals to work in New York, particularly if living in border states. This can be done with safeguards in place that protect the integrity of licensure.

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

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. The Nurses Across New York student loan repayment program can be strengthened to incentivize nurses to work in LTC. We urge the Legislature to modify the legislation supporting this program to explicitly identify LTC as an underserved population for the purposes of eligibility.

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

LTC providers are held to an overwhelming array of administrative requirements without any recognition of the additional personnel they require, their impact on residents and patients, and the costs they impose. In recent years, laws have been passed imposing requirements that virtually 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, 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 Health Electronic Response Data System (HERDS) reporting, which has been a requirement for nursing homes and ACFs for nearly **four years**. 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 and reporting that is already required to be submitted to local health departments.

CONCLUSION

At a time when New York's older adults need them most, the Executive Budget fails to make needed investments, and in fact proposes disproportionate cuts, in the services older adults rely on. We are already contending with the consequences of decisions made year after year to underfund LTC services. 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. As the primary payer of LTC services in the state, New York bears the responsibility to adequately fund these services. In order to ensure that accessible, high-quality services are available to older adults and people with disabilities now and in the future, this year's budget must make significant investments, not cuts. Failing to do so will have dire consequences.

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.