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2015-16 Health/Medicaid Testimony

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Introduction

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the health and Medicaid aspects of the SFY 2015-16 Executive Budget. LeadingAge NY represents over 400 not-for-profit and public providers of long term and post-acute care (LTPAC), aging services and senior housing, as well as provider-sponsored managed long term care (MLTC) plans.

This testimony addresses Executive Budget proposals that apply across the continuum of Long-term/Post-acute Care (LTPAC), aging and Managed Long Term Care (MLTC) services, as well as those that would affect individual types of providers and managed care plans. While LeadingAge NY supports many of these proposals, we strongly encourage the Legislature to work with the Executive branch to ensure needed investments are made in LTPAC, aging and housing services, as well as overseeing the transition to managed care and delivery system reform. With new payment arrangements and models of care continuously developing, the State must ensure that consumers continue to have access to the high quality services and dedication to local communities that not-for-profit, mission-driven providers have delivered for years. If the concerns of these providers are left unaddressed, efforts to redesign the Medicaid program will be derailed, jeopardizing the well-being of elderly New Yorkers and people with disabilities.

LeadingAge NY's members are playing a critical role in new models of care and payment being advanced by the State and federal governments, such as the Fully-Integrated Duals Advantage (FIDA) Program, Delivery System Reform Incentive Payment (DSRIP) Program and managed care for medically-complex beneficiaries. These providers are actively managing chronic conditions, providing nursing and rehabilitation therapies after an acute care episode and on a long-term basis, and providing assistance with activities of daily living and social supports for frail elderly and medically-complex patients in community-based and facility settings. As the State moves to allocate billions of dollars under DSRIP to transform the delivery system, it is critical to recognize the important role played by aging service providers that furnish long term and post-acute care and social supports to a high-risk population. Investment in these services is essential to the success of efforts to reduce avoidable hospitalizations and ensure better health and better care at a lower overall cost.

Cross-Continuum Initiatives

Value-based Payment (VBP)

The Executive Budget confers broad authority on the Commissioner of Health to promulgate regulations governing VBP arrangements between managed care plans, providers and Performing Provider Systems (PPSs) participating in the DSRIP Program. Under the State's Medicaid Section 1115 waiver and DSRIP, 90 percent of payments to providers by Medicaid managed care plans must be made through a value-based methodology within five years. Similarly, the State's FIDA Program requires the implementation of non-fee-for-service provider reimbursement methodologies. DOH intends to submit a plan for adopting VBP arrangements to the Centers for Medicaid & Medicaid Services (CMS) and to receive CMS approval by April 1, 2015. While LeadingAge NY supports the concept of paying for value rather than volume and rewarding providers for quality and outcomes, there are significant concerns about the pace and scope of the planned shift to VBP in New York, including:

- ***Assumption of Financial Risk:*** Most of the VBP arrangements under consideration involve the assumption of some level of risk for the cost of care delivered by providers. Many, if not most,

LTPAC providers are unprepared to evaluate and manage the financial risk associated with these arrangements. LTPAC providers in New York are already grappling with dislocating changes in their payer mix, administrative processes and cash flow as a result of the roll-out of mandatory managed care for the patients they serve. Adding risk-based payment arrangements to the array of changes under way may irreversibly destabilize essential providers and jeopardize access to services.

- ***Information Technology Infrastructure:*** All of the VBP arrangements under consideration require robust information systems to collect, analyze and share clinical and financial information electronically. Providers will not be able to meaningfully participate in DSRIP and in VBP without electronic health records and capacity to engage in electronic health information exchange. Robust financial and clinical management software that collects and analyzes utilization, cost and quality data and supports predictive modeling will be essential to managing financial risk. However, LTPAC providers have been left behind in meaningful use incentives and capital financing programs aimed at promoting deployment of interoperable health information technology; many lack the necessary capital to invest in these systems. Without this basic infrastructure in place, many LTPAC providers will be unable to succeed in DSRIP Performing Provider Systems and risk-based payment arrangements.

- ***Timeframes for Development and Implementation of VBP:*** LeadingAge NY believes that implementing VBP arrangements will require significant time for managed care plans and providers to develop and operationalize the required contracting, quality reporting/ measurement, training and billing systems. Developing validated data sources and outcome measurements are essential for providers and plans to report and analyze data in a consistent manner, and will take time. Yet, the State is expecting to achieve a 90 percent rate of risk-based payment in only five years.

  Recommendation: *Implementation of value-based payment in Medicaid should be transparent and allow meaningfully engagement with stakeholders. The compressed time frame for CMS approval threatens to undermine transparency and stakeholder input. Further, the VBP arrangements permitted under DSRIP should include those that reward quality and outcomes, without requiring the assumption of downside financial risk for the cost of care. To support successful implementation of DSRIP and value-based payments, the State should make available dedicated funding for investment in health information technology and health information exchange in the LTPAC sector. Payment arrangements that involve downside financial risk should be phased in very gradually, and only when providers have the necessary expertise and infrastructure to manage risk, and after the State has put in place adequate risk mitigation mechanisms.*

Meeting Capital Needs in LTPAC

Last year's enacted budget created a $1.2 billion Capital Restructuring Financing Program (CRFP) designed to assist health care providers with the capital investments needed to reconfigure the State's delivery system. However, it became apparent that the capital needs associated with advancing the DSRIP program goals were overwhelming the available funding. LeadingAge NY member nursing homes, home care agencies and assisted living providers seeking to participate in hospital-led DSRIP Performing Provider Systems are also reporting great difficulty obtaining access to the CRFP funds for needed facility modernization, service reconfiguration and health information technology.

The Executive Budget proposes $1.4 billion in additional capital funding aimed at shoring up acute care services in Brooklyn; constructing a new hospital in Utica; and restructuring debt and funding capital projects in rural communities.

Recommendation: *LTPAC providers are in major need of capital funds to upgrade aging physical plants, rightsize/restructure their existing services, add new services and deploy electronic medical records and other technologies to be able to meaningfully participate in DSRIP and managed care initiatives. A portion of the $1.4 billion in additional capital funding should be specifically earmarked for these purposes.*

Universal Assessment System-NY (UAS)

New York recently made the transition from the Semi-Annual Assessment of Members (SAAM) to the UAS. This patient evaluation tool is used by the State's Medicaid enrollment broker, NY Medicaid Choice, and MLTC plans. The UAS determines the patient's clinical qualification for coverage; it drives the development of the patient's care plan, and it further drives the risk scores that are used to set MLTC reimbursement rates.

The UAS was implemented on Oct. 1, 2013, in the last quarter of a managed care plan year. The calendar year forms the basis of the plan year and the risk scores during the plan year drive reimbursement to MLTC plans for a subsequent period. There are two fundamental concerns: (1) there is not a one-to-one correlation between a SAAM and UAS score; and (2) as with any type of patient evaluation tool, there is a learning curve that evaluators need to develop confidence and expertise in its use. These are serious concerns for the MLTC plans, which are facing significant changes in the new programs they are operating (e.g., FIDA and HARP), along with changing and expanding populations and benefits they are expected to manage (i.e. the nursing home transition and other new mandatory populations) need consistency in the basic factors and assumptions that determine patient referrals and care planning and drive their risk scores. The Department of Health (DOH) has a workgroup in place to address these very concerns. LeadingAge NY offered recommendations to the workgroup to include an incremental phase in of UAS scores for rate setting, and maintaining consistency in the basic weights and predictors used to develop risk scores.

MLTC plans have also had to invest significant resources and time in managing the transition to the UAS. This includes upgrading computer systems, staff training time and additional nursing hours to complete evaluations. From the patient's perspective, the transition to the UAS and the current phase-in of a new "Conflict Free Evaluation and Enrollment Center (CFEEC)" has created a situation in which individuals are being subjected to multiple UAS evaluations. These evaluations are quite lengthy with a single patient evaluation and interview taking up to two hours to complete. An individual enrolling in Medicaid managed care may be subjected to multiple evaluation sessions between the CFEEC, the MLTC and the home health agency.

Recommendations: *The State should: (1) ensure consistency and reliability in the transition from the SAAM to the UAS; (2) quantify the cost of the transition and recognize these costs in the MLTC rates; and (3) examine the current process for completing the UAS in order to minimize the need for individuals to be subjected to multiple evaluation sessions.*

Support for Non-Profits

The Executive Budget includes proposals aimed at supporting community-based non-profit organizations with capital and other assistance:

- ***Nonprofit Infrastructure Capital Investment Program***: This program would provide up to $50 million for capital projects that will improve the quality, efficiency and accessibility of human services organizations providing direct services to New Yorkers. Eligible investments would include renovations or expansions of space used for services; technology to support electronic records, data analysis and/or confidentiality; modifications to provide for sustainable, energy-efficient spaces; and renovations to promote accessibility. The program would be funded through the issuance of bonds by the Dormitory Authority and the Urban Development Corporation.

- ***Office of Faith-Based Community Services:*** This new office would be authorized to assist community and faith-based organizations in providing education, health, workforce training, food programs and social services to communities. The Office will also work with the Empire State Development Corporation to encourage the development of faith-based businesses.

  Recommendation: *The Legislature should support these initiatives and take into account the needs of elderly and disabled individuals, as well as affordable housing initiatives for seniors, when outlining grant and program criteria and eligible organizations.*

Managed Care

The implementation of mandatory Medicaid managed care for the LTPAC population continues at a rapid pace throughout the State as new services, populations and geographic areas are brought in to the program. A foundation of Medicaid Redesign is the concept of "care management for all." LeadingAge NY's not-for-profit, provider-based MLTC plan members have indeed stepped up to the plate, and, arguably are playing the most critical role in implementing the current reforms. In playing such an integral part of the process, MLTC plan sponsors are facing their own set of challenges that need to be recognized and addressed by lawmakers. Unfortunately, the Executive Budget is silent or only marginally addresses these matters. To fully meet the goals of the MRT, lawmakers need to fully recognize the challenges facing managed care plans; the critical and invaluable role these plans are playing in the current transition; and the need to fully address these concerns.

- ***Timing and Transitioning:*** The State continues to pursue very aggressive timeframes for the transition to mandatory managed care, which often leads to plans having to function with an unacceptable level of uncertainty in their business operations. Planning for the future in this environment becomes extremely difficult because MLTC plans are unsure of how to allocate resources. The State itself has often had to backtrack on published deadlines, often due to the lack of federal approvals. By delaying the timeline, major disruptions are caused for both plans and service providers, and may undermine the credibility of the process.

  Recommendation: *The State should work more closely with the Plans and adjust time frames to be more realistic in terms of what the Plans determine to be feasible.*

- ***Administrative and Reporting:*** Additional administrative and reporting requirements have been added to the plans at a time when every available resource should be dedicated to meeting the needs of a rapid expansion. The new UAS patient assessment tool is a good example. It must be

kept in mind that there is no additional funding from Medicaid to help plans with the additional requirements.

Recommendation: *Medicaid must seek new ways to reduce the administrative burden on MLTC plans as the current situation demands that resources be committed to managing the transition and expansion of managed care services.*

- ***Rate Adequacy:*** Rate adequacy remains an ongoing concern. Both the home health aide wage parity requirements and the requirement that the MLTC plans enroll new, higher risk cohorts of patients have created a new and very real concern regarding the adequacy of current managed care plan rates. Perhaps most concerning for plans is the incorporation of the nursing home benefit and population into managed care effective Feb. 1, 2015. This is a new, large and expensive cohort of individuals for the plans to incorporate, and current premiums fail to cover even half the cost of a nursing stay.

  MLTC plans are also very uncertain regarding the rates set out for the FIDA demonstration – a program that combines the funding and services offered under both the Medicaid and Medicare programs – in the NYC area. Plans are once again being asked to take on a whole new cost structure related to the Medicare coverage, with significant uncertainty regarding rates and significant delays in updating rates to reflect those costs. Plans are also frustrated by the need for more transparency in the rates setting process. The major factor in determining rate adjustments from one plan year to the next are the underlying assumptions made by the State's subcontracted actuary (i.e., Mercer). Often these assumptions are unclear or unknown to the plans until rates are actually promulgated.

  Recommendation: *Medicaid needs to ensure that timely and actuarially sound rate updates are being provided, so that the rates reflect the increased risk, wage parity and patient assessment issues that are currently driving significant operating cost increases for providers. DOH and its subcontractor need to be as transparent as possible in their calculation, and seek a more collaborative approach in advance of actually publishing rates.*

- ***Transportation Carve-out***: The Executive Budget includes an administrative proposal to eliminate transportation from the MLTC benefit package and attributes a $14.7 million savings to the action. The savings would grow to $29.4 million in SFY 2016-17. The savings would presumably be generated from reductions in MLTC premiums. The proposal is not reflected in the legislation accompanying the budget, so plans have limited information on this proposal.

  It is unclear why the State wants to move in this direction. It is not consistent with the movement towards more coordinated care. Plans feel strongly that they want to maintain control and coordination of transporting their enrollees. Including transportation in the benefit package gives providers an added eye towards medical necessity and assists with coordination of care.

  Recommendation: *The Legislature should reject this proposal and restore the associated cut to ensure that rates are adequate, and plans are able to appropriately coordinate the care of their enrollees.*

Nursing Home Services

All of the organizations involved in the State's seismic health care system transformation, from providers to managed care plans, are facing numerous financial challenges and uncertainties. With the dawn of the FIDA Program, the transition of the nursing home population and benefit into managed care, and the planned move to value-based payments, the coming year will be an especially challenging one for nursing home providers. Half of the New York's nursing homes are already losing money. The last time Medicaid rates were adjusted for inflation was in 2007. With the State relying on nursing homes to play a key role in reducing hospital use, the financial stability of these providers is of major concern.

- ***Two percent Cut:*** In 2011, due to State fiscal pressures, the State implemented a two percent across-the-board payment cut to Medicaid providers. While LeadingAge NY is grateful that the Governor proposed, and that the Legislature passed, the restoration of this two percent cut in last year's State Budget, the restoration, which was to be effective April 1, 2014, has yet to be implemented. For nursing homes, the cut was implemented as a 0.8 percent increase in the cash receipts assessment, a strategy that yielded the same amount of savings to the State as a two percent payment reduction. While the State retained its authority to continue the 0.8 percent assessment, it indicated its intent to reinvest the proceeds into nursing home services.

  Recommendation: *With the end of the State fiscal year approaching, it is crucial to ensure that the proceeds from the 0.8 percent assessment for SFY 2014-15 be reinvested in nursing home care. The State should apply for any necessary federal approvals to accomplish this without delay.*

- ***Universal Settlement of Litigation and Appeals:*** Equally important is the inclusion of any legislation and appropriation necessary to facilitate the long awaited Universal Settlement of Litigation and Appeals. This agreement – which would absolve the State from having to process thousands of outstanding Medicaid rate appeals and settle most pending Medicaid rate litigation in exchange for $170 million in annual payments for five years – currently enjoys support from the vast majority of nursing homes.

  Recommendation: *The State should commit to providers that this five-year obligation is met, so providers can confidently enter into legally binding agreements.*

- ***Vital Access Provider (VAP) program:*** The VAP program is a key source of funding for health care organizations undergoing transformation to adjust to the State's new health care environment and the needs of their communities. This funding is a lifeline for hospitals, nursing homes, home care agencies and clinics, and LeadingAge NY is pleased that the Executive has proposed $290 million for this program. This year's budget proposal would set aside $10 million for hospitals, nursing homes and clinics serving rural and isolated areas, a provision LeadingAge NY fully supports. The proposal also looks to increase the VAP funding reserved for Critical Access Hospitals from $5 to $7.5 million. In 2013, funding from the Financially Disadvantaged Nursing Home program, which provided $30 million annually to vulnerable nursing homes, was transferred into the VAP program. This funding was essential to many homes, and the transfer was made contingent on a minimum of $30 million in VAP funding being earmarked for nursing homes annually.

Recommendation: *LeadingAge NY supports increasing funding for Critical Access Hospitals, but urges that nursing homes also be eligible for this critical access set-aside funding. Given the State's initiatives to reduce hospitalizations, nursing homes are playing an increasingly important role in this type of care and should be included in this set-aside. In addition, the $30 million provision to vulnerable nursing homes should be memorialized in legislation along with the other specific VAP set-asides.*

- ***Shared Savings Programs:*** A nursing home capital workgroup comprised of DOH staff and provider representatives has been working on various capital financing and reimbursement issues for two years. The Energy Efficiency and Emergency Preparedness Initiative in the Executive Budget grew out of the efforts of the workgroup, and LeadingAge NY fully supports this proposal. One important initiative developed by the workgroup, which is missing from the budget proposal, is a shared savings incentive to encourage refinancing of facility debt.

  Recommendation: *State lawmakers should implement a shared savings incentive to encourage refinancing of nursing home capital debt. In those cases where savings can be achieved through refinancing, nursing homes should be permitted to share in the savings that accrue from the transactions. The workgroup developed a number of specific provisions of such a program that LeadingAge NY would be pleased to discuss further with the Legislature.*

Home and Community-based Services (HCBS)

Home and community-based services are vitally important in keeping seniors in their homes and communities for a longer period of time, and must be considered a key component during the transition to managed care. Unfortunately, more so than any other provider group, home care agencies continue to struggle with an untenable level of operational uncertainty as they experience the effect of mandatory MLTC enrollment of many of their patients. In addition, across-the-board cuts, provider taxes, elimination of inflation adjustments and unfunded mandates, which would be continued from previous budgets, are exacerbating the operational and financial uncertainty facing many of the State's HCBS providers.

- ***MLTC Enrollment***: Mandatory MLTC enrollment of the Medicaid HCBS population has put several providers in an extremely difficult financial situation. Some home health agencies that have signed contracts with MLTC plans continue to struggle with reimbursement issues, while many continue to seek home care-managed care regulatory relief and clarity on roles and responsibilities within their MLTC contracts. In many instances, the result of these pressures is staff layoffs. With staff unable to care for patients in the community, patients are entering into more expensive levels of care at a higher cost to the State. This goes against the State's policy direction of reducing avoidable hospitalizations and controlling Medicaid costs. In addition, more needs to be done to assist home care agencies and managed care plans to navigate issues like doctor's orders, utilizing telehealth, supervision of home care cases, supervision of home health aides, and safe discharges.

  Recommendation: *State agencies should offer needed guidance and regulatory relief in order for providers to efficiently manage operations. Absent regulatory relief and clarification to reduce over-lapping and duplicative responsibilities, providers continue to be at risk of having to reduce their staff, which is likely to undermine the transition to managed care and the goals of the Olmstead decision. The Legislature should follow-up on the recommendations of the Home and*

Community Based Care workgroup that was appointed in the past two budgets to help to ensure a smoother transition is managed care.

- ***Advanced Home Health Aide:*** LeadingAge NY appreciates that the Executive Budget again includes a proposal for an Advanced Home Health Aide (AHHA). Under this proposal, an AHHA would be authorized to provide advanced tasks under the supervision of a registered nurse and pursuant to an authorized practitioner's ordered care. This new role could potentially advance the field of direct care workers and increase efficiencies.

  Recommendation: *The Legislature should continue to support the AHHA proposal, but take into consideration the cost in relation to reimbursable expenses; geography; the nurse shortage; and settings in which the AHHA may work. Such recommendations are currently being designed by a DOH AHHA workgroup, on which LeadingAge NY is represented. In addition, LeadingAge NY recommends that the resulting statute or DOH regulations/policy should explicitly note that the AHHA will be available in ACF and assisted living settings.*

- ***Transportation Needs***: LeadingAge NY supports the Executive Budget proposal for funding enhancements for medical transportation, increased funding for caregiver respite services, the Olmstead Mobility Management Pilot and a rate increase for services provided through the Traumatic Brain Injury and the Nursing Home Transition and Diversion Medicaid waivers. The continued investment in the NY Connects program by replacing federal Balancing Incentive Program funds with State funding, will continue the work of providing additional supports to seniors and those with a disability to remain at home. LeadingAge NY also supports exploring the creation of the Office of Community Living. Improving service delivery and reducing fragmentation and silos across State agencies has the potential of again supporting the State's Olmstead plan.

  Recommendation: *The Legislature should continue to support and increase funding for services that are vital to helping seniors and individuals with a disability remain at home. For example, it is imperative to increase funding for programs such as Community Services for the Elderly and the Expanded In-Home Services for the Elderly Program which face growing demands and stagnant funding levels.*

- ***Certified Home Health Agency (CHHA) Episodic Payment System (EPS)***: LeadingAge NY is concerned with the steep cuts facing CHHAs as a result of rebasing the CHHA EPS using the 2013 base year. DOH has projected that updating the base year from 2009 to 2013 will result in a $30 million annual reduction in Medicaid reimbursement for CHHAs. The changes that will have to be made with rebasing calculations and updating billing systems to a new CHHA EPS base price will require time to reconfigure systems. The new rates are to be effective April 2015, which is intended to conform to existing statutory requirement of rebasing at least every three years.

  Recommendation: *The Legislature should inquire into the $30 million negative impact of rebasing and the underlying reasons for it. Many new CHHAs have been established in recent years to accommodate the increased demand for this service resulting from mandatory enrollment in Medicaid managed care plans. Significantly lower CHHA reimbursement rates could seriously undermine the financial viability of these newer providers and even more well-established agencies. Minimally, the rebasing should allow providers an opportunity to reconfigure their billing systems and to analyze the potential impact this may have on cash flow once more detail is forthcoming from DOH.*

Adult Care Facilities (ACFs) and the Assisted Living Program (ALP)

Adult care and assisted living facilities provide an option for seniors who can't remain in their own home, and do not need the continual skilled nursing services of a nursing home. These services are less expensive and more affordable than nursing home care, and will become increasingly important as the State seeks to keep people out of less institutionalized settings. Ironically, the Executive Budget proposes significant cuts to these cost-effective services, which will undermine the ability for low-income seniors to be served in ACF and assisted living settings, at the very time when we need to make it *more* feasible.

- ***Enhancing the Quality of Adult Living (EQUAL):*** Unfortunately, the Executive budget proposal repeals the statute that created the EQUAL program for ACFs, and eliminates the funding for the program. Historically, this program is funded at $6.9 million, but was funded at $6.5 million last year. EQUAL is made available to ACFs that serve recipients of Supplemental Security Income (SSI) or Safety Net Assistance; a population that is generally Medicaid-eligible. The SSI rate does not pay what it costs to provide the package of services that ACFs and assisted living provide to all of the residents on a daily basis. Eliminating the EQUAL program has a significant impact on over 250 facilities statewide; crippling their ability to keep Medicaid-eligible seniors in the most integrated setting possible.

  Recommendation: *The Legislature should reinstate the EQUAL statute and re-appropriate $6.5 million in order for the EQUAL program to continue to provide financial support to ACFs that serve low income seniors.*

- ***Enriched Housing Subsidy:*** The Executive budget does not include a direct appropriation for the Enriched Housing Subsidy. Instead, this program is lumped among 41 public health programs that would be divided into five pools and cut by 15 percent. Given the construct of this aggregate appropriation, it is impossible to know what the total cut to this subsidy would be. The current program pays $115 per month per SSI recipient to certified operators of not-for-profit certified enriched housing programs. The program has historically been funded at $502,900, though it was reduced to $475,000 last year.

  Recommendation: *LeadingAge NY urges the Legislature to reject this approach, and rather recommend the specific line item of each program, with the Enriched Housing Subsidy funded at a minimum of last year's level of $475,000.*

- ***Supplemental Security Income (SSI) Congregate Level 3 Rate:*** The State has not increased the SSI rate in seven years, leaving the State's ACFs who serve SSI-level residents to operate without adequate funding. Many facilities that serve SSI recipients have closed, and the cuts in the Executive budget proposal will make it more difficult for these facilities to serve low-income seniors.

  Recommendation: *To support ACF and assisted living facilities that serve low-income seniors in the most integrated setting possible, LeadingAge NY recommends an increase in the State's SSI Congregate Care Level 3 rate. LeadingAge NY recommends a phased-in approach of a five dollar increase annually over three years to bring the rate up to an adequate level.*

- ***Appropriations and Re-appropriations for ACF Programs:*** Over the past few years, LeadingAge NY has fought for past years' appropriations to be re-appropriated, and funds to be distributed

for programs that support ACFs and the people they serve. The programs include past funds for EQUAL, the SSI Enriched Housing Subsidy and the now defunct QUIP and EnAbLE programs. All of these funding programs support facilities that serve low-income individuals, and aim to improve the quality of life for residents. In addition to prior years' funding that has never been paid out, this year, the Executive Budget proposes only the re-appropriation of $1.7 million of the EnAbLE funding from 2009.

Recommendation: *The Legislature should pay out to ACF operators the approximate owed amount of $11.7 million in past years' funding for the programs mentioned above. Perhaps, for administrative simplicity, the funds can be paid out in another mechanism, rather than reinstating a defunct program.*

- ***Assisted Living Program (ALP) Medicaid Rate***: The ALP, which is the only Medicaid assisted living option in the State, has been struggling with annual budget cuts and increased requirements and costs. The ALP Medicaid rate is based off of the 1983 nursing home rate, which is outdated. At the same time, there is continual confusion over which types of Durable Medical Equipment (DME) and supplies are included in the rate, which has created billing problems, exposure to Office of the Medicaid Inspector General audits and significant time and resources for ALPs, DME providers and DOH. The viability of the ALP is critical as the State moves the final LTPAC populations into mandatory Medicaid managed care.

  Recommendation: *LeadingAge NY proposes that the base year for the ALP Medicaid rate be updated, and that statute is amended to provide greater clarity and simplicity regarding the ALP's financial responsibility. Together, these actions would provide greater predictability, eliminate billing confusion and modernize the ALP as the population moves into MLTC.*

Investing in Affordable Housing

LeadingAge NY applauds the Executive Budget's investment in affordable housing through the House NY program, which provides $42 million to the 44-project Mitchell Lama portfolio. In addition, the Executive budget also allocates $254 million in funding for the MRT supportive housing initiative over the next two years; as well as JP Morgan Settlement funds, which will provide funding to programs serving the elderly, veterans, homeless, mentally ill and those recovering from past Super Storms. These funds would create a significant opportunity to address the growing need for low-income senior housing and support services.

New York State faces a significant and growing gap in the supply of affordable senior housing, as well as long term services and supports, due to the steep growth in the number of senior citizens. LeadingAge NY and the State must work together to ensure that affordable senior housing and the infrastructure needed to support the goals of Medicaid redesign, while enhancing resident quality of life and promoting independence, are included in a final enacted budget.

Recommendation: *The Legislature should support programs that fund capital and supportive services in senior housing to preserve and update existing affordable senior housing properties; provide gap funding for new senior housing construction to include supportive housing building features; and infuse supportive services into existing affordable senior housing. The Legislature should earmark a portion of affordable housing and supportive housing investments for senior housing development.*

Continuing Care Retirement Communities (CCRCs)

While CCRCs are not outlined in the Executive Budget proposal, it is important to know that CCRCs are exceptional models of care. The CCRC combines housing, health care and an insurance component to allow seniors to invest in a community and age in place with dignity, comfort and security. To expand the concept of the CCRC further, the Governor recently approved legislation for a new CCRC service, known as Continuing Care at Home. Effective April 1, this new law will allow seniors who reside in the community in their own homes to access services from their local CCRC.

CCRCs are an overlooked resource in New York. LeadingAge NY is looking to reverse this situation by working with the State to develop a CCRC "revitalization" initiative. In those limited areas of the State that have a CCRC, they are beyond a doubt a powerful economic driver, adding value to the local economy. LeadingAge NY is currently putting together a report that highlights the economic benefits of each CCRC.

In other states, where CCRC development is much more expansive, the consumer has spoken and people are choosing the CCRC option. Unfortunately, here in New York, consumer choice is severely limited to the dozen geographic areas that have a CCRC. However, Pennsylvania, right across the border, has close to 200 CCRCs; thereby enabling seniors to leave New York to access services where there is an abundant supply and an array of options. Unfortunately, we are not just losing seniors to the Sunbelt; we are losing them to neighboring states with just as much snow as we have.

The reason New York lags so far behind in CCRC development is simple, and typical of factors that have limited economic growth in other sectors of our economy, over burdensome regulations and excessive administrative oversight. Even existing CCRCs that are seeking to expand and upgrade services are confronted with bureaucratic hurdles that make it almost impossible to do business. In some cases, CCRCs are confronting bureaucratic delays that have cost millions in terms of penalties and interest payments to banks and developers.

Beyond the problems of developing or upgrading a CCRC in New York, there are ongoing issues of operating in an environment that is over-regulated and ties the hands of operators who would otherwise be seeking to innovate to better meet the needs of their consumers. For example, CCRCs are overseen by not one, but two State agencies (DOH and the Department of Financial Services, creating an incredible amount of over-regulation. Another example is that each element of the CCRC community has to be separately surveyed for compliance by a separate division of DOH. These surveys are often redundant and even sometimes contradictory in their findings.

By exporting our seniors, we are also exporting dollars and economic activity. Seniors are being denied access to a model of service and care delivery that the national experience proves is highly successful. Perhaps cruelest of all is the fact that seniors who chose to stay in New York and do not have access to a CCRC end up following the all too common route of divesting their assets and in the event of needing institutional care, accessing Medicaid benefits.

Recommendations: *LeadingAge NY is seeking a partnership with lawmakers and policymakers to develop a plan to revitalize the CCRC industry in New York, with specific recommendations on how we can make the CCRC a viable option for consumers seeking this alternative for long term housing and care needs. This plan should include specific steps to: (1) encourage capital investments; (2) eliminate unnecessary and overly burdensome oversight and regulatory processes; and (3) eliminate barriers to the development and expansion of CCRCs.*

Conclusion

As this testimony illustrates, there are a number of concerns and unanswered questions relative to how the Executive Budget would affect elderly and disabled New Yorkers, and the not-for-profit and public agencies that serve them. At the same time, there are several proposed initiatives that have the potential to advance population health, improve the patient care experience and reduce the cost of services. LeadingAge NY looks forward to working with the Legislature and Executive on the 2015-16 budget and the State's ongoing reform initiatives. For questions or concerns, please feel free to contact the LeadingAge NY advocacy and policy staff at 518-867-8383.

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