2018-19 Health/Medicaid Testimony

Provided by

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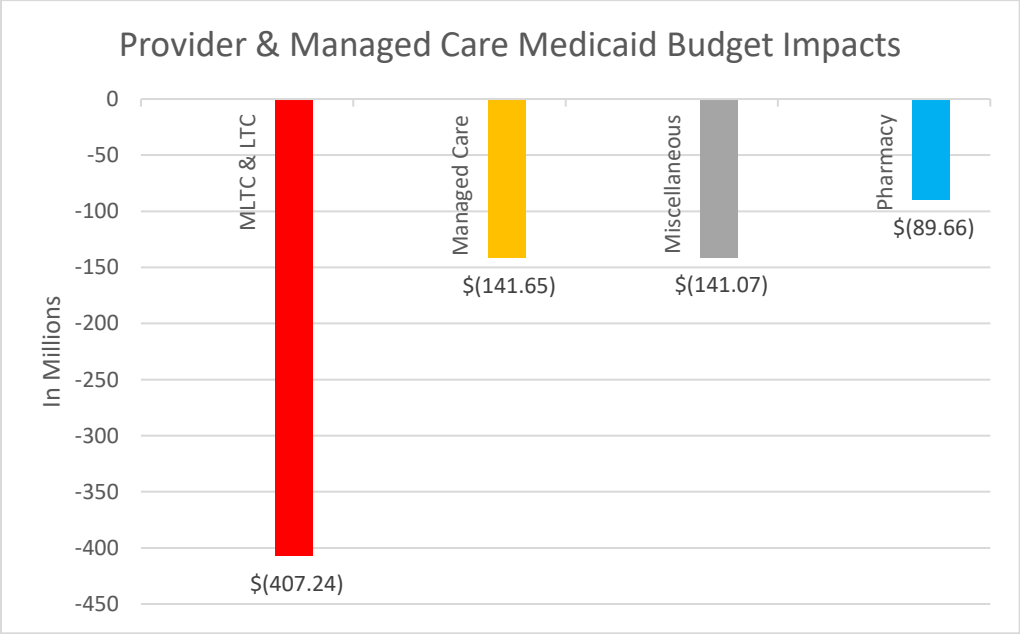
Introduction

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the health, aging, and Medicaid aspects of the SFY 2018-19 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 the Executive Budget proposals that apply across the continuum of LTPAC, aging, and MLTC services, as well as those that would affect specific types of providers and managed care plans.

LTPAC providers and the people they care for continue to shoulder a disproportionate share of budget cuts and to be left behind in many of the reforms and investments that are being provided by the State. New York's population over age 65 is expanding, and consumers are already facing gaps in care and services. The Executive Budget proposals will exacerbate the problem with a $407 million reduction in spending on services and supports for seniors. This reduction comes on top of hundreds of millions of dollars in new and continuing LTPAC cuts over the past several years, as well as new fiscal and operational pressures occasioned by upheaval in Medicaid reimbursement methodologies, home care wage mandates, and the implementation of mandatory managed care enrollment for Medicaid beneficiaries receiving long term care services.



Furthermore, we are disappointed that LTPAC and senior services providers have failed to receive the necessary investments through the State's Delivery System Reform Incentive Payment (DSRIP) program. Under DSRIP, through which the Department of Health (DOH), with federal support, is investing $6.42 billion over five years to transform the health care delivery system, providers across the continuum of care and managed care plans are directed to create collaborations in which they share clinical information electronically and enter into value-based payment arrangements with shared risk. LTPAC providers are expected to participate in this health care transformation, implementing innovative models of care and payment and developing the physical, technical, and administrative infrastructure to

do so. However, the vast majority of funds made available through DSRIP and other State and federal infrastructure programs have continued to fund acute and primary care providers.

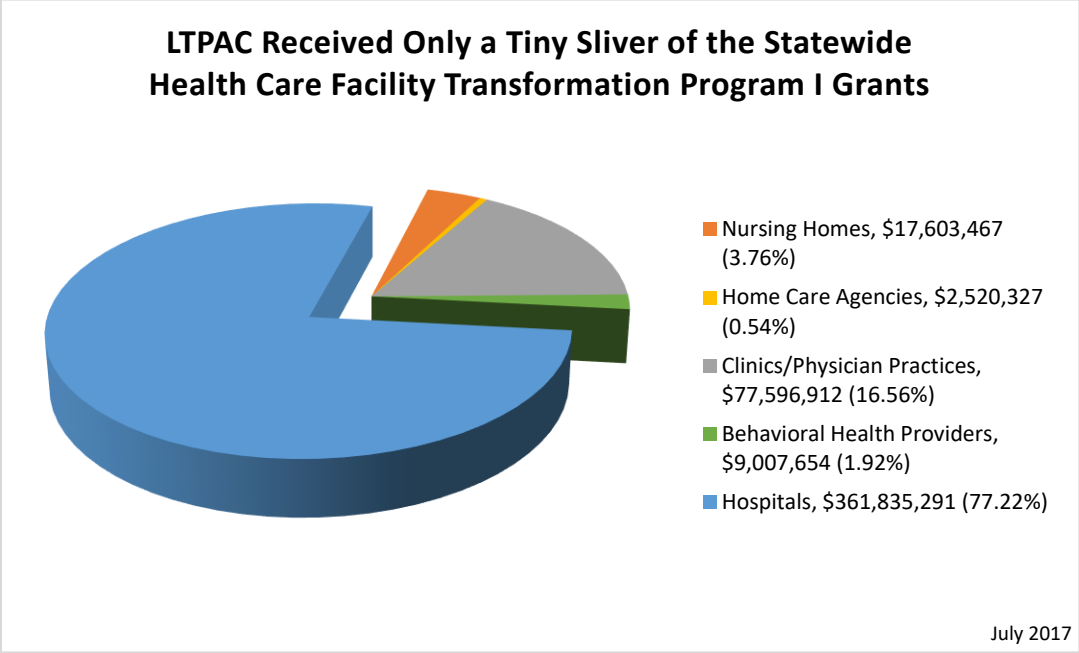
Given this lack of investment in services and supports for seniors, we are concerned about the State's readiness to address the needs of aging Baby Boomers. As the State pushes providers to adapt to new payment arrangements and models of care, it must recognize the important role played by aging service providers that furnish LTPAC and social supports to high-risk populations. 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.

I) Cross-Continuum Initiatives

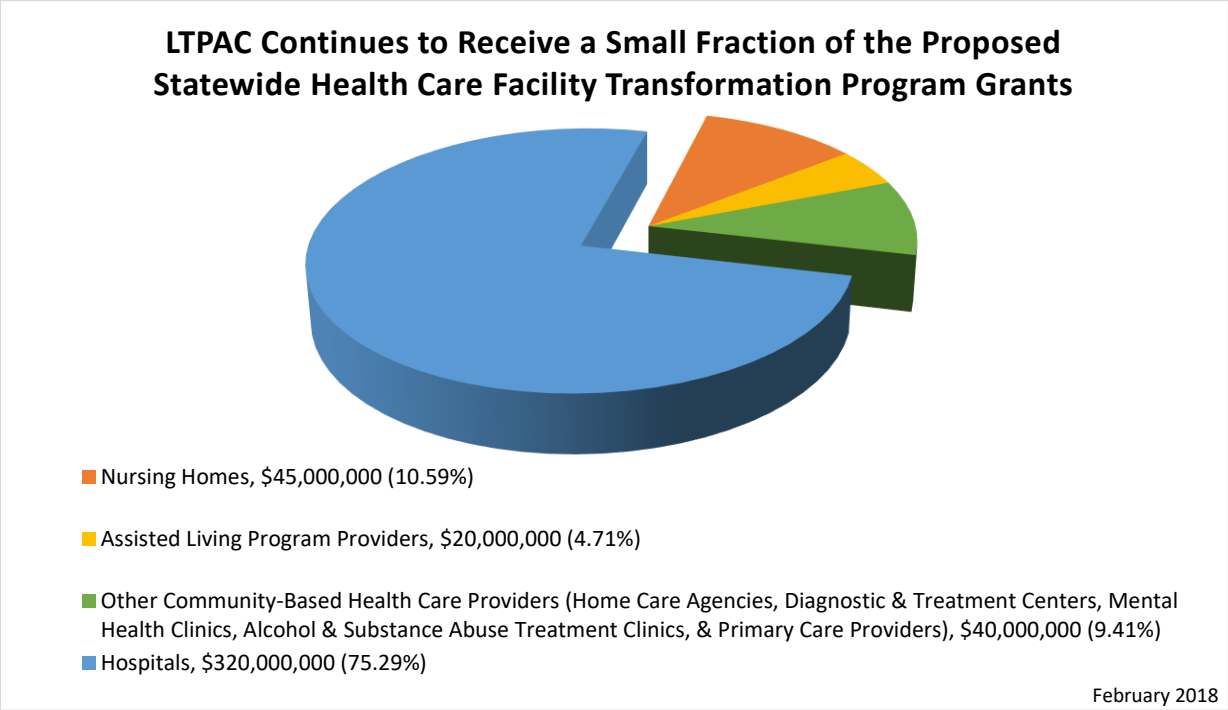
a) Meeting LTPAC Infrastructure Needs

LTPAC providers are in dire need of infrastructure funding to upgrade aging physical plants, rightsize/restructure existing services, add new services, deploy electronic health records and engage in health information exchange, and adopt telehealth and data and analytics platforms in order to be able to meaningfully participate in DSRIP, managed care initiatives, and value-based payment. In spite of these compelling needs, LTPAC providers have not received sufficient State financial support for the critical infrastructure necessary to survive in today's changing delivery system. Funding opportunities available through State grants, DSRIP, and federal meaningful use incentives have overwhelmingly been aimed at acute and primary care providers and sometimes explicitly exclude LTPAC providers.

Our review of the DSRIP Performing Provider System (PPS) funds flow distributions shows that of the more than $1.1 billion flowed since 2015, less than 10 percent has gone to the LTPAC sector. Furthermore, LTPAC providers received only a tiny sliver (less than 5 percent) of the $491 million in Statewide Health Care Facility Transformation Program grants awarded in 2017.



While the Executive Budget does dedicate third round Statewide Health Care Facility Transformation Program funding for nursing homes, Assisted Living Program (ALP) providers, and community-based health care providers, it continues to be only a small fraction of the total amount available.



Recommendation: *Dedicate $150 million of the Governor's $425 million Statewide Health Care Facility Transformation Program investment for LTPAC infrastructure. Furthermore, we urge the Legislature to include language to ensure that the funding is available to all LTPAC providers, including hospice programs.*

b) Workforce Recruitment and Retention

LTPAC providers are experiencing workforce shortages that have led to thousands of authorized home care hours going unfilled and ongoing recruitment and retention challenges for nursing homes, assisted living, and adult care facilities. These shortages have resulted in long waiting lists for community-based services, increases in emergency room (ER) visits and hospitalizations, and reliance on overtime and staffing agencies. LeadingAge NY urges the Legislature to ensure that DSRIP and MLTC workforce funding is distributed to *all* LTPAC sectors, that other available workforce recruitment and retention funds are made available for LTPAC services, and that a comprehensive plan is developed to meet the demand for LTPAC services.

Recommendation: *Support a comprehensive plan to address workforce recruitment and retention and ensure that DSRIP and MLTC workforce funding is distributed to all LTPAC providers.*

c) Managed Long Term Care

MLTC plans now manage and pay for long term care services provided to the majority of the state's most vulnerable individuals. As a result, a large portion of Medicaid revenue to long term care providers

is derived from reimbursement by MLTC plans, many of which are operating at or below the break-even point. Cuts to plan reimbursement, as well as the additional costs of new requirements that are imposed without adequate reimbursement, undermine plan and provider finances and destabilize the long term care delivery system for consumers.

The Executive Budget proposes approximately $325 million in savings related to MLTC in SFY 2018-19, growing to $537 million in SFY 2019-20. This represents a disproportionate share of proposed statewide Medicaid savings and includes several provisions with potentially far-reaching consequences that DOH proposes to implement administratively without formal legislative review. For several of the provisions, the full intent is uncertain, key implementation details seem to be undetermined, and the source of savings estimates are unclear. While DOH has indicated a willingness to engage in some discussion with stakeholders on these provisions, such discussions should be scheduled early in the budget process to allow stakeholders and policymakers to understand the implications of these proposals as fully as possible.

DOH has expressed concern that MLTC enrollment is growing more quickly than projected and has proposed several provisions that would limit MLTC program eligibility to those for whom it is most appropriate. While we agree that MLTC enrollment should be focused on those who could most benefit from its intensive care management, we urge the State to make policy decisions based on analysis of the considerable enrollment, demographic, and utilization information to which it has access to ensure that proposed solutions best target the problem being addressed. The State must also recognize that if efforts to curb enrollment are successful, plans will have fewer, sicker members, which will increase the per-member administrative cost. In such a scenario, proposing cuts to an already capped and inadequate administrative component is especially egregious.

Of special concern to LeadingAge NY are those proposals that would potentially separate consumers from their preferred service providers. Although DOH has indicated that hardship exceptions would be considered to help address care access concerns, proposals to limit the number of Licensed Home Care Services Agencies (LHCSAs) in a plan's network to 10 and to restrict the ability of an individual to receive care after MLTC enrollment from the same provider as they used prior to enrollment are overly restrictive. Similarly, the proposal aimed at achieving social day benefit efficiencies requires additional detail. This proposal removes significant funding from the MLTC premium without making any programmatic change that would reduce costs or drive savings. In fact, a likely consequence of attempted social day service reductions would be an increase in higher-cost levels of care (e.g., increased personal care hours) and appeals and fair hearing requests that would also increase administrative burden and cost.

We appreciate the State's intentions to develop rates prospectively and to make necessary mid-year updates. Historically, this has been a significant challenge, and recent experience with tight implementation deadlines for new initiatives, combined with late or inadequate information and guidance, have been frustrating to plans and providers. Such situations serve to undermine the collaborative relationships that are needed to implement value-based payment arrangements. With the prospect of new services and populations moving into the MLTC benefit package, plans need to receive complete information with sufficient lead time to develop and operationalize any new requirements and enter into or modify network provider contracts. Along with advance rate information, plans need timely and adequate reimbursement to pay for services for their members as well as related administrative activities.

Recommendation: *We ask that the Legislature (1) restore $131.3 million of the $325 million in savings proposed for the MLTC program; (2) require reimbursement for administrative activities commensurate with costs and new mandates; (3) prohibit DOH from setting caps on contracts with network providers without legislative review; (4) block proposed provider marketing and referral bans that interfere with continuity of care; and (5) support serving permanent nursing home residents outside of managed care.*

d) Transportation Carve-Out

LeadingAge NY is concerned with the Executive Budget proposal to carve transportation services out of the MLTC benefit package and rates of payment to adult day health care (ADHC) programs. Many plans and providers have invested in their own vehicles to deliver transportation services, and others have long-standing contracts with high-quality transportation providers. They are able to deliver personally-tailored transportation to the frail elderly and disabled individuals whom they serve. These services may include a driver shoveling snow from a beneficiary's walk to ensure a safe passage from door-to-door or carefully timing a route to drop off a beneficiary when an informal caregiver is available to receive him/her. The State's contractors are often unable to deliver the same level of service, resulting in lengthy waits, stranded clients, and missed medical appointments.

Recommendation: *Preserve the ability of MLTC plans and ADHC programs to manage transportation services for the Medicaid beneficiaries they serve by rejecting this proposal and restoring the associated funding.*

II) Nursing Home Services

This year's Executive Budget proposes several Medicaid savings provisions that would reduce nursing home funding by an estimated $42.6 million annually. Chief among the cuts are proposals to cap case-mix rate increases and reduce capital rates. Homes that serve residents with greater needs require more, not less, funding to support the added costs, and facilities and lenders rely on adequate capital reimbursement to ensure repayment of existing debt and for underwriting new loans.

a) Capital Rate Cut

The Executive Budget would arbitrarily reduce nursing home and hospital annual capital funding by 1 percent. DOH would convene a workgroup to recommend ways to "streamline" Medicaid capital reimbursement to produce savings. The Department would be authorized to implement a $13.4 million annual cut, even if the workgroup does not come up with recommendations. The provision would take effect April 1, 2018 and result in an estimated $7.6 million cut to nursing home funding.

Recommendation: *Reject this proposal. Facilities and lenders rely on adequate capital reimbursement to ensure repayment of existing debt and for underwriting new loans.*

b) Case-Mix Rationalization

This administrative proposal would reduce Medicaid patient acuity adjustments by $15 million annually. DOH and providers would revisit the current case-mix data collection and calculation process to promote accurate reporting and reduce audit findings. In advancing the proposal, DOH expressed concern about continuing acuity growth as well as an increase in case-mix audit findings. This provision would be effective April 1, 2018 and reduce Medicaid reimbursement by $15 million annually.

Recommendation: *Reject this proposal. Facilities that serve residents with greater needs require more, not less, funding to support the added costs.*

c) Low Quality Score Penalty

This Executive Budget proposal would cut Medicaid reimbursement by 2 percent for homes with DOH quality scores in the lowest quintile in the most recent year and bottom two quintiles in the prior year. This would affect nearly 100 homes, but DOH could waive the cut in cases of financial distress. The provision would take effect April 1, 2018 and cut Medicaid reimbursement to impacted homes by $20 million annually.

Recommendation: *Reject this proposal, which will only make improvement more difficult for homes whose scores are related to financial distress.*

d) One Percent Rate Supplement

This administrative proposal would stretch out payment over the next four fiscal years of retroactive Medicaid rate supplements already owed to nursing homes. The rate supplement would make nursing homes whole for an unreimbursed 0.8 percent tax they paid during the period 2014-17, which was implemented in lieu of a 2 percent across-the-board cut imposed on most Medicaid providers. For other provider types, that 2 percent cut was eliminated April 1, 2014, but nursing homes have continued to pay the tax. If this proposal is adopted and approved by the Centers for Medicare and Medicaid Services (CMS), the State would pay one year of the retroactive funding increase in each of the next four years.

Recommendation: *Support but modify this proposal to include an agreement that DOH develop regulations and pursue CMS approval in a timely way.*

e) Fee-for-Service Medicaid for Long-Stay Nursing Home Residents

Lastly, this Executive Budget proposal would exclude nursing home residents from MLTC plan enrollment after six months of nursing home care, returning these residents to fee-for-service Medicaid. The provision would be effective April 1, 2018 and is expected to save $147 million (all funds) in SFY 2018-19 and $245 million in SFY 2019-20.

Recommendation: *Support but modify this proposal to exclude long-stay residents from MLTC. Administering the nursing home benefit through MLTC has been a challenge for DOH, plans, and providers and has increased costs with little to no benefit for permanent residents.*

III) Hospice Services

Hospice programs care for 50,000 terminally ill New Yorkers each year in a dignified, holistic, and cost-efficient manner. However, despite our growing aging population, hospice utilization in New York State ranks 48th in the country. LeadingAge NY urges the Legislature and Executive to invest in hospice providers and implement policies to break down barriers to hospice so that New Yorkers can plan for and choose their desired end-of-life care.

a) Transformation Grant Funding for Hospice Programs

Of the $425 million in funding provided in the third round of the Statewide Health Care Facility Transformation Program, $60 million is allocated to community-based health care providers, which would include home care agencies and ALP providers. LeadingAge NY supports adding hospice programs to the list of providers eligible for funds to increase access to this cost-efficient and preferred provider.

Recommendation: *Support investment in hospice through the Statewide Health Care Facility Transformation Program.*

b) Hospice Residence Rate

LeadingAge NY supports the Governor's proposal to administratively increase hospice residence rates by 10 percent, set a benchmark rate, and include specialty rates in the weighted average rate calculation. Hospice residences are an alternative to a hospital or nursing home for patients at the end of life and also serve as an alternative for those who lack a stable home environment. These providers have not received a rate adjustment in 20 years, and increased utilization of hospice would improve the quality of life for patients and their caregivers, as well as the cost-effectiveness of care.

Recommendation: *Support the Governor's proposed increase in hospice residence rates.*

c) Opioid Surcharge

The Executive Budget proposes a new surcharge on the first sale of any opioid in the state by a pharmacy, manufacturer, wholesaler, or outsourcing facility. The seller would be prohibited from passing the surcharge on to customers. The surcharge is expected to raise $127 million in the first fiscal year, which would be deposited into an Opioid Treatment and Recovery Account that would be used to support opioid abuse prevention, treatment, and education programs.

LeadingAge NY supports the concept of this proposal, both to discourage the over-prescription of opioids and to generate funds to help battle the epidemic, but is concerned that the 2 cents-per-milligram surcharge will be passed down to providers, causing unintentional increased costs for opioids for hospice providers and nursing home-operated pharmacies. Opioids are widely used by hospice programs to alleviate patients' pain at the end of life, and their pharmaceutical costs are anticipated to increase 25 to 50 percent as a result of concealed price increases due to this surcharge.

Recommendation: *Develop a proposal that ensures that the opioid surcharge does not get passed down to hospice programs and nursing home pharmacies.*

IV) Home and Community-Based Services (HCBS)

Home and community-based services (HCBS) are the key to a healthy aging population in New York State. They provide quality care and supportive services to people in their homes and communities and pay off in the long run by preventing ER visits, hospitalizations, hospital readmissions, nursing home care, and the extensive costs associated with these settings. LeadingAge NY appreciates DOH's continued recognition that HCBS and underlying social determinants play a significant role in population health. However, home care providers continue to struggle as they face a lack of investment, inadequate reimbursement, workforce challenges, unfunded mandates, elimination of inflation adjustments, and

other operational and financial challenges. This uncertainty and lack of support prevents this industry from meeting the needs of the growing number of New Yorkers seeking care at home and in the community.

a) LHCSA Cap for MLTCs

The Executive Budget caps the number of Licensed Home Care Services Agencies (LHCSAs) with which an MLTC plan can contract at 10. LeadingAge NY believes this proposal would cause significant disruption to patients and providers of home care services across the state. We question DOH's rationale for this measure and believe it would result in micromanagement of MLTC plans regarding practices that could address LHCSA consolidation through market forces if, in fact, they were necessary.

Currently, MLTC plans contract with a significant number of LHCSAs, some as many as 100. The cap of 10 would apply across the board to MLTCs serving patients in local, regional, and statewide plans. LHCSAs provide a broad range of clinical and cultural specialties and services that MLTCs need to serve the diverse needs of their patients. Plans require a broad pool of providers to draw from in both urban and rural communities. A cap would cause significant disruption to patient care and patient/provider relationships, and it would restrict patient choice. It would also change the face of home care from local and familiar providers that know the community and its resources to entities that are more corporate in nature.

Recommendation: *Reject this administrative budget proposal.*

b) MLTC Provider Marketing and Referral Ban

The Executive Budget proposes two significant changes in this area: it prohibits all community-based long term care provider-sponsored marketing regarding Medicaid, and it prohibits providers that refer patients to the Conflict-Free MLTC Enrollment Center from becoming those patients' service providers.

LeadingAge NY opposes these proposals. It is our understanding that the ban on marketing would apply to marketing of any and all services, regardless of payer. This would be unfair to the home care industry, which has other payers in its market besides Medicaid. Overall, LeadingAge NY believes these proposals are ill-defined and overbroad reactions to growth in MLTC enrollment, which can be more effectively addressed through other policy changes. Moreover, the referral ban would interfere with consumer choice and continuity of care.

Recommendation: *Reject this administrative budget proposal and work with MLTCs and the provider community to determine rational guidelines for enrollment and utilization of the MLTC benefit.*

c) DOH Study of Home and Community-Based Services in Rural Areas

The Executive Budget requires DOH to conduct a study of HCBS available to Medicaid beneficiaries in rural areas of the state. It authorizes DOH to provide a targeted Medicaid rate enhancement for fee-for-service personal care rates and rates under Medicaid waiver programs in an aggregate amount of $3 million minus the cost of conducting the study. The study would include a review of factors affecting availability such as transportation costs, costs of direct care personnel, opportunities for telehealth services, and technological advances to improve efficiencies.

LeadingAge NY supports this study to home in on understanding the barriers to HCBS in rural New York, including studying the shortage of health care providers, many of whom are seeking employment outside of the health care industry. This is a significant challenge facing our state. We need the study to include the advancement of a broad range of strategies and solutions to ensure HCBS access in our rural areas.

Recommendation: *Increase funding for this initiative and allow the funds to be used for MLTC services where appropriate.*

d) TBI/NHTD Carve-Out of Medicaid Managed Care

LeadingAge NY supports bipartisan legislation that would allow individuals with traumatic brain injuries (TBI) or who qualify for nursing home diversion and transition (NHTD) Medicaid waiver services to continue to receive such services outside of managed care programs. The budget does not incorporate any savings associated with moving TBI/NHTD into managed care. Given the significant programmatic changes absorbed by Medicaid Managed Care and MLTC plans in recent years and the Executive Budget proposals to limit enrollment in and utilization of MLTC, the interests of all stakeholders would be best served by focusing on current populations and benefits.

Recommendation: *Support A.2442 (Gottfried)/S.1870 (Hannon), which would keep this high acuity population out of Medicaid Managed Care.*

e) Telehealth Expansion

The Executive Budget proposes to expand the definition of "originating site" for purposes of Medicaid reimbursement for telehealth services to include a patient's residence as well as any other location where the patient may be temporarily located. The proposal would also clarify that "remote patient monitoring," which is the transmission of data to a distant telehealth provider for use in monitoring and managing medical conditions, could include additional interaction triggered by previous transmissions, such as follow-up telephone calls or additional interactive inquiries through communication technologies.

Recommendation: *Support this initiative.*

V) Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs) and assisted living provide an option for seniors who can't remain in their own home, but do not need the continual skilled nursing services of a nursing home. These services are cheaper than nursing home care and have a more 'home like' environment than a nursing home. Such options are thus becoming increasingly important in the context of State and federal priorities as well as consumer preferences.

Unfortunately, while we have a growing population of seniors that is less able to pay for their long term care needs, ACFs and assisted living facilities that serve low-income individuals are struggling. Meanwhile, the cost of providing care is rising, and the responsibilities and expectations of these providers are increasing. These providers serve a critical function, and if these facilities close or can't afford to continue to serve Medicaid-eligible seniors, we will see an increase in unnecessary nursing

home placement, with a significant cost to the State. We urge the Legislature to provide more support to these facilities to ensure their viability in the years to come.

a) SSI Increase

We are extremely disappointed that the Executive Budget failed to include an increase in the State portion of the Congregate Care Level 3 Supplemental Security Income (SSI) rate. This rate has not been increased in *10 years.* The SSI rate of just under $41 per day falls far short of what it costs to provide the services that ACFs are, by regulation, required to provide. In fact, the average cost per day is *double the reimbursement.* We are on the cusp of a crisis for low-income seniors.

LeadingAge NY conducted a cost analysis of facilities that serve predominantly the low-income population, and the average cost, based on 2015 data, was approximately $83. Thus, these facilities experience an average shortfall of $42 per day for each SSI recipient they serve—the shortfall has now surpassed the daily SSI rate. It is notable that we conducted the same analysis with 2013 data, and in that two-year period, the average cost went up *$14 per day*. Even more concerning is that we know those costs continued to climb in the last two years with the rising cost of health insurance, the implementation of an increase in the minimum wage, and other mandates. The facilities included in this analysis did not receive any funding to help implement the minimum wage mandate.

According to data from DOH, several ACFs closed in 2017, and even one in 2018 thus far. We know that there are more to come in the year ahead. The consistent financial loss, year after year, is unsustainable. It is critical that the Legislature understand that if the State fails to take action this year, facilities will continue to close, and low-income seniors will be displaced. Because these seniors are Medicaid-eligible and can't live in their own home, most will go to nursing homes at greater cost to the State. Clearly, this makes no financial sense, but it doesn't make for good policy either. All State and federal initiatives point to keeping people in the lowest level of care possible. The decision not to increase SSI is also incongruous with the policy direction of aging and long term care services. But most of all, it's not fair to the 13,000 New Yorkers who rely on SSI to pay for the services they receive in ACFs and assisted living.

Recommendation: *To support ACFs and assisted living facilities to serve low-income seniors in the most integrated setting possible, we recommend an increase of at least $20 per day in the State's Congregate Care Level 3 SSI rate.*

b) Enriched Housing Subsidy

We are very concerned about the Executive Budget proposal to move the Enriched Housing Subsidy program to a pool of public health programs, with aggregate funding reduced by 20 percent. The subsidy supports low-income individuals to remain in as independent a setting as possible, and these enriched housing programs are struggling financially. Cuts to the program over the years have made the subsidy to each provider shrink, including a 20 percent cut last year. If the enriched housing programs that rely on this funding close, their Medicaid-eligible residents are at risk of nursing home placement.

Recommendation: *Restore the Enriched Housing Subsidy as discrete line item, funded at last year's level of $380,000.*

c) Enhancing the Quality of Adult Living (EQUAL)

We appreciate that the Executive Budget maintains level funding for the Enhancing the Quality of Adult Living (EQUAL) quality program for ACFs at $6.5 million. EQUAL supports quality of life initiatives for residents of ACFs that serve SSI recipients; as discussed above, these ACFs incur daily losses.

Recommendation: *Support the Governor's proposal to include EQUAL funding at $6.5 million.*

d) ALP Expansion

The Assisted Living Program (ALP), the only Medicaid assisted living option in the state, is an alternative to a nursing home for lower-acuity seniors. The ALP Medicaid rate is approximately half the cost of a nursing home. We appreciate the Governor's proposal to increase the ALP through three separate initiatives; however, we think this cost-saving program should be expanded to allow eligible applicants that can demonstrate need to develop ALP beds, as opposed to the recent competitive processes. In addition, existing ALPs should be able to expand their programs by nine or fewer beds through an expedited process. Developing greater capacity will help the system to better respond to the growing consumer demand for these services, while saving money.

It should also be noted that the Executive Budget puts conditions on the applicants for new ALP beds. One is a requirement that the facility serve only public pay individuals. While we agree that new added beds should be prioritized for public pay individuals, it is difficult to operate a facility that is entirely public pay, for reasons already mentioned. In addition, existing facilities might want to designate a portion of their beds as ALP, in which case only the new ALP beds should be reserved for public pay. Otherwise, the policy has the effect of segregating public and private pay individuals. The other condition that raises concern for us is the requirement that ALPs participate in value-based payment arrangements to the degree that such arrangements are available. Many such arrangements have used the prevention of hospitalization and ER visits as a measure; however, ALPs are limited in their ability to impact these measures given that they cannot utilize their own nurses to provide nursing services directly. As such, we think this condition should be removed.

Recommendation: *Refine the Governor's ALP expansion proposals, and expand upon them by establishing a need-based application process to enable rational expansion of the ALP in the future.*

e) Capital Funding for ALPs

ALPs, like many other Medicaid providers, need financial support to address infrastructure needs. We are very appreciative of the Executive Budget proposal to identify ALPs as eligible applicants for the third round of the Statewide Health Care Facility Transformation Program, and to earmark dollars for ALPs and other home and community-based and long term care providers. The funds could also be used to support the development of new programs in areas where there is a lack of services, and for existing ALPs to provide better integrated services. Capital funding is critical to enable ALPs to update their environment to better serve people with Alzheimer's and other dementias. These investments could save Medicaid dollars by preventing nursing home placement.

Recommendation: *Include the Executive Budget proposal to allow ALPs to be eligible applicants for the Statewide Health Care Facility Transformation Program, and earmark some of those funds to ensure they reach ALP providers.*

f) Ensuring Access to Assisted Living for Low-Income Seniors with Alzheimer's Disease and Dementia

Currently, there are limited options for consumers in New York who have specialized and intensive care needs related to dementia and limited income and resources. Oftentimes, nursing home placement is the only option. We are pleased to see an interest in this issue with an assisted living voucher program for people with dementia included in the Executive Budget. There are many aspects of the program that must be determined, however, and it is critical that assisted living providers be included in the development of the program. In addition, we urge the Legislature to consider implementing a Medicaid dementia rate add-on to the Medicaid ALP rate, as is done in the nursing home rate, to cover the additional resources needed to care for this population. A modest investment could save significant Medicaid dollars by reducing the number of Medicaid-eligible people with dementia in nursing homes.

Recommendation: *Work with LeadingAge NY, the Alzheimer's Association, and other provider groups to further develop strategies for low-income seniors with dementia to remain in assisted living.*

g) Allow ALP Residents to Access Hospice Services

Current Medicaid regulations and payment policy prevent terminally ill ALP residents from accessing hospice services. As a result, many are forced to transfer to a nursing home in their last weeks of life. If ALP residents were able to access hospice services in the ALP, not only would they be able to remain in a familiar location at the end of life, but there would also be a savings for the Medicaid program. There were 7,900 individuals being served by ALPs at the end of 2016. If just 10 percent of ALP participants whose care is funded by Medicaid were to remain in the ALP rather than transfer to a nursing home to access hospice services, the State would see an estimated $1.3 million in savings. This savings calculation assumes that 10 percent of ALP residents transfer to a nursing home for their final two weeks of life and that the average nursing home rate is twice the ALP rate. While this savings is compelling, allowing people to remain in the place they call home in their last weeks of life is even more valuable.

VI) Senior Housing Resident Service Advisor Program

LeadingAge NY is extremely pleased with New York State's historic commitment of $125 million in capital appropriations for the construction and rehabilitation of senior housing over the course of five years, and extend our gratitude to the Legislature for the role it played in securing this funding. The newly-created Senior Housing Program that was designed by Homes and Community Renewal (HCR) to facilitate the disbursal of these funds provides the perfect opportunity to bring support services into affordable senior housing that can have a significant impact on seniors' ability to remain in their communities in an extremely cost-effective manner.

It is imperative that New York create a housing with services model for low- to moderate-income seniors because of the incredible growth in the senior population that will occur as the "Baby Boom" population reaches retirement age. Approximately 10,000 Baby Boomers, the 78 million Americans born between 1946 and 1964, turn 65 every day, creating ever-growing costs for Medicaid. Providing low-income seniors with access to affordable housing with support services can have a significant impact on their ability to remain in the community and may delay or prevent them from entering more costly levels of care, creating significant savings for the State's Medicaid program.

LeadingAge NY, along with a coalition of senior housing providers and associations, has called for the creation of a Senior Housing Resident Service Advisor Program, to be administered by DOH, and the addition of $10 million to the budget to fund service advisors in 140 senior housing properties around the state. We propose that grants of approximately $70,000 per property be made available to congregate senior housing operators to work with seniors, and that those advisors specifically focus on linking residents to the services they need to remain healthy in their communities. The State bears much of the cost of Medicaid-funded nursing homes, which can range from $30,000 to upwards of $50,000 per year in State expenditures. If a service advisor can keep two people out of a nursing home for one year, the savings covers the cost of the grant. If an advisor works in a building with 70 to 100 people and emphasizes health education, wellness programming, more effective use of primary care, reduced use of emergency departments, and better management of chronic health conditions, the savings potential is enormous.

Evidence of these savings has been demonstrated in recent studies conducted in Oregon and New York. In 2016, the Center for Outcomes, Research & Education issued a report on a study conducted in Oregon that showed a decline in Medicaid costs of 16 percent one year after seniors moved into affordable housing with service advisors.[1] Their analysis included 1,625 individuals, 431 of whom lived in properties that serve older adults and individuals with disabilities. The statistic of 16 percent savings in Medicaid costs breaks down to a savings of $84 per month for each individual in this subset, or $434,000 over a 12-month period for the relatively low number of 431 individuals.

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

Recommendation: *A $10 million, five-year strategic investment to bolster the planned $125 million in capital funding is an extremely low-cost way to ensure that New York's growing senior population is being taken care of while also saving money for the State. The Service Advisor Program aligns directly with the goal of HCR's Senior Housing Plan to develop rental housing that has healthy aging programming that affords seniors with the option to age in their own homes and communities. It ultimately represents a modest investment that will improve seniors' quality of life, save Medicaid dollars, and help the State implement its ambitious Olmstead Plan to serve people in the least restrictive settings appropriate to their needs.*

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

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 providers that serve them. We are very concerned that the Executive Budget offers insufficient opportunity or investments for LTPAC providers and plans while imposing new cuts, costs, and mandates. We urge the Legislature to remedy this by ensuring that the final enacted budget includes infrastructure investments and additional Medicaid funding to accommodate increased costs to providers and the MLTC plans that pay them. LeadingAge NY looks forward to working with the Legislature and Executive on the 2018-19 budget and the State's ongoing reform initiatives.

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.