2020-21 Health/Medicaid Testimony

Provided by

Karen Lipson
Executive Vice President
LeadingAge New York

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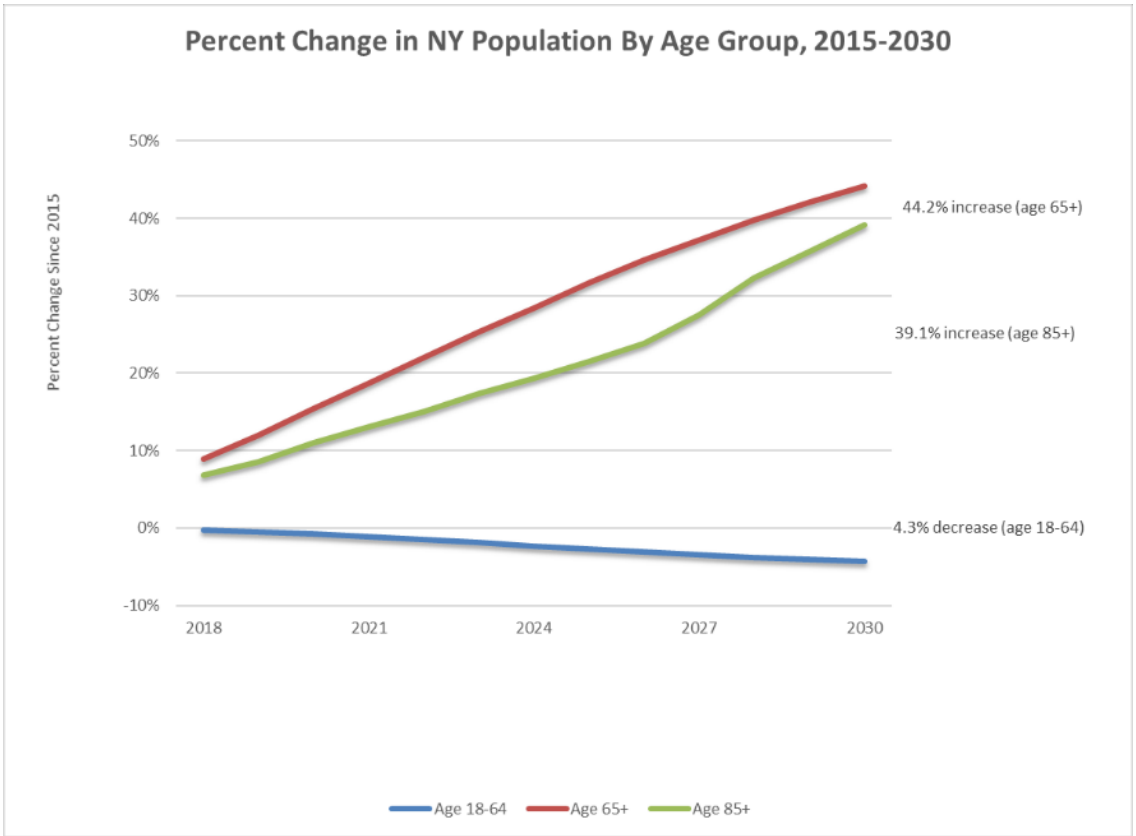
INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the aspects of the SFY 2019-20 Executive Budget impacting long-term care providers and older adults. LeadingAge New York 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.

Who Will Take Care of Our Parents and Grandparents? Who Will Take Care of Us?

New York is approaching a demographic crisis. Approximately 3 million adults age 65 and older, representing 16 percent of the population, make New York their home. *Between 2015 and 2040, the number of adults age 65 and over will increase by 50 percent, and the number of adults over 85 will double.*[1] This growth will drive a corresponding increase in the number of New Yorkers with cognitive and functional limitations who need long term care (LTC) services. While the percentage of our population over age 65 is growing, the percentage between 18 and 64 is shrinking.



We are already feeling the effects of a shortage of working age caregivers for our parents, grandparents and neighbors. Today, there are only approximately 4 working age adults for every adult over age 65 in

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

New York and 29 working-age adults for every adult over age 85. By 2040, there will be approximately **3** working-age adults for every adult over age 65 and **15** for every adult over age 85.[2] As described in more detail below, both informal caregivers and direct care workers in the formal care delivery system are already in short supply, and the gap will only grow. Our members are experiencing unprecedented and extraordinary challenges throughout the State filling open positions in all levels of care.

Not only do we have a growing older adult population, we can expect that a significant portion of seniors will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs. One-third of today's older New Yorkers are living at or near the poverty level.[3] Medicaid currently pays for nearly three-quarters of nursing home days and 87 percent of home care services in New York State. These percentages are not likely to shrink as the later Baby Boomers age and retire without the substantial savings and generous pensions that their predecessors enjoyed.

Faced with current and future demographic challenges, New York must take action now and invest in the workforce and long-term services, supports, and technologies that enable individuals to remain in their homes and communities; ensure the availability of high quality nursing facility care for those who need it; and modernize regulations to permit providers to address consumer preferences, optimize efficiencies, improve quality, and effectively deploy an increasingly scarce workforce.

What Are We Doing to Prepare for Demographic Change?

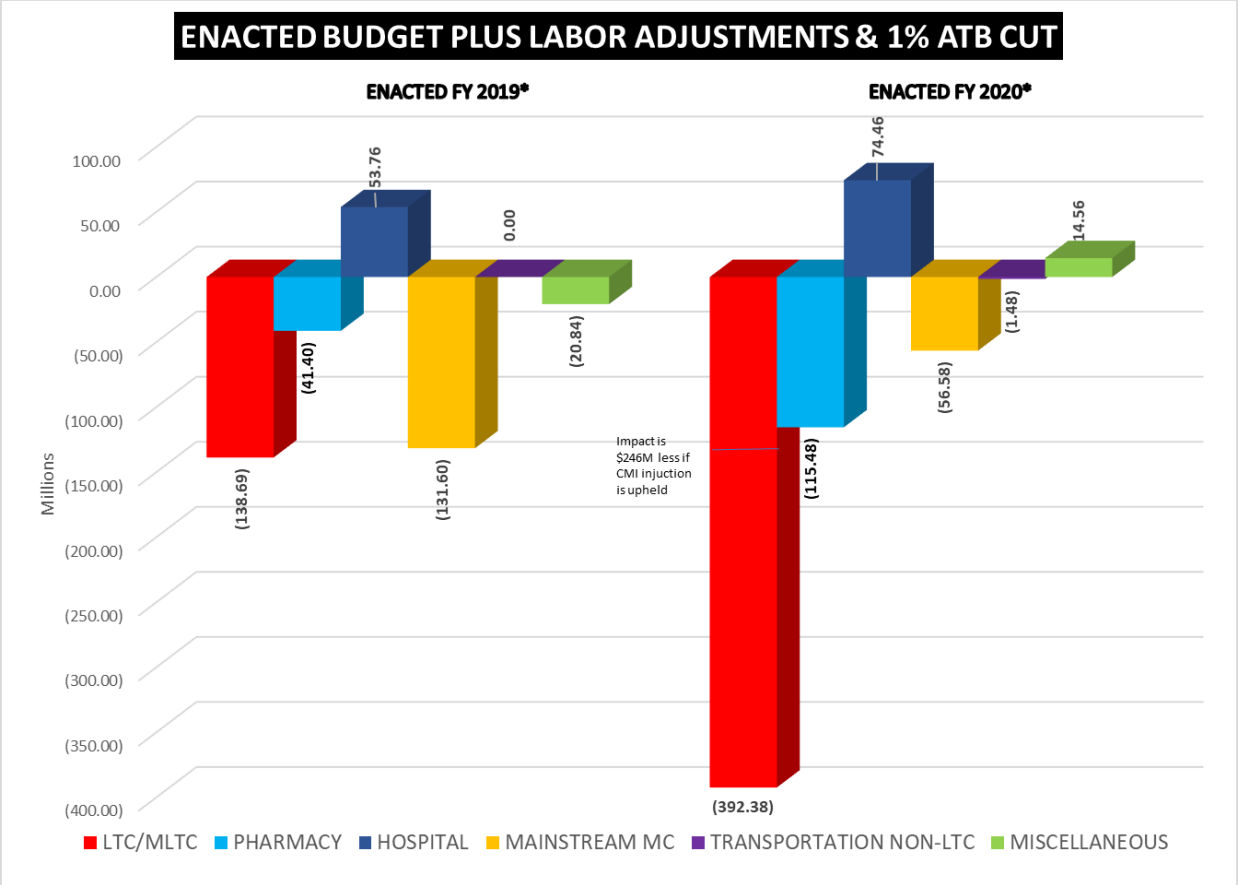
The Executive Budget should be commended for its historic $33 billion investment to address climate change. Unfortunately, the State has not pursued a similarly coherent and proactive policy to address demographic change -- the approaching "Silver Tsunami." On the contrary, for the past several years, the State has focused its health care investments on the acute care and primary care sectors and its budget cuts on the long-term/post-acute care sector.

Notwithstanding the demographic wave that is already driving up demand for long-term care services and limiting the supply of workers, this year's Executive Budget points to managed long-term care (MLTC) enrollment growth as a primary culprit in the Medicaid deficit and appears poised to target budget cuts on long-term care yet again – only this time a multi-stakeholder Medicaid Redesign Team (MRT) will be tasked with making hard choices and casting votes. As discussed in more detail below, we urge the Legislature and the MRT to find a way to close the Medicaid budget gap other than by slashing rates paid to long-term care providers and MLTC plans and to implement a "Gray New Deal" that addresses demographic change.

Rates Have Been Cut Year After Year Leading to Negative Margins and Closures Among LTC Providers

As the graph below demonstrates, LTC providers and plans have borne the brunt of Medicaid cuts over at least the past two years:

[2] *Ibid.*
[3] New York State Office for the Aging, New York State, January 2020.



*Each bar reflects budget cuts or investments that impact provider or plan rates or impose penalties. Budget initiatives that rely on maximization of federal funds, impact program eligibility, or shift payment sources are excluded from the amounts indicated.

They cannot absorb another year of deep cuts and continue to offer high-quality and accessible services to Medicaid beneficiaries. LTC providers have not received an increase in their Medicaid rates in almost **12 years** despite rising wage and benefit costs,[4] increased utility and food costs, and new regulatory requirements related to information technology, nursing assessments, care planning, reporting, compliance, infection control, and labor laws.[5] Demands of managed care and new payment models have required additional data and analytics investments, dedication of administrative resources in value-based contract management and chasing unpaid claims. Growing acuity of residents and patients has demanded new equipment, more professional staff and more training.

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

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

From these already depressed rates, the State has taken year-over-year cuts, with each new cut typically extending for at least three years. The cuts have affected almost all services, from nursing homes to home care and managed long-term care (MLTC) plans. It is important to recognize that, in the context of mandatory enrollment of Medicaid LTC beneficiaries into MLTC plans, a cut to MLTC rates represents a cut to LTC services and supports for vulnerable New Yorkers.

The fiscal and operational pressures created by inadequate rates, workforce shortages, and new mandates are reflected in the thin or negative operating margins across the long-term care continuum:

- New York's **nursing home Medicaid rates cover only 80 percent of the daily cost** of care, creating a $64.00 per day shortfall.[6] 38 percent of nursing homes have negative operating margins, and the statewide average margin is 0.3 percent.[7] This slim margin is likely to be pulled below zero with the implementation of the one percent across the board cut, since Medicaid resident days represent over 70 percent of total nursing home days.[8]
- **72 percent of certified home health agencies** (CHHAs) have negative margins, and the median margin is -12 percent.[9]
- **50 percent** of hospice programs have negative margins.
- The **adult care facility (ACF) SSI daily rate is $41.63/day**, which is approximately half of the average cost per day according to *2015* figures—that gap has only grown since the implementation of minimum wage and other cost increases.
- **One-third of partially capitated MLTC plans**, which represent the vast majority of MLTC enrollment in the State, reported that Medicaid expenditures exceeded Medicaid premiums received from the state in 2018 - a figure that excludes the three plans that closed in 2019.

Clearly, there is not much fat to trim from long-term care provider or plan budgets. Fiscal pressures are leading to closures of not-for-profit nursing homes, adult care facilities (ACFs), adult day health care programs, and provider-sponsored MLTC plans:

- Since 2014, a dozen nursing homes have closed and nearly 50 public and not-for-profit homes have been sold.
- Between 2017 and 2019, 16 medical model Adult Day Health Care programs have closed.
- Since 2017, 25 ACFs have closed voluntarily statewide. Others are on the brink of closure.
- In 2019, three MLTC plans closed, forcing the transfer of thousands of beneficiaries to new plans and disrupting relationships with aides and care managers.

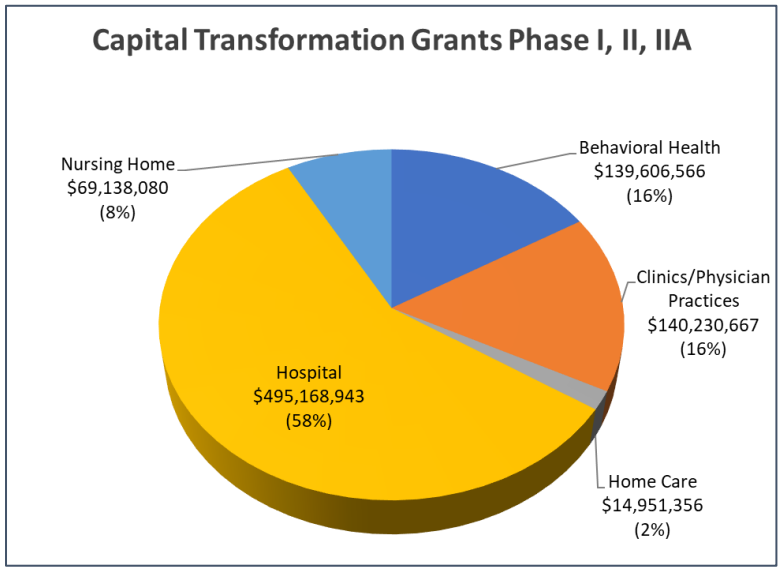
Each closure displaces vulnerable New Yorkers from a home or a program that has provided them with necessary care and separates them from familiar caregivers and/or settings that offer comfort and knowledge of their needs and preferences. Each closure causes havoc and stress in the families that help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

Infrastructure and System Reform Investments Have Overlooked Long Term Care

Not only have LTC providers and MLTC plans shouldered significant cuts over the past few years, they also have been largely neglected as the State has invested hundreds of millions of dollars in health care

[6] Hansen Hunter & Company, "A Report on Shortfalls in Medicaid Funding for Nursing Center Care, American Health Care Assn., Nov. 2018.
[7] LeadingAge New York Analysis of 2018 RHCF Cost Reports.
[8] LeadingAge NY analysis of 2018 RHCF Medicaid cost report data
[9] "State of the Industry 2019," Home Care Association of New York State, Feb. 2019.

through capital transformation grants and the Delivery System Reform Incentive Payment (DSRIP) program. Only about 2 percent of DSRIP funds and 10 percent of the Statewide Health Care Facility Transformation Grant funds have been allocated to long-term care providers.



We appreciate the Department of Health's recognition of long-term care as a "high priority area" in its recent application to CMS to extend and renew the DSRIP program. This is a step in the right direction. However, it appears that, once again, few if any funds are specifically dedicated to the long-term care system. Instead, under the new proposal, funds will once again flow through entities controlled by hospitals and large physician practices with mandates to address a variety of primary, acute, behavioral health, and pediatric issues, as well as long-term care. We fear that DSRIP 2.0 will merely continue the pattern of neglect of long-term care that characterized the first round.

A $2.5 Billion Cut in Already Inadequate Medicaid Rates will Inevitably Hurt Consumers

We are concerned that the 2020-21 Executive Budget implicitly targets long-term care providers and MLTC plans for cuts once again. The Budget estimates a $2.5 billion Medicaid gap that must be filled, and it must be filled without adversely affecting consumers or increasing the local share of Medicaid. There are only 4 ways to achieve State savings in Medicaid (i) limits on consumer eligibility for services, (ii) new restrictions on benefits or utilization; (iii) an increase in the local or federal share of Medicaid; or (iv) cutting provider and plan reimbursement. The only strategy feasible under the Executive Budget plan is to cut provider or plan reimbursement. Although the Executive Budget acknowledges that it is enrollment growth that is driving increased Medicaid spending in long-term care, it appears that providers and plans will be asked to continue to provide the same level of services to a growing number of consumers at reduced rates. Moreover, it is unrealistic to suggest that additional cuts will not adversely affect consumers in the form of reduced quality and access.

There must be another way to find the savings or the revenue to fill the $2.5 billion budget gap other than by depleting funding for services to New York's most vulnerable residents. Additional cuts will only exacerbate an already untenable situation. We ask the Legislature to look closely at the budget and its underlying assumptions in a holistic way so that the health system does not have to absorb the entire

$2.5 billion in cuts. We urge you to look for waste and excess spending in other areas of the budget to help fill the Medicaid gap. In particular, we ask you to ensure that long-term care does not once again bear the brunt of Medicaid cuts.

What Should We Be Doing to Address the Needs of a Rising Number of Older Adults in the Context of a Shrinking Workforce and Limited Government Funding?

If New York is to ensure access to high-quality care for a growing number of older adults in our communities, we need to infuse resources into the long-term care system, not drain them. However, we also recognize that an acceleration in the growth rate of Medicaid long-term care spending occasioned by members of the Baby Boom generation entering their eighties will be unsustainable. State and federal policymakers, along with stakeholders, need to intensify efforts to develop alternative strategies to fund long term care services. We must be willing to innovate and invest now to create more efficient models, slow the growth in spending, build capacity, and secure resources for the future.

Accordingly, LeadingAge New York proposes a five-point plan as a critical first step in helping slow spending growth and ensure the availability of services:

i. **Implement workforce development programs that bring new workers into long-term care and adopt reforms that enable optimal use of a limited workforce;**
ii. **Support the delivery of services in the most appropriate setting for each individual, including lower intensity settings that enable older adults to live longer and healthier in the community, such as affordable senior housing with services and assisted living;**
iii. **Improve efficiencies and encourage the use of the most appropriate levels of care through investment in infrastructure and technology;**
iv. **Implement regulatory reforms that reduce unnecessary and costly mandates; and**
v. **Support provider-sponsored managed care programs that integrate Medicare and Medicaid.**

The remainder of our testimony offers greater detail on this 5 Point Plan and then provides a series of budget positions pertaining to each of the service lines operated by our members:

- Nursing Homes
- Managed Long Term Care
- Home and Community-Based Services
- Assisted Living and Adult Care Facilities
- Affordable Independent Senior Housing

It also includes a section on the Executive Budget's proposed limits on the long-term care insurance tax credit.

5 POINT PLAN

I. Implement Workforce Development Programs and Adopt Reforms that Enable Optimal Use of a Limited Workforce – *#WIN4Seniors*

Given the aging demographics of New York State, we must build the LTPAC workforce and identify ways to use a shrinking pool of workers more efficiently and effectively. Long-term care providers are struggling with severe workforce shortages statewide at all levels. Of the 150,000 health care job openings anticipated annually, 89,000 are personal care aides, home health aides, and nursing

assistants.[10] According to the Center for Health Workforce Studies, 59 percent of home care agencies report difficulty hiring full-time workers, and 32 percent of home care workers who work part-time do so for non-economic reasons, which include personal and family obligations and health problems. Similarly, 69 percent of nursing homes report difficulty hiring workers for evening, night, and weekend shifts.[11] These shortages extend to nurses as well. Job openings for registered nurses and licensed practical nurses exceed graduation rates by over 4,600 annually.[12]

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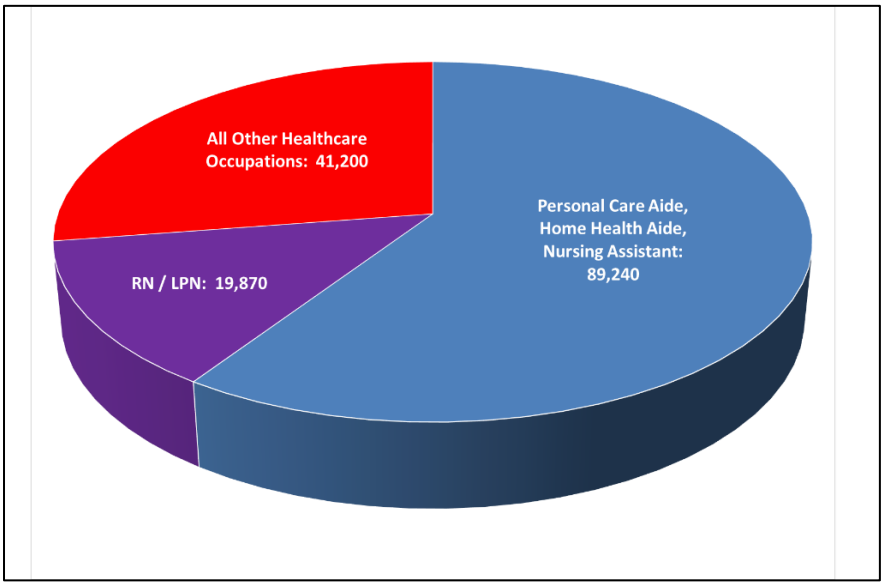


The inability to hire sufficient aides and professionals has resulted in long waiting lists for certain community-based services, inability to fill authorized home care hours, admission of individuals to higher levels of care due to lack of access to community-based services, inability to admit nursing home residents with complex medical conditions and/or high supervision needs, and reliance on overtime and staffing agencies.

Despite the demographic imperative and existing shortages, the only significant long-term care workforce initiative implemented in recent years – the MLTC workforce component of the State's 1115 Medicaid waiver – focuses on enhancing the training of the existing workforce. While this is clearly an important goal, the funding does not adequately address the need to bring new workers into the field.

[10] New York State Department of Labor Employment Projections; https://www.labor.ny.gov/stats/lsproj.shtm; accessed Jan. 11, 2019.
[11] Martiniano R, Krohmal R, Boyd L, Liu Y, Harun N, Harasta E, Wang S, Moore J. *The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers*. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; March 2018.
[12] *Ibid.*

We are concerned that the Department of Health application for extension and renewal of the program does not remedy this shortcoming.

We welcome the Executive Budget's investment of $175 million in workforce development generally and its continuation of funding for minimum wage increases. We are concerned, however, that the 1 percent across-the-board Medicaid cut implemented administratively this month will apply to minimum wage funding, as well as provider rates. We are also concerned that the $175 million in workforce development funding will not be allocated to long-term care training and education activities. The focus of the program appears to be on science and technology and advanced manufacturing jobs, rather than caregiving jobs. In order to ensure sufficient caregivers as the Baby Boomers age, we must engage in a proactive and focused effort to build the long-term care workforce.

LeadingAge New York has developed a multi-faceted workforce plan that includes both investments and no-cost regulatory and statutory reforms. The plan is described in detail in our ***#WIN4Seniors*** brief.

Recommendations:

*Support **#WIN4Seniors** by dedicating at least $50 million of workforce funding to support initiatives to train, recruit, and retain the long-term care workforce, including programs that provide:*

- *Funding for enhanced wages and benefits*
- *Access to transportation for workers*
- *Job-related social supports for workers*
- *Funding for adult learning/certification programs at community college and BOCES*
- *Supports and stipends for trainees*
- *High school pre-apprenticeship programs*
- *Apprenticeship programs*
- *Peer mentoring*

These funds should be made available to both Medicaid providers and senior services providers that do not bill Medicaid.

We also urge the Legislature to:

- *Appropriate and direct the allocation of $8 million from nursing home civil money penalties (CMP) that have been collected but are not being spent. Invest these funds in a New York Careers in Aging program to offer scholarships for CNA trainees, provide work-related supports to trainees and aides, provide a bonus to CNAs after 6 months of employment, and support a public relations campaign to encourage CNA training as a career ladder to nursing.*
- *Fully fund the Criminal History Record Check (CHRC) process to cover rising costs and new providers, ensure re-appropriation of past years' funding, expand CHRC access points, and expedite and improve the process to avoid delays in clearance.*

In addition to these budget actions, LeadingAge New York is seeking an array of statutory, regulatory, and operational reforms. These include:

- *Enable aides to obtain and retain multiple certifications by aligning credentialing with experience and competencies and eliminating duplicative training requirements for CNAs, HHAs, PCAs.*
- *Clarify that CNAs who work in nursing homes, like CNAs in hospitals, are eligible to complete a competency evaluation to be certified as HHAs, in lieu of the standard training.*

- *Align HHA training program requirements with federal requirements by allowing LPNs to conduct training under general supervision of RN.*
- *Reduce duplicative home care aide in-service training requirements by including completion of in-service training hours on the aide registry.*
- *Align state requirements with federal regulations for nursing home feeding assistants training.*
- *Expand the use of patient care technicians in nursing homes and authorize the use of medication technicians.*
- *Authorize nurses to practice nursing in assisted living facilities and authorize them to provide influenza and pneumococcal immunizations to residents and staff.*
- *Clarify that NPs and PAs are permitted to conduct the initial health history and physical and to sign nursing home admission orders for new nursing home residents initiating Medicaid stays.*
- *Permit NPs and PAs to conduct medical evaluations for assisted living program (ALP) residents.*
- *Allow the nursing home medical directors to issue orders for continued services in their affiliated adult day health care program, in lieu of a community physician.*

II. Support the Delivery of Services in the Most Appropriate Levels of Care, Including Lower Intensity Settings that Enable Older Adults to Live Longer and Healthier in the Community

Affordable residential settings for older adults with functional limitations or those who need some social supports are in short supply. While affluent New Yorkers are fortunate to have various options for retirement living, older adults of modest means struggle to find affordable housing or assisted living options. Affordable senior housing developments and adult care facilities (ACFs) provide lower-cost solutions to some of New York's most pressing challenges in caring for seniors. These settings can delay or prevent the need for more costly nursing home care for some residents, thereby slowing individuals' spend-down of resources to qualify for Medicaid and reducing Medicaid spending.

LeadingAge New York was delighted with the State's historic commitment of $125 million in capital appropriations for the construction and rehabilitation of affordable senior housing over the course of five years and is grateful to the Legislature for the role it played in securing this funding. That investment should be paired with an appropriation of $10 million over five years to provide resident assistant services in affordable senior housing. As described more fully below, this model generates Medicaid and Medicare savings by providing low-income seniors with "light-touch" services that help them to prolong their independence and improve their quality of life. Rigorous studies have shown that affordable senior housing with supportive services reduces Medicare and Medicaid spending.[13] Based on an annual investment of $2 million in an Affordable Independent Senior Housing Assistance Program (AISHAP), we estimate net Medicaid savings of $1.5 million.

For seniors who require more assistance with activities of daily living, adult care facilities (ACFs) and Medicaid Assisted Living Programs (ALPs) provide personal care services and assistance with medications in home-like settings, at a fraction of the cost of nursing home care. By offering services in a congregate context, they also make efficient use of a scarce workforce; a true asset in communities

[13] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* Oct. 2018. Li, G., Vartanian, K., Weller, M., & Wright, B. *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.

where the workforce cannot support 24-hour in home care for seniors. The State should be forward-thinking in bolstering these services for those that serve the low-income and middle-income population.

Unfortunately, as discussed in greater detail below, government rates for adult care facilities have not kept pace with costs, and ACFs that serve lower income residents are closing. When SSI beneficiaries are displaced from ACFs, in many communities nursing home care is the only alternative. And, the cost of their nursing home care, which is paid for by Medicaid, is several times greater than the cost of an ACF. For every 44 low-income seniors with functional limitations who are served in ACFs rather than nursing homes, the State will save approximately $1 million.

Recommendations:

- *Invest $10 million over 5 years to create an Affordable Independent Senior Housing Assistance Program that would generate a net Medicaid savings (after accounting for the investment) of $1.5 million.*
- *Invest in the development of additional adult care facility and ALP units; update the ACF SSI congregate care rates and ALP rates; reject the Executive Budget's proposed re-programming of EQUAL funding.*

III. Improve Efficiencies and Encourage the Use of the Most Appropriate Levels of Care Through Investment in Infrastructure and Technology

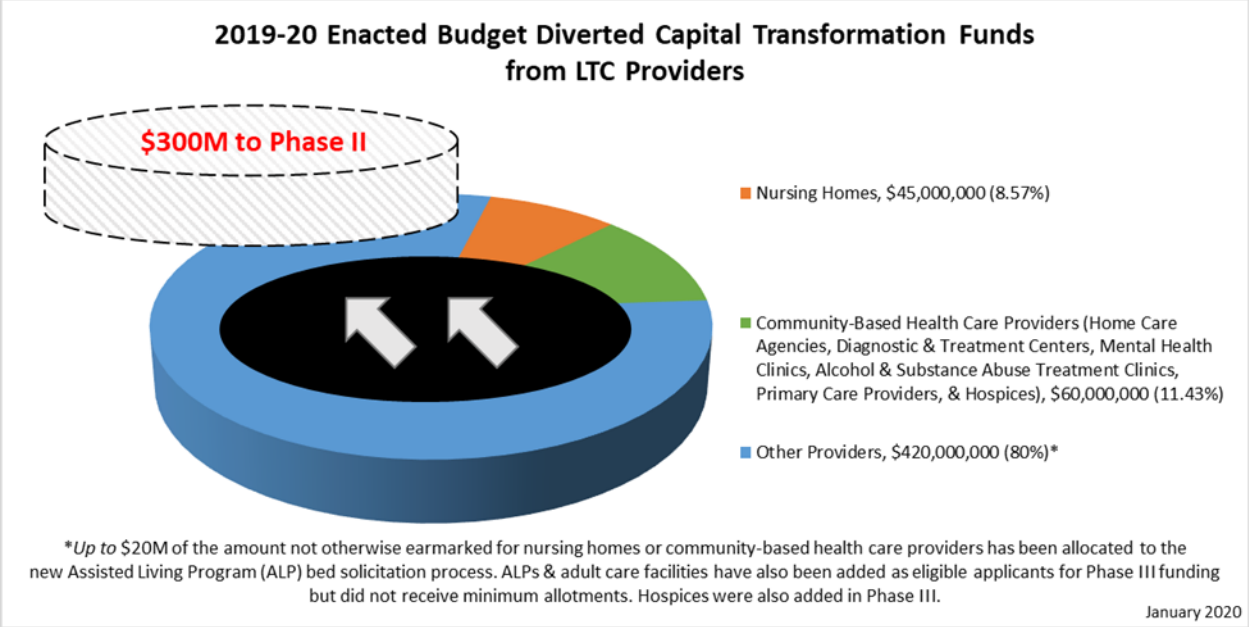
Long-term care providers are in dire need of infrastructure funding to upgrade inefficient physical plants, right-size/restructure existing services, add new services to address increasingly complex care needs, deploy electronic health records and engage in health information exchange, and adopt telehealth and data and analytics platforms in order to be able to meaningfully participate in DSRIP, managed care initiatives, and value-based payment.

For example, as hospital lengths of stay have declined, nursing homes are being asked to admit residents from hospitals earlier in their recovery with complex conditions requiring what was once considered acute care. In addition, nursing homes are asked to treat residents with acute conditions in place in order to avoid unnecessary transfers to hospitals. In order to deliver optimal care and meet the needs of these residents, nursing homes need to invest in advanced telehealth technology and medical monitoring systems, and other advanced modalities.

In spite of these compelling needs, these providers have not received sufficient State financial support for the critical infrastructure necessary to operate efficiently and effectively in today's changing delivery system. Funding awarded under State grants, DSRIP, and federal health information technology meaningful use incentives has overwhelmingly been aimed at acute care facilities, primary care providers, and physician practices.

Our review of the DSRIP Performing Provider System (PPS) funds flow distributions shows that only a small sliver of the DSRIP funding through the third quarter of the fourth year has flowed to the long-term care sector. Furthermore, LTPAC providers received only a sliver (approximately 10 percent) of the Statewide Health Care Facility Transformation Program grants. Nevertheless, LTC providers are expected to invest resources in partnering with providers across the continuum of care to share clinical information electronically, coordinate care, and enter into value-based payment arrangements with shared risk.

Although we were pleased to see dedicated capital funding promised to LTPAC providers through the SFY 2018-19 budget for Phase III of the Statewide Health Care Facility Transformation Program ("Capital Transformation Program"), we are disappointed that the State has not even released applications for those funds. Moreover, instead of implementing the 2018-19 budget provisions, last year's budget shifted the majority of the funding from Phase III ($300 million of the $525 million total) to fund applications submitted under Phase II. It is important to note that Phase II *did not* include dedicated funding for nursing homes, and it excluded hospice and assisted living program providers. Thus, hospice and assisted living program providers would not have submitted applications in that round and are no longer eligible for $300 million of the Phase III funds that were shifted to Phase II as a result of the 2019-20 budget.



Recommendations:

- *Amend transformation funding allocations to ensure that LTC providers have access to sufficient capital funding under the Statewide Health Care Facility Transformation Program and establish statutory deadlines for release of Phase III applications and awards.*
- *Ensure that DSRIP 2 dedicates funding for adoption of long-term care health information technology, health information exchange, telehealth, and services needed to address complex health care needs in nursing homes and home care.*
- *Exempt projects undertaken by non-profit long-term care and senior housing providers from prevailing wage requirements and from the proposed CON fee increase.*

IV. Implement Regulatory Reforms and Eliminate Unnecessary and Costly Mandates

Long-term care providers are subject to extensive federal and State (and sometimes local) laws and regulations. While well-intentioned, these regulations are sometimes duplicative but not identical, sometimes inconsistent, and sometimes unnecessary. They add to administrative and operational costs at a time when resources are already stretched. LeadingAge New York has advanced a package of regulatory reforms to the Executive Branch that would ease the administrative burden on long-term

care providers. Some of these proposals are outlined below under the specific service sections below. In addition, the employment protections in the proposed Cannabis Law may create administrative complexity for long-term care providers that are subject to federal oversight. Similarly, the proposed CON fee increase and prevailing wage mandate will impose additional costs on long-term care providers that seek to update their facilities or expand access to affordable housing or assisted living services. In an era of growing demand and shrinking resources, unnecessary regulation and fees must be abandoned.

V. Support Provider-Sponsored Managed Care Programs That Integrate Medicare and Medicaid

Long-term care providers and MLTC plans are integral players in the health care continuum and serve an important role in reducing avoidable hospital use and generating savings for the Medicare and Medicaid programs. LeadingAge New York's members have been active participants in integrated managed care models that incorporate Medicare services with Medicaid long-term care services, including FIDA, Medicaid Advantage Plus, and Programs of All-Inclusive Care for the Elderly (PACE). We believe these programs present promising strategies to deliver financially- and clinically-integrated and person-centered care for beneficiaries with complex medical conditions and/or functional limitations. They break down the siloes between Medicare and Medicaid and reduce the cost-shifting between the payers that drive inefficiencies, clinical fragmentation, and sub-optimal outcomes.

We also believe that MLTC plans sponsored by non-profit, long-term care (LTC) providers can play a key role in strengthening these initiatives. These plans offer a person-centered approach to care management, have expertise in the issues faced by older adults and the services they utilize, use health care professionals as care managers, and have been strong partners in the State's long-term care policy initiatives. Through close personal contact with beneficiaries and their formal and informal caregivers and geographic proximity, plans sponsored by non-profit long-term care providers are able to conduct accurate assessments, make informed care management decisions, and create strong linkages with health and social services providers in their members' communities.

Recommendations:

- *Ensure that State policies support the expansion of integrated managed care programs sponsored by long-term care providers, including the expansion of PACE programs.*
- *Ensure that rates paid to integrated managed care plans appropriately reflect the acuity of the beneficiaries served and the costs of the services delivered.*

SERVICE- AND SETTING-SPECIFIC RECOMMENDATIONS

I. Nursing Homes

LeadingAge New York's nursing home members are committed to provide high-quality, compassionate care to long-term and post-acute residents. They are serving individuals with increasingly complex and unstable conditions due to shorter hospital stays and consumer preferences to live longer in the community before seeking nursing home care. Notwithstanding policy and consumer preferences to serve consumers in the lowest intensity setting, nursing home occupancy rates remain high, and acuity levels of residents are rising. Even with the increase in community-based long term care options and decreasing lengths of stay, the median nursing home occupancy is above 94 percent in the state and has decreased by less than one percent over the last three years. Nearly a quarter of non-profit homes have

occupancy rates that exceed 97 percent.[14] Despite the desire of most people to age in place, we will always need nursing home care for people who lack appropriate housing or informal supports to remain in the community, who have complex conditions that require skilled care, or who simply cannot find aides and nurses to provide home care on a 24/7 basis.

a. Case Mix

With the continuing shift of medically-complex care from hospitals to post-acute care settings, nursing homes play an increasingly important role in helping reduce hospital length of stay. Many have strengthened their clinical capacity to serve residents with complex medical conditions, allowing patients to be discharged from hospitals more quickly and managing in place many conditions that previously required hospitalization. At the same time, the increased availability of services in the community has decreased the number of lower-need individuals living in nursing homes. These changes are in line with the Medicaid Redesign Team goals and Medicare policy initiatives and result in an increase in the average acuity of the nursing home population.

This translates to increased staffing costs which need to be reflected in the Medicaid reimbursement methodology. We strongly support rate adjustments that accurately reflect the staff time and resources needed to serve residents based on their acuity. Adjustments should be applied in a fair and consistent manner to ensure integrity of the process and adequacy of rates.

The Medicare program shifted to a new acuity measurement system in October 2019 that focuses on resident characteristics to predict the cost of care rather than relying on the amount of services provided. This shift was preceded by several years of transparent analysis on the part of the Centers for Medicare and Medicaid Services (CMS), extensive discussions with stakeholders and two years of provider education and preparation. The state should investigate whether the two systems can be better aligned. The discussions of the acuity workgroup convened by DOH in 2019 and the resulting recommendations are a good first step. The Department should reconvene the workgroup to facilitate a cooperative, fact-based discussion that would help improve efficiency and predictability for both DOH and providers.

Recommendation: *Reconvene the Acuity Workgroup to discuss options for updating the Medicaid case mix methodology to ensure its efficacy and to better align it with the approach used in Medicare.*

b. Staffing Ratios

As discussed previously, providers across the state are having increasing difficulty finding staff. All indicators suggest that the challenges are only going to intensify. While we support efforts that assist in supporting, attracting, recruiting, and retaining health care workers, mandating staffing ratios is not a viable approach. Academic research does not support the proposition that specific staffing ratios produce higher quality of care. In fact, the only outcome of staffing ratios would be higher Medicaid costs, increased recruitment and retention challenges, and less quality of life (e.g., recreational therapy) programming for nursing home residents, as providers would be forced to shift resources away from these programs to meet mandated ratios.

[14] LeadingAge NY analysis of most current federal Payroll Based Journal data for New York nursing homes for Q2 of 2019 and Medicaid RHCF cost report data for 2016 through 2018.

Staffing ratios that have previously been proposed would conservatively cost $1 billion annually to implement in nursing homes, although it is unlikely that the required number of qualified workers would be available.

Recommendation: *Reject staffing ratios legislation.*

c. Medication Technicians

The State needs to support ideas that most effectively deploy available staff. One such idea adopted in other states is the use of Medication Technicians in nursing homes. Specially trained certified nurse aides could provide routine medication passes in nursing homes, freeing nurses to provide other care while creating a career ladder option. The Department of Mental Hygiene is already doing this and has created a program that allows direct care aides to administer medication under the supervision of a nurse. A similar approach should be authorized in nursing homes.

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

d. Advanced Training Initiative

The State's Advanced Training Initiative (ATI), offers participating nursing homes the opportunity to train certified nurse aides and other front-line workers on early detection of changes in a resident's status that could lead to health declines and/or hospitalization. However, participation is limited to homes whose employee retention rates are better than the statewide median retention rate. Because retention rates vary based on regional dynamics, this requirement excludes many facilities even if they have highly favorable retention rates in their region. Eligibility should be based on regional, not statewide, criteria.

Recommendation*: Extend eligibility for ATI to facilities with staff retention rates above the median retention rate of their region.*

II. Managed Long Term Care (MLTC)

MLTC plans now manage and pay for the vast majority of the LTC services provided to aged New Yorkers eligible for Medicaid. While 90 percent of members are enrolled in partially capitated plans that coordinate care and pay for Medicaid services, thousands of New Yorkers are served by Programs of All-Inclusive Care for the Elderly (PACE) and Medicaid Advantage Plus (MAP) plans that combine Medicare and Medicaid services. These three programs allow some of the most vulnerable individuals in the state, many with multiple chronic conditions, to remain in the community by providing robust care management and a custom-tailored set of intensive services.

Consumer surveys have consistently found high participant satisfaction and the State's quality monitoring has reported high quality outcomes for individuals served by these programs. The most recently published satisfaction survey results indicate that 87 percent rated their plan as good or excellent. The most recent quality report from the State found that ninety-six percent of enrollees had

no falls resulting in injury in the past 90 days and that enrollees averaged just 3.4 potentially avoidable hospitalizations per 10,000 days of plan enrollment.[15]

Plans operated by not-for-profit long term care organizations performed especially well. Of the partially capitated plans in New York City (i.e., those serving the vast majority of the state's MLTC participants), **those operated by non-profit LTC organizations had an average overall score of 4.0 (of five stars) and accounted for all of the plans receiving an overall five star rating.**[16]

The Executive's Budget Briefing Book notes that MLTC, which provides coverage exclusively to older adults and individuals with disabilities, "costs about 10 times more than the coverage for individuals enrolled in mainstream managed care." This is completely appropriate – MLTC covers long-term care services for individuals who are determined, based on an assessment by the State's independent contractor, to need long-term care services for "a continuous period of more than 120 days."[17] MLTC beneficiaries typically require daily assistance with activities of daily living (e.g., dressing, toileting, bathing, transferring). By contrast, the typical mainstream managed care enrollee is under 65 and requires a few physician visits and a few prescriptions each year.

The Executive's Briefing Book also notes that From FY 2013 to FY 2019, MLTC spending grew by 301 percent. It fails to mention that in August 2012 through 2014, the State began mandatory enrollment of community-based long-term care beneficiaries into MLTC plans, and in 2015, it began mandatory enrollment of new nursing home residents into MLTC plans. Thus, it is hardly surprising that MLTC enrollment grew significantly during that time period, and many of those new MLTC enrollees were likely receiving long-term care services through the Medicaid fee-for-service program prior to their MLTC enrollment. With the data available, it is difficult to determine how much of the MLTC enrollment growth between FY 2012 and FY 2016 was offset by shrinkage in the fee-for-service program.

Furthermore, it is important to recognize that consumer eligibility and enrollment processes are controlled by the State and its independent enrollment contractors. Plans' advertising is limited by the State, and they do not make eligibility determinations. Policymakers and the MRT need to recognize that it is the State's established eligibility rules and enrollment mandates, *not* increases in plan premiums, that are increasing spending above projections. In fact, excluding minimum wage funding, which is passed through to providers and their employees, the per member per month rates paid to most MLTC plans *decreased* from the prior year.

Much of Medicaid reimbursement of long term care service providers, especially community-based providers, flows through MLTC. Cuts to plan reimbursement, as well as the additional costs of new requirements that are imposed without adequate reimbursement, undermine both plan and provider finances and destabilize the LTC delivery system for consumers. Nevertheless, for the past two years, the State has imposed deep cuts on MLTC plans without accompanying programmatic initiatives that generate the level of savings reflected by the cuts. They are simply cuts in the rates paid to plans for providing the same level of service. Notably, MLTC plans are required to spend at least 86 percent of

[15] 2018 Managed Long-Term Care Report, NYS Department of Health, Nov. 2018: https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2018.pdf
[16] 2018 Consumer Guide to Managed Long Term Care in New York City, Aug. 2018: https://www.health.ny.gov/publications/3339.pdf
[17] MLTC Partial Capitation Model Contract, Art. IV, sec. A, January 2020.

their premiums on medical/LTC services (a ratio known as the MLR) or face recoupments by the State.[18] Accordingly, neither prior year's cuts nor the need for future cuts can be justified by excessive premiums or the accrual of lavish plan profits. Even if the premiums paid by the State exceeded the MLR, plans would not be permitted to retain the excess.

Cuts in MLTC rates are especially difficult to manage when premium updates are done on a lag. For example, plans are still awaiting their 2018 quality incentive pool payments. The MLTC Quality Incentive Pool has been a repeated target of cuts and was most recently reduced in the 2019-20 State Budget. Many plans utilize this funding for value-based payment arrangements with network providers, arrangements that the state has made a priority. Quality pool reductions impacting prior periods reduce funding that has already been contractually committed and serve to undermine the desired shift to value based payment models. The State cannot impose deep cuts in MLTC rates year after year and expect plans to continue to provide the same level of service.

It is important to recognize that, in the context of mandatory enrollment of Medicaid LTC beneficiaries into MLTC plans, a cut to MLTC rates is a cut to LTC services and supports for vulnerable New Yorkers.

Recommendations:

- *The Legislature and the Executive, together with stakeholders, should analyze available data to understand why MLTC enrollment growth continues to exceed projections.*
- *Rates paid to MLTC plans should not be cut unless there is evidence that an associated programmatic initiative will generate equivalent savings within the same time frame as the rate cut. Efforts to improve efficiencies in MLTC must not threaten the solvency of MLTC plans and the viability of the LTC services they support.*

III. Home and Community-Based Services

A majority of older adults in New York and nationwide want to age at home and in their communities. For most, this will entail a safe home, access to healthy food, assistance with activities of daily living through informal and formal supports, care coordination, transportation to doctors' appointments, and social activities. Home care and other community services enable older adults to age in place.

However, the ability of consumers to access the services they need to age in place is threatened throughout the State by inadequate reimbursement and workforce shortages. Additional Medicaid cuts, whether imposed directly or through MLTC plans, will have devastating effects on home care agencies, which rely heavily on Medicaid reimbursement and are already experiencing thin or negative margins. Certified home health agencies (CHHAs) are struggling not only with Medicaid reimbursement shortfalls, but also with reductions in Medicare fee-for-service rates and inadequate Medicare Advantage rates.

Staffing shortages are already resulting in unfilled hours of authorized home care and waiting lists throughout the state. Agencies must turn away cases due to a lack of available registered nurses to

[18] Based on federal regulations, PACE programs are not subject to recoupments of excess premium.

assess and admit patients and supervise aides. Home care agencies have difficulty both with recruitment and retention. Turnover rates statewide average around 25 percent, but can be as high as 80 percent for RNs, and average 29 percent for home health aides. The time and expense of repeatedly recruiting and training staff is significant in relation to overall budgets.

Lack of access to home and community-based care not only affects the older adult waiting to be discharged from the hospital or nursing home and his or her family. It has a ripple effect on the long-term care continuum, the broader health care system, and the community. Without adequate access to home care, hospital and nursing home beds remain occupied by individuals waiting for discharge and are unavailable to those who require admission. Individuals who are living in the community without needed home care may experience avoidable exacerbations of chronic conditions, functional decline, falls, and ultimately nursing home admissions. Caregiver stress increases and their productivity at work diminishes. These outcomes add to the State's Medicaid spending and place a strain on the health system and our communities.

a. Consumer Directed Personal Assistance Program

The Executive Budget cites significant growth in the Consumer Directed Personal Assistance (CDPAP) as a source of excess Medicaid spending. CDPAP is a valuable resource for self-directing individuals and in areas of the state experiencing rapid growth in the population of older adults along with a dwindling workforce. It is important to recognize that particularly in some upstate communities the CDPAP program may be the only avenue to expand access to home care services. Any changes in the program must recognize regional variation and workforce challenges.

b. Expanded In-Home Services for the Elderly Program (EISEP)

LeadingAge New York fully supports the Executive's second year of $65 million investment in the Expanded In-Home Services for the Elderly Program (EISEP), which funds non-medical, in-home services; case management; non-institutional respite care; and ancillary services for functionally impaired older adults. These services are critical to the aging in place of New Yorkers, and a major increase for this program is long overdue.

c. Electronic Visit Verification

The 21st Century Cures Act requires New York to implement an electronic visit verification system to track delivery of Medicaid funded care of personal care aides by 2021, and home health aides by 2023. LeadingAge New York supports adequate funding of EVV for providers, as they will be required to implement, train, and operationalize this requirement. We have been unable to identify a funding source for EVV in the Executive Budget.

Recommendations:

- *Support #WIN4Seniors as outlined above.*
- *Ensure an appropriate allotment of funding from the Capital Transformation Program for home care and hospice providers.*
- *Expand access to hospice through advance care planning education and eMOLST adoption.*
- *Support the $65 million investment in EISEP.*

- *Ensure proper funding for EVV implementation during its rollout this year and beyond.*

IV. Adult Day Health Care

The last five years has brought significant change to the landscape and delivery of long term care services and supports. To keep up with the changes, adult day health care (ADHC) providers see an increased need for flexibility in how, when, where and to whom services are delivered. The model must adapt to meet the needs of payors and consumers to stay relevant into the future. We are pursuing the following regulatory amendments with the Department of Health to streamline operations and processes to allow for a more cost-effective and person-centered model.

Recommendations:

- ***Allow Medicaid fee-for-service, Medicaid managed care, Medicare and private-pay consumers to utilize unbundled services payment option (USPO).*** *The Department of Health adopted regulations to "unbundle" the all-inclusive adult day health care rate to permit managed long term care plans to contract for discrete services within the ADHC setting based on the needs of the registrant. However, only MLTC plans are allowed to unbundle and purchase ADHC services in this innovative way. ADHC programs increasingly turn away individuals with developmental disabilities and behavioral health conditions who would benefit from a structured and regulated ADHC environment, but may not need skilled services every day. By expanding USPO to additional Medicaid beneficiaries and private pay population, these functionally impaired individuals will receive services tailored to fit their needs in a safe and regulated setting.*
- ***Allow nursing home medical director or hospitalist to sign orders for admission and continued stay.*** *ADHC programs must currently rely on the registrant's community physician to sign orders for admission and every six months for continued stay. Although well-intentioned, this requirement is burdensome for consumers. Individuals seeking discharge from the hospital to ADHC have to wait days or weeks to schedule an appointment with a primary care physician to obtain the orders. This gap in care is critical and unnecessary. Admissions into ADHC would be much more efficient, immediate and person-centered if the hospitalist could sign orders for treatment. Likewise, the medical director employed by the ADHC's sponsoring nursing facility should be able to sign orders for treatment and continued stay.*
- ***Allow interdisciplinary care plan and UAS-NY to be completed during any day of the month it's due****. ADHC regulations state that the care plan and UAS-NY must be completed "every six months." This is difficult to arrange because this day may fall on the weekend or the registrant may have an unexcused absence from program. MLTC plans have the flexibility to assess on any day during the month that the UAS is due. ADHC providers request this same flexibility to accommodate the registrant's unpredictable schedule, maintain a person-centered environment and stay in compliance.*

V. Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs) and assisted living (AL) options provide residents with personal care services and assistance with medications in a homelike setting, enabling residents to be as independent as possible, while supporting their health and safety. ACFs and AL options also make efficient use of a scarce workforce; a true asset in communities where the workforce cannot support 24-hour in home care for seniors with functional limitations.

a. SSI Increase

Unfortunately, ACFs and AL facilities that rely on public funds are struggling to survive, as costs have risen and rates have not. The SSI Congregate Level 3 rate of **$41.63** per day falls far short of what it costs to provide the services that ACFs are, by regulation, required to provide. In fact, according to our calculations using *2015 data* for facilities that predominantly serve the SSI population, the average cost per day is *double the reimbursement.* The facilities included in this analysis received no state funding to help pay for the minimum wage increases, and we know that gap has only widened in the past five years, given the cost of wage increases and other expenses. Year after year, LeadingAge New York members are disappointed that the Executive Budget fails to include an increase in the State portion of the Congregate Care Level rate. The last increase to the State supplement was implemented in 2007; before that, it was 17 years. These infrequent, unpredictable increases have made it extremely difficult for ACFs to serve SSI recipients.

The consistent financial losses as a result of these rates are unsustainable. Since 2017, there have been 25 ACFs that have closed voluntarily, and we are aware of others that are on the brink of closure. In that period, one rural county saw three ACFs close. As a result of just one of those closures, approximately one-third of their residents had to be placed in a nursing home, where the State is now paying several times more *in Medicaid dollars for these former ACF residents*. This is terrible outcome for the residents who were displaced from their homes and an absurd result for the New York State budget. And, this is just one example.

As ACFs that serve SSI beneficiaries close, Medicaid nursing home spending will rise. Because these seniors are Medicaid-eligible and cannot live in independent housing, most will go to nursing homes at a greater cost to the state. Clearly, this makes no financial sense and is contrary to State and federal policy to support individuals in the most integrated setting appropriate to their needs.

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

b. ALP Medicaid Rate Modernization

The assisted living program (ALP) is the only Medicaid assisted living option in New York. While ACFs offer personal care and some health-related services, the ALP offers additional health care services for nursing home-eligible individuals. It provides an alternative to nursing home placement for many low-income seniors who do not need ongoing skilled services, at approximately half of the nursing home Medicaid rate. If ALPs cannot survive due to the inadequacy of the SSI and Medicaid rate, then those Medicaid-eligible residents will need to be served in nursing homes at twice the cost.

Like other Medicaid-funded long-term care providers, ALP programs have not received a trend factor increase since 2007, while the costs of providing care go up each year. Changes in the Medicaid payment processes for durable medical equipment and supplies have resulted in the ALP having to absorb the cost for items that were not contemplated when the program was established. Lastly, the ALP cares for people with dementia, but the ALP Medicaid rate is insufficient to truly address the needs to care for individuals with dementia. Historically, the nursing home Medicaid rate has included a dementia add-on; the ALP should have an analogous rate adjustment to enable more people with dementia to live in the ALP.

Recommendation: *Modernize the ALP Medicaid rate to ensure that it is best prepared to meet the future needs of Medicaid-eligible seniors and prevent nursing home placement by:*

- *Updating the base year of the nursing home rate upon which the ALP Medicaid rate is calculated to better capture true costs;*
- *Instituting a dementia rate add-on in the ALP Medicaid rate to help prevent unnecessary nursing home placement; and*
- *Further clarifying the durable medical equipment and supplies that should be included in the ALP Medicaid rate.*

c. EQUAL

EQUAL supports quality of life initiatives for residents of ACFs that serve SSI recipients. We oppose the Executive Budget proposal's re-programming of the Enhancing the Quality of Adult Living (EQUAL) funding, which divides the historic funding level of $6.5 million into two separate, very specific funding programs. The proposal allocates $3.266 million to ACFs which serve a threshold number or percentage of individuals with serious mental illness and directs the spending to very limited purposes, such as staff training or resident skills training. Overall, this new approach to EQUAL diverts essential funding away from ACFs serving low-income seniors that are struggling financially and directs much of it into activities that are already being funded in a variety of ways though other State initiatives.

The proposal then allocates an additional $3.266 million for capital expenditures for ACFs with the highest populations of residents who receive SSI. While funds for ACF capital projects are sorely needed, the proposal is too prescriptive. These facilities, which serve predominantly low-income seniors, also need support with operational costs and workforce challenges. These ACFs, which are focused on survival, should be able to work with their residents to determine how they can use this limited funding to have the greatest positive impact on resident quality of life.

As previously highlighted, the SSI payment does not cover the cost of providing care, much less allow a surplus of funds to invest in the building, programming or other resident benefit. While we agree that the EQUAL funding program needs to be revised, providers should have *more,* not *less* flexibility to use the funds in the way that a particular program needs, for the benefit of the residents.

Recommendation: *Reject the Governor's proposals to modify EQUAL funding by splitting it into two new prescriptive funding programs. Rather, take the $6.532 million and expand the options for use to ensure that ACFs, together with their residents, can identify what investments will have the greatest impact of quality of life and sustainability of the program.*

d. Enriched Housing Subsidy

We appreciate that the Executive Budget maintains level funding for the Enriched Housing Subsidy at $380,000. While these funds do not make up for the inadequate SSI rate, they do help ensure that facilities can undertake needed projects and offer amenities or resources for the benefit of their residents.

Recommendation: *Support the Governor's proposal to level fund the Enriched Housing Subsidy funding at $380,000.*

e. Criminal History Record Check Funding

We appreciate that the budget allocates $1.3 million for ACFs for criminal history record check (CHRC) funding. We want to ensure that past years' appropriations also remain in the final budget agreement, as ACFs have not yet been paid for 2018 and 2019 criminal history record checks. These delays in payment put further financial stress on already distressed ACFs. The payment delays also raise questions concerning the adequacy of the appropriation, as it no longer reflects current or even recent costs incurred.

Recommendation: *We urge the state to pay ACFs immediately for 2018-19 CHRCs and pay for CHRCs in ACFs in a timely manner moving forward. We urge the state to ensure that the budget includes enough funds to pay for past record checks and keep up with the volume of present day CHRCs.*

VI. Affordable Independent Senior Housing Assistance Program

As discussed above, New York should create a housing with services model for low- to moderate-income seniors. Providing low-income seniors with access to affordable housing with support services can have a significant impact on their ability to live independently in the community and may delay or prevent them from entering more costly levels of care, creating significant savings for the State's Medicaid program. Based on an annual investment of $2 million in an Affordable Independent Senior Housing Assistance Program (AISHAP), we project net Medicaid savings of $1.5 million.

LeadingAge New York, along with a coalition of senior housing providers and associations, has called for the creation of AISHAP , to be administered by DOH, and the appropriation of $10 million over five years to fund resident assistants in 25 senior housing properties around the State serving 2500 seniors. 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 assistants specifically focus on linking residents to the services they need to remain healthy in their communities. If a resident assistant can keep two people out of a nursing home for one year, the savings covers the cost of the grant. If an assistant works with approximately 100 individuals, 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 resident assistants.[19] Their analysis included 1,625 individuals, 431 of whom lived in properties that serve older adults and individuals with disabilities.

Additionally, a three-year research study that was recently conducted by Dr. Michael Gusmano of Rutgers University focused on the health care savings and utilization of Selfhelp residents living in Queens compared to older adults from the same zip codes based on New York State Medicaid claims data. Selfhelp's provides affordable housing complemented by an array of services. Among the key findings in this study is that the average Medicaid payment per person, per hospitalization for Selfhelp residents was $1,778 versus $5,715 for the comparison group. Additionally, the odds of Selfhelp residents being hospitalized were approximately 68 percent lower than for the comparison group, and

[19] 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.

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 resident assistant model.

Recommendation: *A $10 million, five-year strategic investment to bolster the $125 million in senior housing capital funding is a cost-effective strategy to optimize the independence, health and quality of life for New York's growing senior population. Moreover, the Affordable Independent Senior Housing Assistance 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.*

VII. Long Term Care Insurance

With the aging of the Baby Boomer generation and the strain this will place on government budgets, it is important to adopt public policies that encourage individuals to plan and pay for their future care needs. Long-term care insurance is an under-utilized method of planning and paying for services older adults are likely to need in order to age comfortably. The Executive Budget proposes to cap the maximum amount and income threshold for the long-term care insurance tax credit. This proposal further increases the cost to the consumer of long-term care insurance. It shifts State policy away from encouraging self-financing of long-term care and does nothing to mitigate the growth in Medicaid long-term care expenditures. The tax credit for long-term care insurance should be expanded rather than restricted.

CONCLUSION

LeadingAge New York's not-for-profit members are committed to providing high-quality care to their patients and residents. They are also committed to direct care workers, who are the unsung heroes in their organizations. They are struggling to meet growing demand for services and intensifying needs among the people they serve, in the context of a shrinking workforce and shrinking government support. They cannot continue to carry out their mission without adequate reimbursement. As this testimony illustrates, New York must act now to prepare for demographic change. It needs a Gray New Deal that builds the long-term care workforce; promotes efficiencies through investments in technology and infrastructure; supports the most appropriate care setting for each individual, including lower intensity residential options; streamlines regulations; and promotes provider-sponsored, integrated managed care programs.

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.