2022-23 Health/Medicaid Testimony

Provided by

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INTRODUCTION

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the aspects of the State Fiscal Year (SFY) 2022-23 Executive Budget impacting long-term care and post-acute care (LTC) providers,[1] aging services, and older adults. LeadingAge New York represents over 400 not-for-profit and public providers of LTC, aging services, and senior housing, as well as provider-sponsored Managed Long Term Care (MLTC) plans and Programs of All-Inclusive Care for the Elderly (PACE). This testimony addresses the Executive Budget proposals that apply across the continuum of LTC, aging, and MLTC/PACE services, as well as those that would affect specific types of providers and managed care plans.

After years of cuts and chronic under-investment in LTC, the Executive Budget for SFY 2022-23 is a welcome shift in direction. Indeed, many proposals are intended to alleviate the financial stress and workforce shortages that LeadingAge New York members are experiencing. However, the proposals do not go far enough to address the years of underfunding in this sector, the needs of our growing population of older adults, or the ongoing needs associated with the pandemic. Significant investments, both additional across-the-board Medicaid adjustments and targeted funding, and a multi-pronged approach to the workforce crisis are needed now to ensure the availability of quality not-for-profit LTC and aging services to meet the future needs of a growing population of older adults in New York.

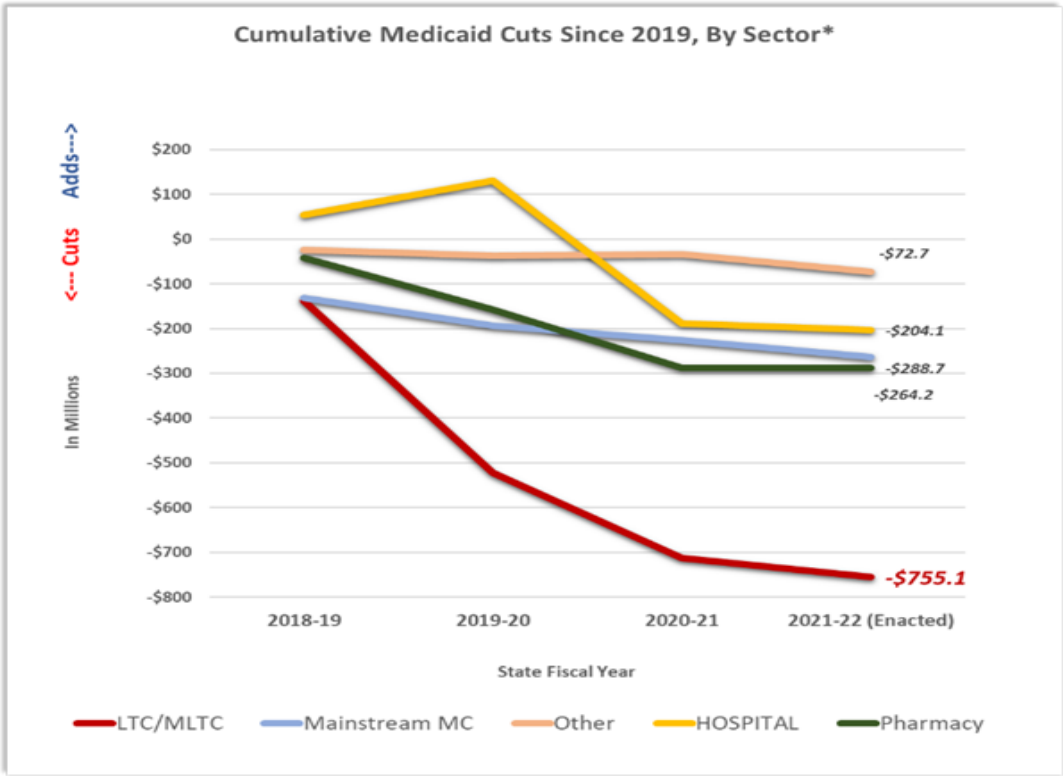
As policymakers act on the proposed SFY 2022-23 budget, it is critical to understand the current status of LTC and aging services and the essential role they play in the health care delivery system. The pandemic, which hit the people served by this sector the hardest, not only exacerbated longstanding problems, but also highlighted the interdependence of hospitals and the long-term/post-acute care system. Stress in one sector has ripple effects on the others and will inevitably impact all health care consumers.

Chronic Underfunding of LTC and Aging Services

Medicaid is the *de facto* insurance program for LTC, paying for over 70 percent of nursing home days and over 80 percent of home care services in New York. As the primary payer for LTC services in New York and nationwide, Medicaid bears significant responsibility for access to high-quality LTC services, the financial viability of the LTC sector, and its capacity to compensate staff appropriately for the difficult and essential services they deliver.

Despite the rapidly growing population of older adults in New York State, New York's principal focus for LTC policy for the past several years has been to reduce Medicaid spending on these services. Year after year, New York's LTC sector has borne deeper Medicaid cuts than any other health care sector, while costs have risen and administrative requirements have grown exponentially.

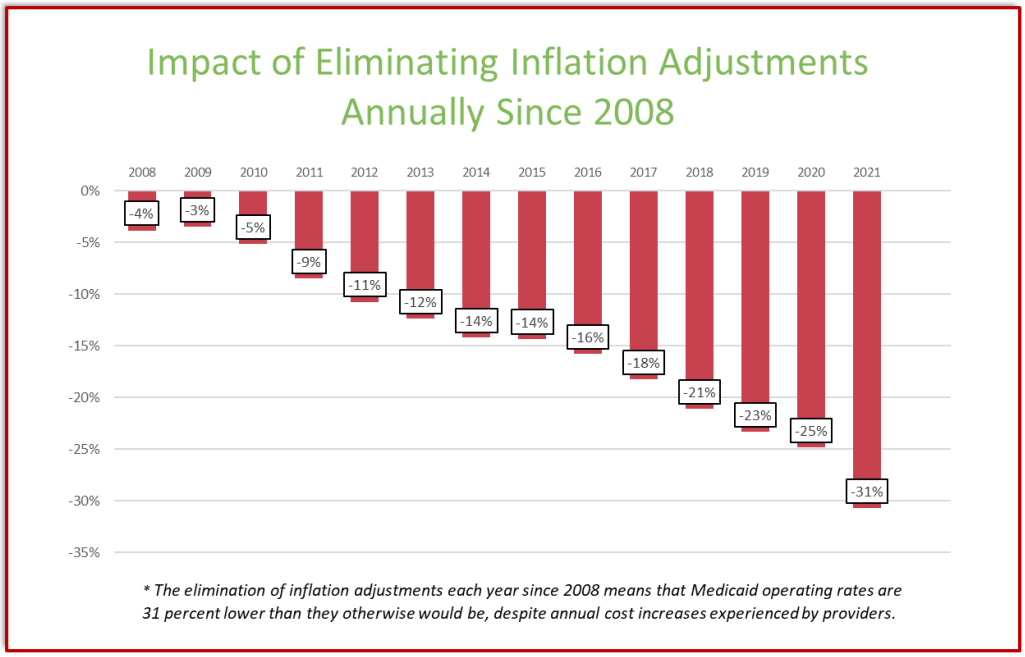
[1] The term LTC providers is used throughout this testimony to refer to providers that deliver long-term and/or post-acute care. These providers include home care agencies, nursing homes, hospice programs, adult day health care programs, and adult care/assisted living facilities.



*Note: Figures are based on State-calculated impacts of new Medicaid budget actions since 2018-19, as well as enacted cuts reflected in the SFY 2021-22 Medicaid spending plan. More than $1.5 billion in retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due to the pandemic are not reflected, nor are savings actions that are not attributable to a specific health care sector.

The impact on LTC providers of the State's elimination of Medicaid inflation adjustments alone has been staggering. Current Medicaid rates for LTC providers would be **31 percent higher** today if trend factors had not been eliminated for the past 14 years. And now, costs are skyrocketing as providers continue to contend with pandemic-related expenses, as well as increased costs of staffing, supplies, and energy. According to a national study, New York has among the largest shortfalls in the nation between the cost of care and its Medicaid nursing home rates.[2]

[2] Hansen Hunter & Company, "Report on Shortfalls in Medicaid Funding for Nursing Center Care – 2018 Update." The brief update estimates that unreimbursed, allowable Medicaid costs in New York in FY 2018 exceeded $1.2 billion, averaging $54.77 per Medicaid resident day. Prior to that, the most recent full "Report on Shortfalls in Medicaid Funding for Nursing Center Care" issued in Nov. 2018 found New York's Medicaid shortfall to be even greater ($64 per day, the largest shortfall of the 28 states the report analyzed.)



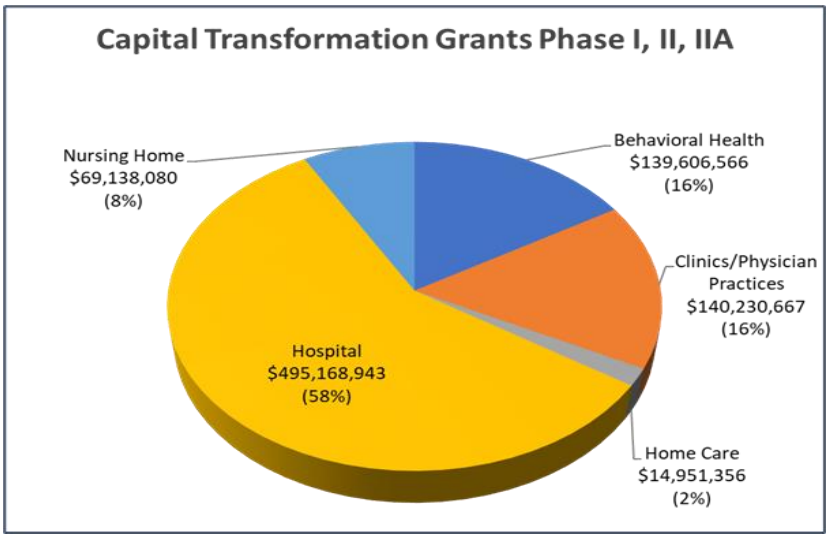
The State's policy of underfunding LTC continued even when the pandemic struck and public health experts projected that older adults and those living in congregate care facilities would be at gravest risk for severe disease and death. New York State cut Medicaid reimbursement by 1.5 percent. By contrast, according to the Kaiser Family Foundation, during the pandemic, **more than two-thirds of states increased Medicaid payments for home and community-based services (HCBS) providers, and more than half increased Medicaid payments to nursing homes.**

New York's depletion of resources from its LTC providers and the losses and extraordinary costs arising from the pandemic have brought the state's system of LTC services and supports to the precipice. The inadequacy of the State's Medicaid rates is forcing providers that want to deliver high-quality care to leave the market. Since 2014, approximately 20 nursing homes have consolidated or closed, and approximately 50 public and not-for-profit nursing homes have been sold to for-profit entities. During the pandemic, this trend has accelerated, with six closures, several not-for-profit homes sold or in sale negotiations, and additional quality providers planning to substantially reduce their available beds. We fully expect these numbers to grow.

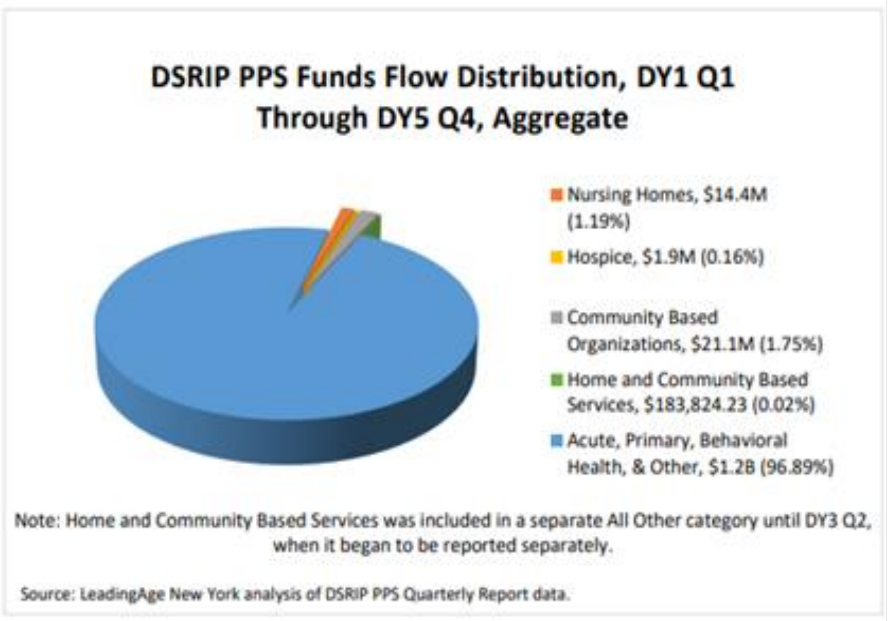
Like nursing homes, adult care facilities (ACFs) that serve Medicaid beneficiaries have also been struggling to survive with inadequate public funding. Their Supplemental Security Income (SSI) Congregate Care Level 3 rate of **$43.16 per day** covers less than half of the cost of State-mandated services. And, a majority of the state's home care programs were incurring operating losses before the pandemic, including 67 percent of certified home health agencies (CHHAs) that report negative or negligible operating margins, with an average margin of -14.78 percent.[3]

[3] "State of the Industry 2020," Home Care Association of NYS, February 2020, accessed at https://hca-nys.org/wp-content/uploads/2020/02/HCA-State-of-the-Industry-Report-2020.pdf.

Although New York's LTC providers have taken more than their fair share of cuts, they have not gotten their fair share of capital investments; 10 percent of Statewide Health Care Facility Transformation Program funds have been allocated to LTC providers. Our LTC system is facing a future in which choice of setting and provider is severely limited and nursing home services are predominantly delivered by for-profit enterprises in outdated, institutional facilities.



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



Alarming Demographic Trends and Workforce Shortages

While New York has been disinvesting in LTC services, its older adult population has been growing and the percentage of working-age adults has been shrinking. *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.*[4] At the same time, the percentage of our population between ages 18 and 64 is shrinking. Today, there are only approximately four working-age adults for every adult over age 65 in New York and 29 working-age adults for every adult over age 85. By 2040, there will be approximately three working-age adults for every adult over age 65 and 15 for every adult over age 85.[5]

Unfortunately, the supply of workers is not keeping up with demand, and nursing homes, assisted living (AL), home care agencies, and hospice programs are not able to fill existing job openings. For example, between 2016 and 2026, the average annual openings for home health aides (HHAs) and personal care aides (PCAs) are projected to grow by 52 percent and 41 percent, respectively, while openings for registered nurses (RNs) are projected to grow by 20 percent and for nurse aides by 16 percent.[6] These workforce shortages will have a more severe impact on LTC providers than other sectors because they rely heavily on public funds for reimbursement and cannot offer wages that compete with hospitals and staffing agencies.

COVID and the LTC Workforce Crisis

Demographics, funding, labor market dynamics, and the effects of COVID have combined to create an unprecedented workforce crisis in LTC. LTC and aging services providers and the people they serve have been disproportionately affected by the virus. On a human level, our mission-driven, not-for-profit providers are exhausted and demoralized. They have lost people they cared for – residents, patients, and co-workers, as well as family members, who succumbed to COVID-19. With great dedication and compassion, they have continued caring for their residents and patients. Repeatedly, they are faced with seemingly impossible tasks and regulatory requirements, but their focus on the residents and patients has kept them grounded. Despite their sacrifices, which are ongoing, LTC leaders and staff have barely been recognized; more often, they have been blamed for circumstances beyond their control. These attitudes have contributed to attrition and have not helped to attract new people to the field.

While workforce shortages are growing, COVID has necessitated additional staff and caused higher absenteeism. Additional staff are needed for cohorting, cleaning, in-room dining, testing, virtual and in-person visitation, and physically distanced activities. State and federal requirements related to the management of the pandemic have added significant, labor-intensive administrative responsibilities – daily and weekly State and federal reporting;

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[5] *Ibid.*

[6] Stiegler K, Martiniano R, Moore J, et al. *The Health Care Workforce in New York State: Trends in the Supply of and Demand for Health Care Workers.* Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; April 2020.

administering, tracking, and recording staff screening, testing, vaccinations, and furloughs; and monitoring, analyzing, and complying with federal, State, and local guidance that is continually evolving. COVID-related absences due to illness, family demands, positive test results, and exposures continue and strain an already limited workforce. Extensive absences have generated additional costs to ensure adequate staffing through hazard pay, overtime, and staffing agencies, as well as paid sick leave.[7] Staffing agencies have been charging exorbitant rates and recruiting employees away from providers.

At the same time, the pipeline for new certified nurse aides (CNAs), HHAs, and PCAs has been limited. Earlier in the pandemic, training programs for aides were closed. Nursing homes have been permitted to hire non-certified aides under a temporary waiver, which has helped to mitigate aide shortages, but is far from a long-term or complete solution. The Department of Health (DOH) initiated a hybrid virtual training model for home care aides to jumpstart training during the pandemic. However, few programs have been approved, and trainees are difficult to recruit.

The vaccination mandate and the impending booster mandate have placed additional pressure on an already strained system. We support COVID vaccination as an important, effective, and safe tool in fighting the pandemic. However, providers lost staff as a result of the first State vaccination mandate, and many expect to lose additional staff with the booster mandate that takes effect on Feb. 21st. There are too many staff members who, despite accepting their primary vaccination series, simply do not want to be pressured to receive another dose.

The results of the workforce crisis are being felt by everyone. Home care agencies and nursing homes have been forced to delay and suspend admissions, and consumers are facing barriers to care that lead to prolonged stays in hospitals. Hospitals beds remain occupied by individuals who no longer need acute care, preventing admissions of patients who do.

Financial Impacts of COVID

The financial position of many providers, especially not-for-profit providers, was shaky before COVID, and the situation is now dire. Costs have skyrocketed, and revenues have plummeted. Providers have spent millions on hazard pay, overtime, bonuses, and extortionate staffing agency fees to recruit and retain workers. They have had to absorb the exorbitant, unbudgeted costs of staff testing, infection prevention supplies, personal protective equipment, and more, with no financial support from the State. Mandatory weekly or twice-weekly staff screening tests were among the largest unbudgeted and unreimbursed costs for both nursing homes and ACFs – no other provider type was required to incur these costs.

[7] While the State created a COVID staffing portal in the early months of the pandemic, it was designed for hospitals and did not yield much relief for LTC providers. Individuals who registered for the portal were seeking higher-paying jobs and generally were not prepared for or interested in working in LTC settings. The portal was recently reopened with some modifications to support recruitment of LTC staff, but we have not heard of any successful hires.

These costs are not sustainable, even with a 1 percent Medicaid rate adjustment. While we appreciate the investments proposed in the Executive Budget, more must be done to enable LTC providers to cover the costs of delivering high-quality care during a pandemic.

Along with extraordinary cost increases, nursing homes, ACFs, and home care providers have experienced dramatic drops in patient/resident census and, for nursing homes and CHHAs, significant reductions in Medicare revenue from lower use of post-surgery rehabilitation services, creating growing budget shortfalls. As a result of declining admissions, it is not uncommon for our nursing home members to report COVID-related impacts from increased costs and revenue losses in the millions of dollars. Notably, while rising vacancies in nursing homes have caused financial distress for facilities over the past two years, they also resulted in Medicaid savings for the State. We estimate that reductions in nursing home Medicaid days in 2020 alone resulted in State-share Medicaid savings approximating **$40 million per month**. These funds, together with the overall increased federal Medicaid match, provide a valuable opportunity to invest and reinvest in our LTC sector.

While the federal government has made available Provider Relief Funds (PRF), they have covered less than half of the expenses in nursing homes and an even smaller percentage in AL and home care. For many nursing homes and ACFs, the costs of mandatory staff testing alone have exceeded any relief funding they may have received. A 2020 survey of our members revealed that General Distribution PRF funds covered less than 40 percent of a typical nursing home's COVID losses. While targeted PRF has provided additional funding to nursing homes and ACFs, such relief typically represents less than $4 of every $10 in new COVID-related financial impact. The State was also the beneficiary of federal relief funds, but LTC providers saw no financial support from the State.

The Way Forward

Battered by mounting, unreimbursed costs and workforce shortages, our LTC system is facing a future in which choice of setting and provider is severely limited; nursing home services are predominantly delivered by for-profit enterprises; and high-quality care is accessible only to the affluent. New York must take bold action now, leveraging available federal support and State dollars, to revitalize its LTC system. In the short run, a significant infusion of Medicaid dollars is needed, along with aggressive efforts on multiple fronts to support training, recruitment, and retention of LTC staff. In the longer term, the State's Master Plan for Aging provides an opportunity to consider the entire continuum of aging services, and the integral role of these services in the health care delivery system, as highlighted by the pandemic. The work of the Master Plan for Aging, the Task Force on Long Term Care recently established in legislation, and the 1115 Medicaid Waiver development should all be connected. LTC and aging services should be a priority in all discussions of health and human services, not an afterthought. LeadingAge New York is eager to be a part of these discussions.

With this as context, we offer the following recommendations for the Legislature to consider for the 2022-23 State Budget.

GENERAL RECOMMENDATIONS TO STRENGTHEN THE LTC SYSTEM

Medicaid Funding, Capital Transformation, and Distressed Provider Funds

- ***Accept the 1.5 percent Medicaid cut restoration and provide a substantial across-the-board increase in addition to the 1 percent proposed.***

We appreciate the Executive's proposal for a 1 percent payment increase along with the restoration of some prior Medicaid cuts. While a good start, funding must better approximate the actual costs that providers are facing, especially at a time of unprecedented staffing shortages. Based on the Employment Cost Index (ECI), a Bureau of Labor Statistics measure of the change in the cost of labor by sector, compensation costs increased by 5.7 percent in nursing and residential care facilities in 2021 alone, while the Consumer Price Index (CPI) shows that the average of all costs skyrocketed by 7 percent.

Medicaid providers are struggling with more than a decade of underfunding while trying to recover from the ravages of COVID and manage through unprecedented staffing shortages. At the same time, the State is financially healthy and receiving hundreds of millions of additional federal Medicaid matching dollars during the public health emergency. We urge the Legislature to supplement the 1 percent increase proposed by the Governor and provide a substantial additional increase to address cost growth over the past 14 years and the skyrocketing costs as a result of the pandemic.

- ***Support distressed provider funding and ensure a proportional allocation to LTC providers that could be made available quickly.***

We support the Executive's proposal to add residential health care facilities and ACFs to the entities that would qualify for funding under the Vital Access Provider Assurance Program (VAPAP) aimed at financially distressed providers. Fourteen years without an operating inflation adjustment combined with the extreme financial hardships of the past two years have pushed a number of high-quality providers into financial distress. We have seen an acceleration of closures and sales of not-for-profit homes, some of which might have been saved with temporary, but immediate, financial assistance. Funding should be awarded quickly and equitably by eligible provider type to ensure that LTC is appropriately reflected.

- ***Enact the Executive's health care capital proposal, adding home care and hospice, with assurance of appropriate allocation to LTC.***

We support the Executive's proposal for a $1.6 billion, multi-year Statewide Health Care Facility Transformation Program IV and are pleased that desperately needed capital dollars will be made available. However, the legislation should earmark a proportional amount of the overall capital allocation to LTC, which has been marginalized in previous funding initiatives. In addition, home care and hospice providers should be reinstated as providers eligible to apply

for the Phase IV funding. The use of Phase IV dollars to fund additional projects submitted through the Phase III application process should not delay the awards, and we urge the State to make all awards on a prompt and predictable schedule to help facilitate planning.

We support the proposal to fund innovative, patient-centered models of care and alternative models to traditional nursing home care. Although capital funding is critical for the development of innovative nursing home models, most such models (e.g., Green House) are more expensive to operate due to their staffing patterns. The State should allocate funding for rate enhancements for these models to ensure that they are not just developed, but are financially sustainable going forward.

Additionally, providers need the support of regulators and resources to reconfigure services in a timely way, to meet the current needs and preferences of consumers, and establish new systems that are sustainable into the future. The Certificate of Need (CON) and related applications for construction and reconfiguration or changes in services can take years and become increasingly complicated when involving different types of licensure.

- ***Ensure that HCBS Enhanced Federal Medical Assistance Percentage (eFMAP) funds are equitably and transparently allocated.***

The State's plan for allocating the first tranche of HCBS eFMAP funds ($361 million) has been limited to certain high-billing licensed home care services agencies (LHCSAs). The regional distribution of these funds and the selected providers have not been disclosed publicly. We believe that certain regions of the state may have been omitted. In addition, the funds have not been made available to CHHAs, hospice programs, or Medicaid Assisted Living Programs (ALPs). Another tranche of $1.1 billion for home care workforce funding is slated for SFY 2022-23. A more equitable and transparent distribution of funding is necessary for all phases to ensure that the LTC workforce is supported statewide and throughout the HCBS continuum.

Workforce

- ***Expand the health care worker bonus proposal to include critical providers and key roles.***

We applaud an investment in bonuses for health care workers to enable providers to reward workers who have been working during these challenging times, which in turn will assist in retention. Unfortunately, key workers and sectors were overlooked in the Executive Budget proposal. We urge the Legislature to modify the proposal to include additional worker roles critical to operations in LTC, such as dining, housekeeping, security, and maintenance. In addition, staff in ACFs, assisted living residences (ALRs), and possibly some LHCSAs and hospice agencies were omitted from the proposal; they have been on the frontlines since the beginning of the pandemic and deserve to be recognized and rewarded for their extraordinary dedication and commitment to caring for those most vulnerable to COVID.

- ***Enact the Governor's proposal to authorize medication aides in nursing homes (Part C, §§6-8).***

LeadingAge New York wholeheartedly supports the Governor's proposal to authorize specially trained CNAs to work as medication aides in nursing homes, administering routine medications to residents under the supervision of an RN. This proposal would help to address the nursing shortage in nursing homes, while providing new opportunities for CNAs and preserving quality and safety. Approximately 25 states already authorize medication aides to perform these tasks in nursing homes. In New York State, the Office for People with Developmental Disabilities allows unlicensed direct care staff to administer medications.

The proposal would provide several benefits to nursing home residents and the people who care for them. It would allow RNs and licensed practical nurses to focus on higher-level tasks and provide added attention to residents with more complex clinical needs. It would also provide another step on the career ladder for CNAs, providing them with additional training and compensation and a path to explore the possibility of a nursing degree. A 2011 review of the academic literature by the National Council of State Boards of Nursing concluded that "medication aides are capable of safely administering oral, topical, and some parenteral medications; that is, no evidence suggests that medication aides have higher error rates than licensed nurses." Studies also show that the use of medication aides improved job satisfaction among nurses and medication aides.[8] Given the severe nursing shortages we are experiencing across the state, we cannot afford to forgo this win-win strategy.

- ***Ensure funding for employment-related supports and transparency in allocations.***

To address the barriers to working in LTC, the State should invest in employment-related supports for LTC staff and trainees. These include transportation and child care funding and support for training-related expenses. These supports should be available not only for clinical staff, but also for the essential team members who work in dining, housekeeping, and maintenance. Our members are experiencing dire shortages in all departments. It appears that there may be funding for these purposes in appropriations under career or "caregiver flexibility for direct care workers," "financial burden relief for healthcare workers," and "training capacity expansion" in the Urban Development Corporation appropriations. We have been unable to determine the State's intention for these funds.

- ***Expand access to aide training and criminal history record check (CHRC) sites; eliminate duplicative in-service training.***

The State needs to work collaboratively with providers to eliminate barriers to obtaining and retaining aide certifications and onboarding direct care staff in LTC settings. In rural and

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

exurban areas, we must work to ensure that there is an adequate supply of training programs to certify and recertify aides. Many providers report difficulty finding programs that will evaluate competencies which facilitate flexibility among settings and help maintain certification under special circumstances.

Lack of access to fingerprinting sites for CHRCs has also become a barrier to hiring staff in LTC settings. The State's contractor for CHRCs appears to have closed or reduced hours of fingerprinting access points in many communities, preventing applicants who do not have the time or resources to drive long distances from being fingerprinted and delaying the process for others who cannot get a prompt appointment. As a result, LTC providers are losing viable candidates to other types of employers who can onboard them more quickly. The State should increase CHRC funding to enable the State's contractor to open more fingerprinting access points or deploy technologies to otherwise expand their reach and to support additional State staff to expedite processing.

In addition, the duplicative in-service trainings of HHAs, PCAs, and CNAs who work for more than one employer must be eliminated. Redundant trainings are unnecessary and deprive residents and patients of familiar aides while the aides are engaged in training. Instead, the State should allow aide in-service trainings completed under the auspice of one employer to count toward the in-service training requirements of other employers. The State should also develop a mechanism for including these trainings in the aide registries. Legislation to accomplish this for home care aides was vetoed by the previous Governor. The Legislature should include a similar provision in the final budget for both home care aides and CNAs.

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

We urge the Legislature to modify the Executive proposal for this loan repayment program to explicitly identify LTC as an underserved population and prioritize the benefit to those who work in these settings and services. These providers are less able to compete than the primary and acute care settings.

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

We support the Governor's proposed investments in our health care workforce and proposed reforms that support career ladders for certified personnel and regulatory flexibility for professionals. In particular, we support the proposal to join the Interstate Nurse Licensure Compact. We also appreciate proposals to make permanent some of the flexibilities utilized during the pandemic, including flexibility with ordering and specimen collection of COVID tests. We noted investments in health care tuition, instructional costs, and other supports and would like to provide input into the allocation and uses of these funds.

Reduce Low-Value Administrative Requirements

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

The pandemic has led to the imposition of an overwhelming array of new administrative requirements, without any recognition of the additional personnel they require, their impact on residents and patients, and the costs they impose. Nursing homes and ACFs in particular are staggering under the stresses of a mind-boggling array of growing and ever-changing administrative requirements, in the midst of a staffing crisis. For nursing homes, the daily and weekly Health Emergency Response Data System (HERDS) surveys; weekly National Healthcare Safety Network (NHSN) surveys; oversight, recordkeeping, and reporting of staff and visitor COVID testing and staff COVID vaccinations; and numerous mandated postings and notices of various laws, ratings, and contractual relationships are just a few examples of recent administrative mandates. Many of these requirements (e.g., posting a summary of every contract for goods or services, notifying DOH of every staffing agency contract, satisfying State audit checklists) duplicate federal requirements or offer little, if any, value in terms of quality or safety. Yet, they divert precious staffing resources from resident care to low-value administrative tasks.

Legislators and regulators should consider the impact on residents and staff of any new administrative requirements. One simple step the Legislature can take to support providers is to urge DOH and the Governor to reduce daily HERDS reporting, which has been a requirement for nursing homes and ACFs since March 2020.

SERVICE- AND SETTING-SPECIFIC RECOMMENDATIONS

Nursing Homes

- ***Suspend enforcement of minimum staffing level provisions for two years; ensure that providers are not penalized for circumstances beyond their control.***

The minimum nurse staffing law enacted last year (in the wake of the minimum direct care spending law discussed below) sets inflexible staffing requirements that the vast majority of homes will find impossible to meet during this unprecedented staffing crisis. As a result, the law will trigger penalties on most nursing homes, further depleting the resources they need to recruit and retain staff. Notably, DOH recently proposed regulations with penalty provisions that exceed the requirements of the statute when nursing homes fail to satisfy the standards due to extraordinary circumstances beyond their control. Rather than enhancing nursing home staffing and helping residents, this law will have the opposite effect.

- ***Restore the 5 percent cut to nursing home capital reimbursement.***

The SFY 2020-21 budget reduced the capital component of the daily nursing home Medicaid rate that is intended to cover the Medicaid proportion of a home's capital costs. Not-for-profit nursing homes and their lenders rely on the State to meet its reimbursement commitment for capital projects it has approved. This cut, together with the treatment of capital spending under the minimum direct care spending legislation discussed below, forces lenders to question the ability of nursing homes to meet their debt service obligations going forward. Partnerships with lenders are key to financing renovations and upgrades that support resident safety and comfort. Cutting capital reimbursement for projects the State has agreed to fund through an approval process is a bad precedent. The Executive Budget would restore the 1.5 percent across-the-board payment cut and should do the same with the cut to capital reimbursement.

- ***Provide additional targeted funding through the Nursing Home Quality Pool.***

We support the Executive's proposal to allow the Nursing Home Quality Pool to be funded through appropriations and request that additional funds be dedicated for this purpose. The current Quality Pool is self-funded, redistributing existing Medicaid funding often years after the performance measurement period. Making additional funding available through the Quality Pool would target resources to support quality providers while furthering the State's quality agenda.

- ***Amend the minimum spending provision to exclude capital reimbursement and other pass-through dollars from the minimum spending calculation.***

Although we support the Executive's proposal to exclude cash receipts assessment reimbursement from the nursing home minimum spending requirement enacted in last year's budget, additional amendments are needed. As currently structured, **this legislation will discourage, if not prevent, facilities from making capital investments in their facilities to control the spread of disease** – an irresponsible outcome in the context of an airborne pandemic that has disproportionately affected older adults. The Executive's proposal to exclude capital reimbursement only for homes with certain star ratings should be expanded to exclude capital reimbursement from the calculation for all homes. Star ratings can change quarterly, and all residents deserve to live in home-like and safe environments. In addition, we recommend amending the legislation to include care-related costs arbitrarily excluded from the spending calculation (e.g., security, grounds, and medical records).

PACE and MLTC

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

The Executive Budget proposes a competitive procurement for almost all Medicaid managed care plans, including partially capitated MLTC plans and integrated Medicare/Medicaid Medicaid Advantage Plus (MAP) MLTC plans. The proposal would impose a limit of five on the number of each type of plan in each (yet to be defined) region.

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

- ***Block the Independent Assessor expansion; repeal Section 11 of Part MM of Chapter 56 of the Laws of 2020.***

As a result of legislation enacted in 2020, DOH is expanding its contract with Maximus to conduct not only initial MLTC enrollment assessments, but also, as of May 1, 2022, reassessments. This initiative threatens to create new barriers to LTC services, impede effective care planning, contribute to consumer confusion, and exacerbate nurse staffing shortages. There are already lengthy delays in scheduling just the *initial* assessments by Maximus due to staffing shortages. An expansion of Maximus's responsibilities will only add to delays, which will in turn impede hospital and nursing home discharges and prevent access to needed LTC services.

- ***Raise MLTC premiums from the bottom of the actuarially-sound range.***

We support the Governor's proposal to raise the premiums of integrated MAP plans from the bottom of the actuarially-sound rate range to the middle. However, this policy should also be adopted for partially capitated plans. The State's decision to automatically drive MLTC premiums to the bottom of the rate range deprives the LTC system of needed resources.

- ***Support the restoration of the funding for the MLTC Quality Pool.***

LeadingAge New York supports the Governor's proposal to restore the $17.25 million cut to the MLTC Quality Pool that was enacted two years ago. The MLTC Quality Pool incentivizes the delivery of high-quality LTC services and supports value-based payment (VBP) initiatives with LTC providers. The cut in funding for this pool was ill-advised and disrupted those initiatives.

- ***Support streamlining of licensure of PACE programs.***

The budget proposes to streamline the licensure of PACE programs that offer an effective provider-managed care model for older adults that integrates Medicare and Medicaid services and funding streams. This effective model has been subject to multiple layers of oversight within the State and federal governments. LeadingAge New York supports efforts to integrate regulatory oversight of PACE programs.

HCBS

- ***Wage mandates***

LeadingAge New York supports the payment of appropriate compensation to home care aides and other direct care staff delivering home care services. We recognize that an increase in wages for all LTC workers is well-deserved and must be part of the solution to the workforce crisis. However, a wage mandate is a blunt instrument that can have unintended consequences, particularly in a health care sector that is heavily dependent on public payers and struggling with the impacts of the pandemic and under-reimbursement. We are concerned that a home care wage mandate will threaten the stability of the agencies that deliver this care and disrupt services to the individuals who rely on it.

For example, an increase in reimbursement for Medicaid home care will not cover the costs of wages paid for services reimbursed by other payers such as Medicare, Medicare Advantage, the Expanded In-Home Services for the Elderly Program (EISEP), and commercial payers. Any proposal mandating an increase in home care aide wages above the minimum wage must be funded appropriately to cover costs associated with services reimbursed by government payers. Lastly, any wage initiative must cover both current and out-year costs and address compression impacts.

- ***Support telehealth parity for HCBS providers.***

LeadingAge New York supports the Executive's proposal requiring parity of reimbursement of telehealth services equivalent to in-person services. The Executive Budget provides for parity for Medicaid telehealth services delivered on a fee-for-service basis by CHHAs, but does not clearly include equivalent telehealth services delivered by other Medicaid LTC providers, nor does it clearly include equivalent services delivered under contracts with Medicaid MLTC plans.

Several elements of home care and adult day health care (ADHC) can be enhanced by telehealth modalities, including nursing assessments, physician consultations, supervision of aides, patient check-ins, and remote monitoring of vital signs and other physiological data. The expanded use of telehealth services during the pandemic has demonstrated the value of connecting with older adults and people with disabilities via telehealth modalities. Medicaid beneficiaries who use LTC services, whether enrolled in MLTC plans or in fee-for-service

Medicaid, should continue to have access to these services. Providers and MLTC plans should be appropriately reimbursed for services delivered via telehealth modalities.

In addition, LeadingAge New York supports making permanent telehealth flexibilities afforded to home care and ADHC providers during the pandemic.

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

LeadingAge New York fully supports the Executive's additional funding for EISEP, to deliver personal care services and everyday supports to aging New Yorkers. This funding includes additional monies to address unmet needs of the elderly during these unprecedented times. EISEP supports extend independent living of our seniors, as they can age in place at home in our communities. The State continues to utilize this funding to tackle waiting lists for both EISEP and Community Services for the Elderly (CSE) services.

We also support continued funding at $4.02 million for both traditional and Neighborhood Naturally Occurring Retirement Communities (N/NORCs), including a restoration of $1 million in supplemental funding for nursing services provided as part of the N/NORC program and another $1.5 million to expand the definition of Neighborhood NORC so that more communities can utilize this valuable program. This program also helps older residents age in place by offering preventive health and wellness activities, identifying health risks, and improving the NORC community's health status.

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

- ***Fund resident assistants in affordable senior housing.***

LeadingAge New York, along with a coalition of senior housing providers, associations, and affordable housing advocates, is calling for the commitment of $5 million in the SFY 2022-23 budget to fund the creation and operation of an Affordable Independent Senior Housing Resident Assistance Program in affordable senior housing properties throughout the state. We propose that grants of up to $150,000 per year be made directly to senior housing operators to establish the systems they need to hire resident assistants, who would work to identify residents' unmet needs and link them with the existing community programs and resources that can help them remain healthy and independent. Accounting for administrative costs at the agency level and start-up costs at the building level, we estimate that at least 30 affordable independent senior housing properties could benefit from this investment in the first year of the program, with the opportunity for additional properties to be onboarded in subsequent years.

The program would enable the individuals to optimize their health and independence in the community and delay, if not avoid, nursing home care. The Medicaid program bears much of the cost of nursing home care, with State spending ranging from $38,000 to $52,000 per person, per year. If each resident assistant works with up to 150 low-income seniors throughout the course of a year to promote better day-to-day wellness and help them maintain independence, the savings potential is enormous. Further, a study of older adults in affordable housing with supportive services in Queens compared with other older adults showed significant reductions in hospitalizations and emergency room use among residents of senior housing with services, along with substantial Medicaid savings. 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.[9]

Assisted Living and ACFs

ACF/AL providers offer support and assistance in a home-like setting. Statewide, these providers care for nearly 52,000 New Yorkers. The average resident is 85 years of age, requires assistance with at least three activities of daily living, and has multiple co-morbidities. COVID brought unprecedented challenges to ACF/AL providers, whose residents are among the most vulnerable to COVID. The extraordinary added costs related to COVID are causing considerable financial strain, and workforce shortages are at a crisis.

- ***Include a $75 million allocation for ACFs, ALRs, and ALPs for COVID relief.***

All ACF/AL providers have been contending with COVID for nearly two years now. New York's senior living providers have incurred hundreds of millions of dollars in unbudgeted expenses to procure gowns, gloves, masks, and other infection control supplies; to provide well-deserved hero pay to staff; and to hire additional staff. For more than a year, they were required to COVID test staff weekly at their own expense. Periodic limits on new admissions and visitation restrictions resulted in substantial revenue losses. It was extremely disappointing, therefore, to see no allocation for relief for this sector. Unlike the arts and entertainment sectors that have received financial support from the State, ACF/AL providers have received *no State relief* throughout the pandemic. We urge the Legislature to include a $75 million allocation in the SFY 2022-23 budget to help offset a portion of the costs and losses ACFs, ALRs, and ALPs have incurred to date as they continue to address the pandemic.

- ***Expand the health care worker bonus proposal.***

Unfortunately, the Executive Budget proposal also overlooked most ACFs in the state in the health care worker bonus proposal. While ALPs appear eligible for the program as a Medicaid provider, nearly 400 other ACF and ALR settings – including those with residents who are

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

Medicaid-eligible – are not. All workers critical to operations in the ACF/AL sector deserve to be recognized and rewarded for their extraordinary dedication and commitment to caring for those most vulnerable to COVID-19.

- ***Increase the Congregate Care Level 3 State Supplement Program (SSP) rate by at least $20 per day and build in an annual cost of living adjustment thereafter.***

ACFs that serve low-income older adults are in particular financial distress, due to chronic underfunding that predates the pandemic. Unfortunately, they are even less able to find ways to increase wages, provide bonuses, or make needed repairs to aging buildings. This makes the above omissions in the Executive Budget proposal all the more disheartening. SSI, together with SSP, pays ACFs $43.16 per day, which is entirely inadequate for ACFs to provide residents with regulatorily required services including housing, meals, personal care, case management, and more. There has not been an increase to this SSP since 2007.

LeadingAge New York's analysis of 2017 pre-pandemic ACF Financial Report data demonstrated that it costs ACFs *twice* the daily reimbursement per resident to provide their services – and the gap between costs and reimbursement has grown significantly since then. Since 2017, there have been *39 ACFs that have closed* voluntarily, and there will be more. If SSI/Medicaid-eligible seniors cannot access ACFs in their communities, they will go to nursing homes at a significantly higher cost to the State. LeadingAge New York estimates that *for every 45 low-income ACF residents who can remain in their ACF or are diverted from nursing home placement, the State saves $1 million in Medicaid spending annually.* We urge the Legislature to increase the Congregate Care Level 3 SSP rate by at least $20 per day and build in an annual cost of living adjustment thereafter.

As noted previously, the Executive Budget's inclusion of ACFs among the list of eligible applicants for VAPAP funding is appreciated and could offer a lifeline to some of these providers in financial distress.

- ***Increase the ALP Medicaid rate, and dedicate some HCBS eFMAP funds to ALPs.***

As is the case with other Medicaid providers, the ALP rate has not had a standard trend factor increase for 14 years, and its rate was cut last year. The ALP is the only Medicaid AL option in New York, serving seniors who are at a nursing home level of care, but do not need ongoing skilled services, at approximately half of the nursing home Medicaid rate. The program is in desperate need of an increase, as described earlier in this document, and the State can benefit from federal HCBS eFMAP funds to support the cost of such an increase. The State should also direct additional eFMAP funds to support ALPs and other critical HCBS providers who are in desperate need of financial support.

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

The Legislature could also implement a no-cost workforce solution by enabling nurses working in ACF/AL settings to provide nursing services, consistent with S.1593 (Rivera). Nurses working in these settings across the state have been invaluable during the pandemic in guiding infection control and education efforts, but most are not permitted to provide nursing services directly given restrictions on the duties nurses can perform in these settings. The Enhanced Assisted Living Residence (EALR) is the only ACF/AL setting that permits these professionals to provide nursing services. Particularly during a pandemic, we should be utilizing nurses in ACFs to provide periodic services that would result in better health outcomes, administer immunizations, prevent hospitalizations, support end of life care, and save Medicaid dollars.

ADHC

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

ADHC programs are cost-effective, community-based programs that provide skilled nursing care and therapies to individuals in a congregate day setting. They reduce emergency room visits, reduce hospital admissions, reduce falls, and delay nursing home placement. The State should dedicate the necessary resources to commit to a full return to operational status for ADHC programs. ADHC programs provide nursing home-level care to individuals who live in the community, and it is critical that these resources are re-established as quickly as possible. Additionally, as noted above, the State should ensure that ADHC services are included in telehealth parity as applicable.

In March 2020, all 116 ADHC programs across the state were instructed to close due to COVID-19 – one of the only provider settings to be instructed to close their doors. During that time, individuals statewide lost access to their ADHC services, including personal care, therapies, and skilled nursing services, resulting in preventable hospitalizations, nursing home admissions, and deterioration of member health and hygiene. The loss of opportunities to see friends and participate in enriching activities led to cognitive and emotional decline for many ADHC registrants.

Although ADHC programs were authorized to reopen in March 2021, only 52 ADHC programs have been able to reopen. Others are trying to reopen and are struggling to do so. LeadingAge New York calls on the Legislature to support a full reopening of ADHC programs.

- ***Increase Medicaid reimbursement for ADHC providers and Method 1 transportation vendors.***

We urge the State to increase Medicaid reimbursement of ADHC programs to reflect current costs of care, associated operating expenses, and adequate compensation of staff. Further, we support increased reimbursement for ADHC Medicaid transportation. A critical component of ADHC is assisting registrants with safe transportation to program. Programs struggle to find

vendors willing to provide transportation with the current rate and often have to subsidize additional compensation to bring their registrants to programs.

- ***Ensure that ADHC programs receive adequate HCBS eFMAP funding.***

ADHC programs, along with social day care programs, are also slated to receive $10 million in HCBS eFMAP funding for reopening and operational support. To reopen, these programs have to start from scratch hiring staff and carrying out readmissions and assessments of their registrants. Moreover, programs that have reopened are operating at limited capacity due to staffing shortages, infection and exposure challenges, and transportation issues. While ramping up their staffing and enrollment, programs are having difficulty generating sufficient revenue to pay their bills and stay open. The State should ensure that the eFMAP allocations to ADHC programs are distributed as soon as possible, and that programs have the flexibility to use their funds to address pressing needs, so that programs can continue to work toward reopening.

CONCLUSION

In order to revitalize our LTC and aging services in the wake of this devastating pandemic and ensure that accessible, high-quality services are available to older adults and people with disabilities in the future, we need to make significant investments now. Adequate public funding must be the foundation of this revitalized LTC system. Looking to the future, we can expect that a significant portion of older adults will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs. In addition, we will need a multi-pronged, intergovernmental effort and private and public sector engagement in workforce development. We look forward to working with the Legislature to ensure that LTC is a top priority in the State Budget for SFY 2022-23.

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.