



# 2019-20 Health/Medicaid Testimony

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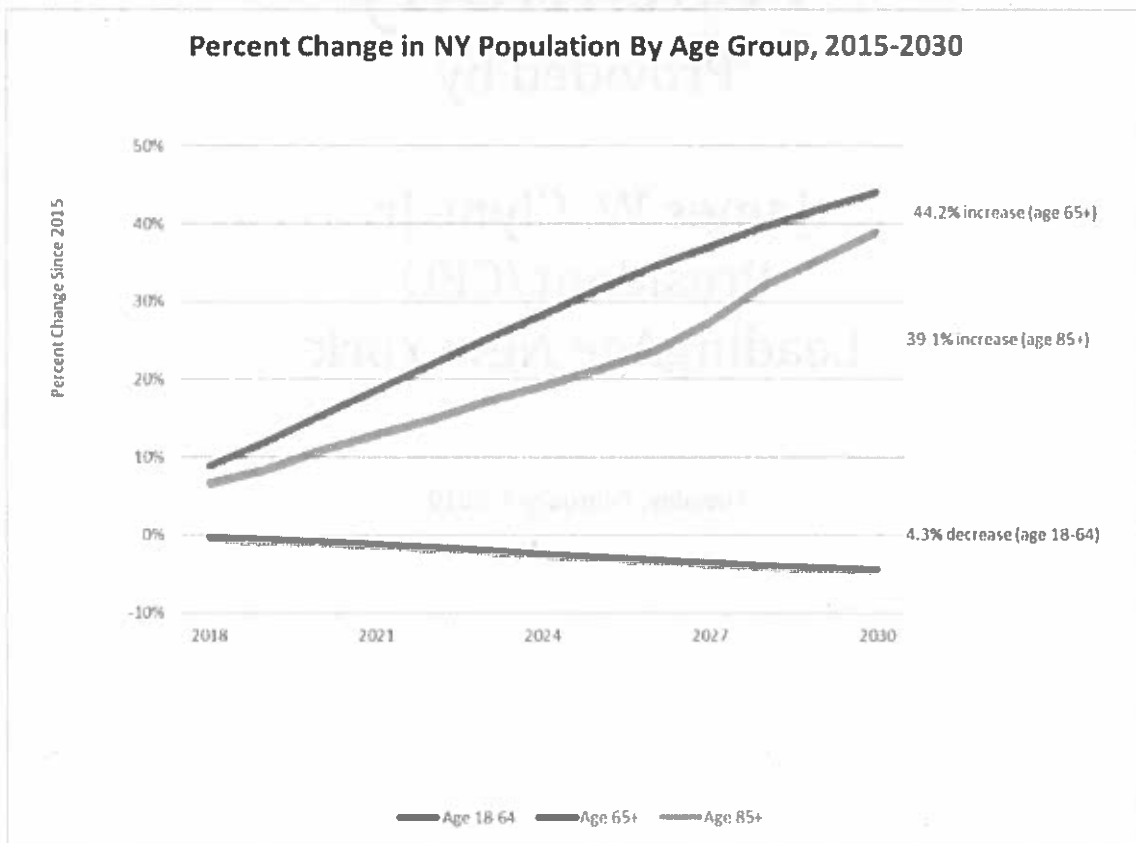
**James W. Clyne Jr.**  
**President/CEO**  
**LeadingAge New York**

**Tuesday, February 5, 2019**

**Introduction**

On behalf of the membership of LeadingAge New York, thank you for the opportunity to testify on the health, aging, and Medicaid aspects of the SFY 2019-20 Executive Budget. 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.

New York is approaching a demographic crisis. Approximately 3 million adults age 65 and older, representing 15 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.<sup>1</sup> 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.



In 2015, there were 28 working-age adults for every adult over age 85. By 2040, there will be only 14 working-age adults for every adult over age 85.<sup>2</sup> Both informal caregivers and workers in the formal care delivery system to support the growing population of seniors are already in short supply, and the gap

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

<sup>2</sup> *ibid.*

will only grow. Moreover, with one-third of today's older New Yorkers living at or near the poverty level, it is reasonable to expect that a significant portion of our growing senior population will continue to rely heavily on public programs – principally the Medicaid program – to cover their LTC needs.<sup>3</sup>

Faced with current and future demographic challenges, New York must take action now and invest in the workforce, long-term services, supports, and technologies that enable individuals to remain in their homes and communities, and it must modernize regulations and provide funding to permit providers to address consumer preferences, optimize efficiencies, improve quality, and effectively deploy an increasingly scarce workforce.

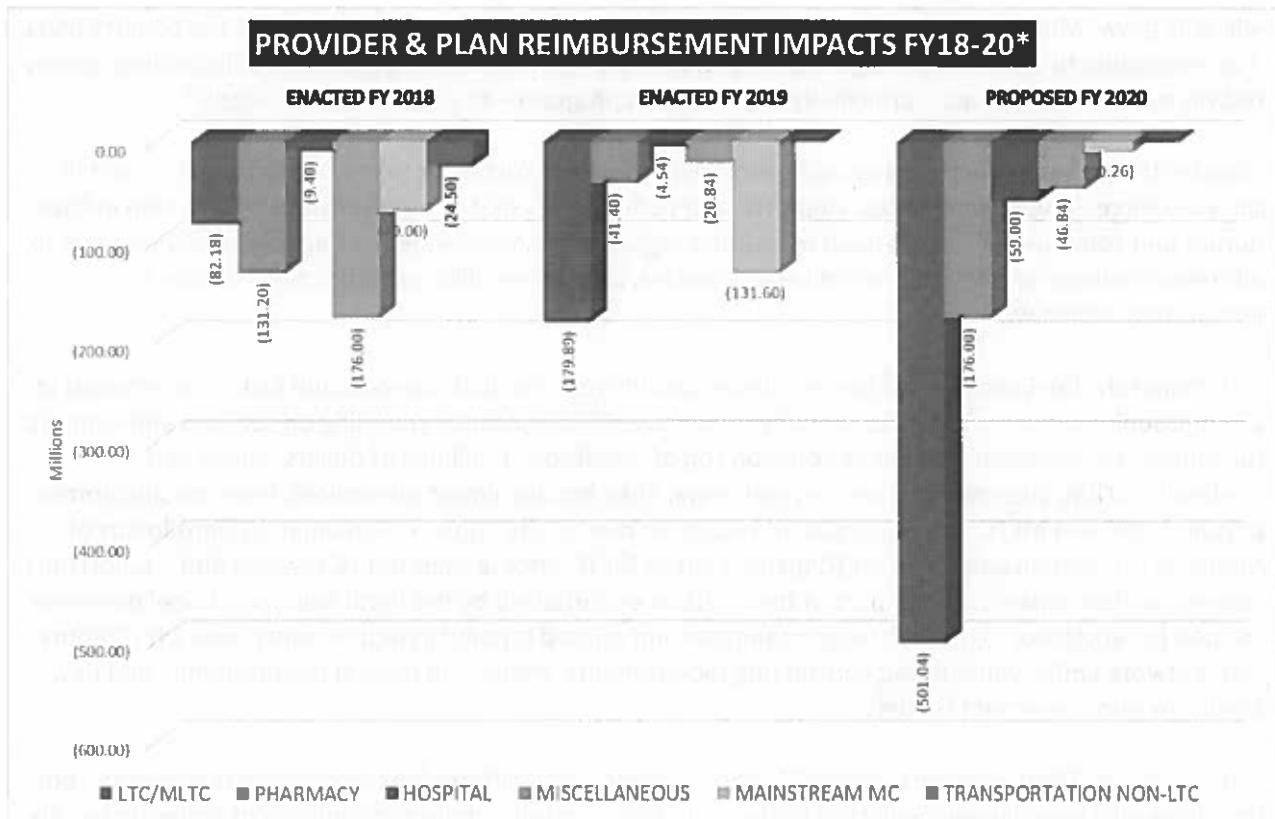
Unfortunately, the Executive Budget continues a multi-year trend of rate cuts and lack of investment in LTC and senior services. The 2019-20 budget cuts over \$500 million in spending on services and supports for seniors. Its proposed reductions come on top of hundreds of millions of dollars in new and continuing LTPAC cuts over the past several years. They impact almost all services, from nursing homes to home care and MLTC. 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. The impact of these cuts is exacerbated by the fiscal and operational pressures created by workforce shortages, wage mandates and related reporting requirements, new MLTC home care network limits, value-based contracting requirements, changes in federal requirements, and new Medicare reimbursement models.

Not only have LTPAC providers and MLTC plans shouldered significant cuts over the past few years, but they have also been largely neglected as the State has invested hundreds of millions of dollars in health care through capital grants and the Delivery System Reform Incentive Payment (DSRIP) program.

Given this lack of investment in services and supports for seniors, we are concerned about the State's readiness to address the needs of aging Baby Boomers. As the State pushes providers to adapt to new payment arrangements and models of care, it must recognize the important role played by aging services providers that furnish LTPAC and social supports to high-risk populations. Investment in these services is essential to the success of efforts to reduce avoidable hospitalizations and ensure better health and better care at a lower overall cost.

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<sup>3</sup> New York State Office for the Aging, County Data Book, New York State, Table 1, Demographics, <http://www.aging.ny.gov/ReportsAndData/2015CountyDataBooks/01NYS.pdf>.



\*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.

Our testimony covers seven major areas:

- Workforce investment and LTPAC infrastructure
- Nursing homes
- Managed Long Term Care
- Home and community-based services
- Assisted living and adult care facilities
- Resident assistants for affordable independent senior housing
- Cannabis regulation

As detailed below, LeadingAge New York urges the Legislature to invest \$50 million in LTPAC workforce recruitment and retention and to ensure a fair allocation of the Statewide Health Care Facility Transformation Program capital funding to LTPAC providers. We further ask the Legislature to seek improved efficiencies in MLTC without imposing cuts that threaten the viability of MLTC plans; reject the excessive nursing home case mix cut that targets homes that provide care to the most medically complex seniors; reject the adult day health care transportation carve-out; revise and restore the Consumer Directed Personal Assistance Program Fiscal Intermediary cut; and increase the Congregate Care Level 3 Supplemental Security Income rate for adult care facilities. We also request funding for resident assistants in affordable senior housing. Finally, we are seeking stronger language in the Cannabis Act to allow providers of care for vulnerable individuals and entities subject to federal oversight to take necessary actions to protect the people in their care and to comply with federal requirements.

## I) Cross-Continuum Initiatives

### a) *Addressing the LTPAC Workforce Crisis – #WIN4Seniors*

LTPAC providers are coping 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.<sup>4</sup> 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.<sup>5</sup> These shortages extend to nurses as well. Job openings for registered nurses and licensed practical nurses exceed graduation rates by over 4.5,000 annually.<sup>6</sup>

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.

While we welcome the Executive Budget's continuation of funding for minimum wage increases, we are disappointed that it does not make any new investments to expand the LTPAC workforce. Despite the demographic imperative and existing shortages, the only significant LTPAC workforce initiative implemented in recent years – the MLTC workforce component of the State's 1115 Medicaid waiver – focuses exclusively on enhancing the training of the existing workforce. While this is clearly an important goal, the funding does not address the need to bring new workers into the field.

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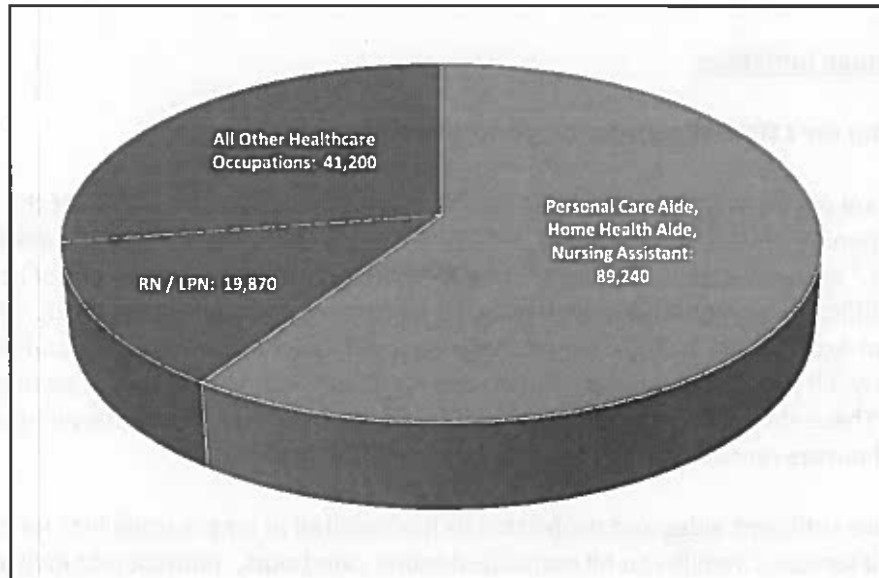
*Of the 150,000 health care job openings anticipated annually, 89,000 are personal care aides, home health aides, and nursing assistants.*

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<sup>4</sup> New York State Department of Labor Employment Projections; <https://www.labor.ny.gov/stats/lspoj.shtm>; accessed Jan. 11, 2019.

<sup>5</sup> 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.

<sup>6</sup> *Ibid.*



Not only does the Executive Budget overlook investment in the LTPAC workforce, but it also imposes a new administrative barrier to recruiting and retaining workers and fails to address shortcomings in the criminal history record check program that impede recruitment:

#### 1) NPI Numbers for Home Care Workers

The Executive Budget would require all home care workers to obtain a National Provider Identifier (NPI) number. NPI numbers are typically assigned to medical professionals and provider organizations that submit bills to payers for their services. Many home care workers have low educational attainment and are not native English speakers. Requiring them to obtain NPI numbers creates yet another barrier to entry into the field and a new administrative burden for employers.

#### 2) Criminal History Record Checks

Currently, non-professional LTC employees, including employees of certified home health agencies (CHHAs), long term home health care programs (LTHHCPs), AIDS home care providers, licensed home care services agencies (LHCSAs), nursing homes, hospice programs, and adult care facilities, must undergo criminal history record checks (CHRCs). New requirements implemented last year added employees to this list, including hospice programs. The State has not yet developed a method of reimbursing hospice programs for CHRCs. Moreover, while the number of workers subject to record checks and the cost of conducting them have increased, the funds appropriated appear to remain level.

At the same time, providers have not been reimbursed for record checks for much of the past year due to technical glitches in the data exchange process. There are also extensive delays in the fingerprinting and clearance processes, which result in the loss of prospective employees.

**Recommendation:** Support #WIN4Seniors by implementing a multi-pronged strategy to address the workforce needs of the LTPAC sector. First, we urge the Legislature to appropriate \$50 million to support initiatives to train, recruit, and retain the LTPAC workforce, including programs that provide:

- *Enhanced wages and benefits*
- *Access to transportation for workers*
- *Social supports for workers*
- *Reimbursement of certificate training expenses*
- *On-the-job training*
- *High school pre-apprenticeship programs*
- *Peer mentoring*
- *Career ladders*
- *Additional staff to support direct care positions*

*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:*

- *Reject the requirement that home care workers obtain NPI numbers; and*
- *Fully fund the CHRC process to cover rising costs and new providers, ensure reappropriation of past years' funding, require the implementation of a process for reimbursing hospice programs for CHRCs, 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:*

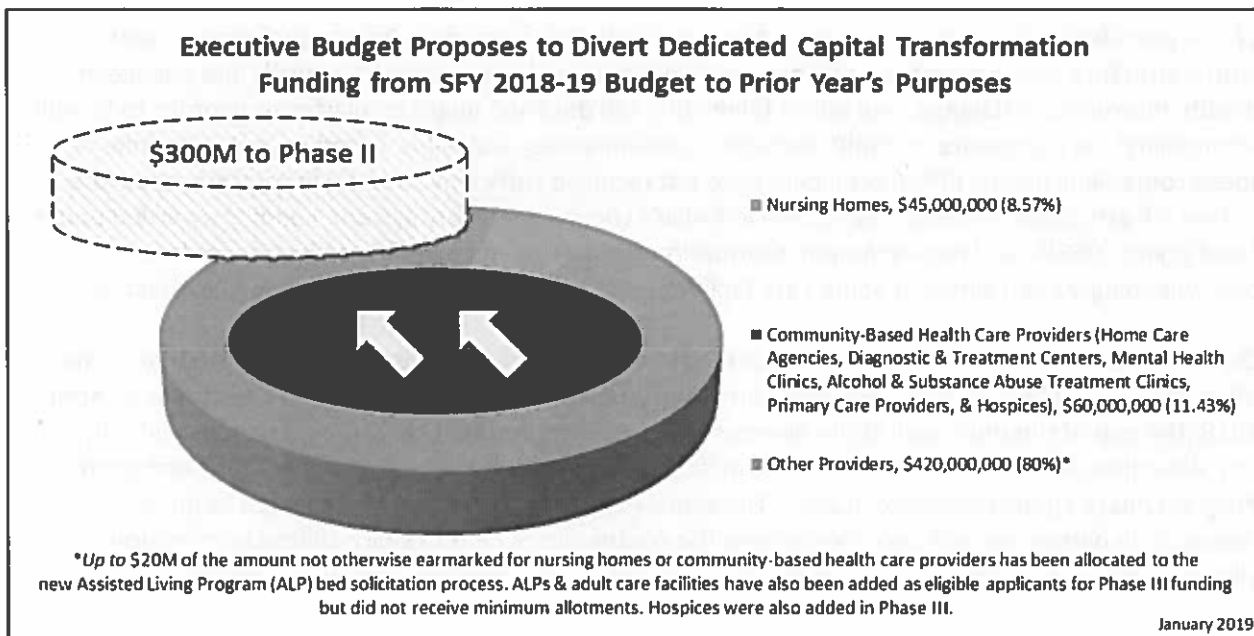
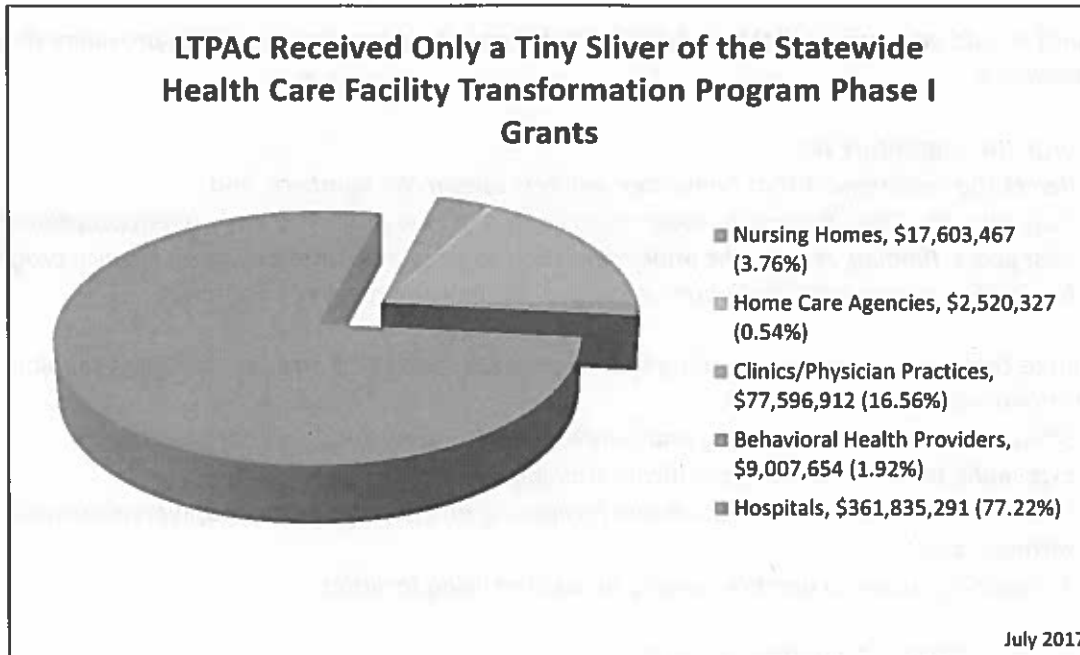
- *Streamlining certificate training and renewal requirements for direct care workers;*
- *Expanding the availability of certificate training courses;*
- *Enabling cross-setting certification and facilitating efficient deployment of workers across settings; and*
- *Authorizing nurses to practice nursing in assisted living facilities.*

#### ***b) Meeting LTPAC Infrastructure Needs***

LTPAC providers are in dire need of infrastructure funding to upgrade aging physical plants, right-size/restructure existing services, add new services, deploy electronic health records and engage in health information exchange, and adopt telehealth and data and analytics platforms in order to be able to meaningfully participate in DSRIP, managed care initiatives, and value-based payment. In spite of these compelling needs, LTPAC providers have not received sufficient State financial support for the critical infrastructure necessary to survive in today's changing delivery system. Funding 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 of the more than \$1.1 billion flowed since 2015, less than 2 percent had gone to the LTPAC sector as of April 2018 (the end of the third year of the demonstration). Furthermore, LTPAC providers received only a tiny sliver (less than 5 percent) of the \$491 million in Statewide Health Care Facility Transformation Program Phase I grants awarded in 2017. Nevertheless, LTPAC 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 last year's budget for Phase III of the Statewide Health Care Facility Transformation Program, we are disappointed that the State has not even released applications for those funds. Moreover, instead of implementing last year's budget provisions, the Executive Budget proposes to shift 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 would not be eligible for \$300 million of the Phase III funds if it were to be shifted to Phase II as proposed in the Executive Budget.





*Recommendation: Modify the Executive proposal to ensure that assisted living programs, adult care facilities, and hospice programs have access to sufficient capital funding under the Statewide Health Care Facility Transformation Program; maintain dedicated allotments for any funds transferred to Phase II; and establish statutory deadlines for release of Phase III applications and awards.*

## II) Nursing Homes

### a) *Case Mix Cut*

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 increased their 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 is why the proposal to reduce case mix-related funding to nursing homes by a staggering \$246 million (all funds) is so troubling. It is by far the single largest proposed cut in the Executive Budget and fails to recognize that an increase in case mix is a positive indicator that the State's efforts to shift the health care system are working. It also fails to recognize that it is a good thing when nurses choose patients over paperwork, especially when providers are struggling to recruit and retain nursing staff. The same lengthy assessments that determine reimbursement drive care planning and are done by nursing staff. For nurses to focus on assessment items that are most important for care and care planning rather than reimbursement is appropriate.

We agree that the State needs a dependable methodology for evaluating resident acuity that relies on accurate assessment data and provides a consistent approach. That is why the Office of the Medicaid Inspector General (OMIG) is tasked with auditing the data that is the basis for acuity adjustments. It is worth noting that along with the OMIG audit process, the current methodology caps case mix changes during a six-month period to 5 percent pending completion of OMIG audits for that rate period. Keeping in mind that nursing home reimbursement is based on 2007 costs and that Medicaid providers have received no inflation adjustment in the last 10 years, a \$246 million cut is unsustainable. As homes face annual staffing cost increases and new labor agreements, such a reduction would not only negate the benefit of a promised 1.5 percent adjustment to reflect increased staffing costs, but it would also destabilize nursing home finances by cutting rates by an average of \$9.50 per Medicaid day.

The impending shift to a new acuity measurement system in the Medicare program beginning in October 2019 provides a good opportunity to review the Medicaid case mix methodology to see if the two systems can be better aligned. However, this should be done in a considered way and should be informed by a workgroup as envisioned in last year's budget negotiations, when the Legislature agreed to acuity-related savings. That proposal promised "to work with the nursing home industry to revisit the current Minimum Data Set (MDS) census collection process in an effort to promote a higher degree of accuracy in the MDS data." The Department of Health (DOH) should convene a workgroup to facilitate a fact-based approach to the issue that would ensure integrity of the process, improve efficiency for both DOH and providers, and minimize unintended consequences.

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

***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. Proposed legislation (A.2954 (Gunther)/S.1032 (Rivera), the "Safe Staffing for Quality Care Act") would mandate specific staffing ratios for nurses and other direct care staff in nursing homes and hospitals. Academic research does not support the proposition that specific staffing ratios produce higher quality of care. In fact, the only outcome of this legislation would be higher Medicaid costs, increased recruitment and retention challenges, and less quality of life programming for nursing home residents, as providers would be forced to shift resources away from these programs to meet mandated ratios.

The staffing standards proposed in this legislation 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. The Governor has proposed that DOH conduct a study to evaluate the impact of staffing on patient safety and quality of care. Along with examining quality and cost, such a study should review the feasibility of and strategies for finding sufficient qualified staff to meet existing and projected demand.

***Recommendation:*** *Reject staffing ratios legislation and support a study that focuses on workforce challenges.*

***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***

Another staff development program, the State's Advanced Training Initiative (ATI), offers participating nursing homes the opportunity to train certified nurse aides and other front-line workers on detecting early 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.*

**e) Court-Appointed Guardians**

There is a need to address a defect related to payment in the case of court-appointed guardians for nursing home residents. When an incapacitated person has little or no assets and needs to have a guardian appointed under the Mental Hygiene Law, the court-appointed guardian often retains the individual's Social Security payment and/or other sources of income to pay guardianship costs. When the person needs Medicaid-covered nursing home care, however, their income is still netted against the nursing home's Medicaid payment, even though the funds are no longer available. The result is an underpayment to the nursing home.

**Recommendation:** *Revise the law to disregard income used for guardianship expenses when determining the individual's Medicaid budget and the resulting payment to the nursing home.*

**III) Managed Long Term Care**

MLTC plans now manage and pay for the vast majority of the LTC services provided to aged New Yorkers eligible for Medicaid. Cuts to plan reimbursement, as well as the additional costs of new requirements that are imposed without adequate reimbursement, undermine plan and provider finances and destabilize the LTC delivery system for consumers. The State cannot impose deep cuts in MLTC rates year after year and expect plans to continue to provide the same level of service.

The Executive Budget proposes approximately \$133 million in cuts related to MLTC in SFY 2019-20, growing to \$148 million in SFY 2020-21.<sup>7</sup> This is on top of approximately \$200 million in cuts enacted and implemented in SFY 2018-19 that will be renewed and annualized in 2020-21.<sup>8</sup> Like many of last year's MLTC budget cuts, the majority of these cuts are not supported by programmatic initiatives that are likely to 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 their premiums on medical/LTC services or face recoupments by the State.<sup>9</sup> Accordingly, these cuts cannot be explained 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.

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*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.*

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<sup>7</sup> These figures include the proposed EISEP offset, personal care utilization management, OMIG integrity penalty, and transportation carve-out.

<sup>8</sup> This figure does not include the \$246 million in savings from limiting the nursing home benefit in MLTC. This initiative, once implemented, will drive genuine programmatic savings, not merely a cut in reimbursement, and should not adversely affect plan or nursing home margins.

<sup>9</sup> Based on federal regulations, PACE programs are not subject to recoupments of excess premium.

**a) EISEP Offset**

One example of the misalignment of the cuts with projected savings is the \$68 million (all funds) cut associated with the \$15 million investment in the State Office for the Aging (SOFA) Expanded In-Home Services for the Elderly Program (EISEP). We support the \$15 million investment, which is intended to help low-income seniors who need some home care to avoid spending down to Medicaid eligibility and transitioning into MLTC or nursing homes. However, DOH has suggested that the \$68 million in savings will not be derived entirely from diverting seniors from enrolling in Medicaid. Instead, at least a portion of the \$68 million will be taken out of the rates that MLTC plans and home care agencies are paid for seniors who *are* enrolled in Medicaid. MLTCs and home care agencies are expected to provide the same level of service to Medicaid beneficiaries but will be paid about \$68 million less for doing so. In a nutshell, the State is proposing to invest \$15 million in EISEP in order to justify removing \$68 million from the Medicaid LTC system.

**b) Personal Care Utilization Management**

In addition to removing up to \$68 million from MLTC and personal care rates in connection with an investment in EISEP, the Executive Budget proposes to remove \$50 million (all funds) from MLTC premiums based on the assumption that yet to be published amendments to fair hearing regulations will drive reductions in personal care utilization. Without first drafting and implementing the proposed regulatory changes, and without experience in the actual effect of those regulations on fair hearing decisions and utilization, the State has no way of knowing whether they will be able to constrain personal care utilization and the amount of savings they will generate. While we support appropriate controls on the utilization of personal care, we oppose significant rate reductions in advance of the implementation of those controls and in the absence of evidence that they will yield savings.

**c) Transportation Carve-Out**

As described in more detail below, the Executive Budget proposes to exclude transportation from the MLTC benefit package, delegating this service to vendors under contract with the State. This will considerably limit the ability of plans to manage and oversee the transportation services that their members rely on for medical visits. While a few plans support the carve-out, others operate their own fleet of vehicles and/or utilize transportation as part of overall care management and supports for members.

**Recommendations:** *Seek improved efficiencies in MLTC without threatening the solvency of MLTC plans and the viability of the LTC services they support. Rates paid to MLTC plans should not be cut unless there is evidence that an equivalent amount of programmatic savings will be generated within the same time frame as the rate cut.*

*Specifically, MLTC rates should not be reduced based on an investment in EISEP that will have no impact on the services consumed or the LTC expenses incurred by MLTC beneficiaries. We ask that the Legislature prevent the \$68 million in EISEP offset savings from being implemented as a rate cut for MLTC plans or home care agencies. Similarly, MLTC rates should not be cut based on assumptions about a reduction in personal care utilization until regulatory changes have been adopted and the impact of those changes on utilization has been demonstrated.*

#### **IV) Home and Community-Based Services**

##### ***a) Adult Day Health Care Transportation Carve-Out***

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

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

##### ***b) Consolidation of CDPAP FIs and Rate Restructuring***

The Executive Budget would cut \$150 million (all funds) from Consumer Directed Personal Assistance Program (CDPAP) fiscal intermediary (FI) rates and significantly reduce the number of FIs by an unspecified amount. It would reduce FI reimbursement by shifting from an hours-based rate system to a per-member-per-month system. FIs manage payroll for participants in CDPAP and offer additional wrap-around services and wage structures for personal assistants. With these added benefits, the program has helped improve access to home care for aging seniors and individuals with disabilities across the state.

LeadingAge New York has serious concerns with the wholesale changes proposed in the FI authorizing legislation. A reasonable number of geographically distributed FIs serving personal assistants and their clients is necessary to ensure the effectiveness of this program. We are concerned that a highly restrictive contracting process will inappropriately limit access to FI services, particularly in upstate communities, and disrupt longstanding relationships between consumers, aides, and FIs. We are also concerned that the size of the proposed cut in FI payments will adversely affect the ability of FIs to carry out their administrative functions while continuing to supplement wages of personal assistants where appropriate.

***Recommendation:*** *Restore the \$150 million cut and revise the FI proposal to promote geographic distribution, efficiency, and appropriate utilization.*

##### ***c) Expanded In-Home Services for the Elderly Program (EISEP)***

LeadingAge New York fully supports the Executive's additional \$15 million investment in the Expanded In-Home Services for the Elderly Program (EISEP), which supports 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. However, as noted above, we oppose any reduction in personal care or MLTC rates to offset this investment.

**Recommendation:** Support the additional \$15 million investment in EISEP and prevent the reduction of personal care and MLTC rates in connection with this investment.

#### V) Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs) and assisted living (AL) provide an option for seniors who cannot remain in their own homes due to functional limitations but do not need the ongoing skilled nursing services of a nursing home. ACF/AL services are less expensive than nursing home care and have a more “home-like” environment than a typical nursing home. There is both a growing need and a growing consumer preference for ACF/AL services. Thus, it should be a priority to ensure that seniors have access to these services, regardless of their income level.

Unfortunately, the State has failed to make needed investments in expanding and retaining ACF/AL capacity, while other factors compound the financial challenges of ACF/AL providers:

- A growing population of seniors is ill-prepared to pay for their LTC needs.
- Operating costs for items such as employee health benefits and food are rising.
- ACF/AL providers are continually absorbing the cost and administrative burden of new mandates.

As a result, ACF/AL options for seniors who can pay privately are becoming more expensive, options for middle-income seniors are scarce, and low-income seniors are struggling to find ACF/AL services because those facilities that serve low-income seniors are in financial distress. We urge the Legislature to provide more financial support to ACF/AL facilities to ensure their viability, to cease imposing expensive mandates, and to work with us to identify how we can better use resources to provide more efficient, higher quality care in ACF/AL settings. Below are some specific budget-focused initiatives to bolster the ACF/AL sector.

##### a) *SSI Increase*

Once again, we are extremely disappointed that the Executive Budget failed to include an increase in the State portion of the Congregate Care Level 3 Supplemental Security Income (SSI) rate. The last increase to the State supplement was paid in 2007; before that, it was 17 years. Such infrequent, unpredictable increases have made it extremely difficult for ACFs to afford to serve SSI recipients. The SSI rate of just over \$41 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 given the cost of wage increases and other expenses.

We have warned that ACF/AL providers that are dedicated to serving the low-income population will close, and we have seen that happen over the last few years. One of our members closed last year, and approximately one-third of their residents had to be placed in a nursing home. This is just one example of the cost to the State for the chronic underpayment of SSI—the State is paying *twice as much in Medicaid dollars, unnecessarily, for these former ACF residents*. There are several other ACFs that have closed, with 19 voluntary closures just in the past 22 months, and others are on the brink of closure.

The consistent financial loss, year after year, is unsustainable. Without an increase, ACFs will continue to close, and seniors will be displaced from the place they call home. Because these seniors are Medicaid-eligible and cannot live in their own homes, most will go to nursing homes at greater cost to the State. Clearly, this makes no financial sense, but it does not make for good policy either. All State and federal initiatives point to keeping people in the lowest level of care possible. The decision not to increase SSI is also incongruous with the policy direction of aging and LTC services. But most of all, it is not fair to the 13,000 New Yorkers who rely on SSI to pay for the services they receive in ACFs and assisted living.

**Recommendation:** *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 Congregate Care Level 3 SSI rate.*

**b) Modernization of the ALP Medicaid Rate**

The assisted living program (ALP) is the only Medicaid assisted living option in New York. It is a wonderful option for seniors who are Medicaid-eligible who require a nursing home level of care but do not need the ongoing skilled services of a nursing home. The ALP provides these critical services at approximately half of the nursing home Medicaid rate; however, that rate calculation is outdated and inadequate. Furthermore, the ALP has not seen a standard trend factor increase since 2007, while the costs of providing care go up each year.

Additionally, 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. We recommend several changes to ensure that the ALP Medicaid rate calculation reflects present day costs and properly captures and provides clarity regarding what the ALP is responsible for within that rate.

Lastly, the ALP cares for people with dementia, but the ALP Medicaid rate is insufficient to truly address the resources needed to care for this population. ALPs would be better able to care for more people who otherwise would be placed in nursing homes at great cost to Medicaid if their rate were enhanced to reflect the resources needed. Historically, the nursing home Medicaid rate has included a dementia add-on; the ALP should have a similar 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 and Enriched Housing Subsidy**

We appreciate that the Executive Budget maintains level funding for the Enhancing the Quality of Adult Living (EQUAL) quality program for ACFs at \$6.5 million. EQUAL supports quality of life initiatives for

residents of ACFs that serve SSI recipients. We also 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 proposals to include EQUAL funding at \$6.5 million and Enriched Housing Subsidy funding at \$380,000.

#### **VI) Affordable Independent Senior Housing Assistance Program**

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

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

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

Evidence of these savings has been demonstrated in recent studies conducted in Oregon and New York. In 2016, the Center for Outcomes, Research & Education issued a report on a study conducted in Oregon that showed a decline in Medicaid costs of 16 percent one year after seniors moved into affordable housing with resident assistants.<sup>10</sup> Their analysis included 1,625 individuals, 431 of whom lived in properties that serve older adults and individuals with disabilities. The statistic of 16 percent savings in

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<sup>10</sup> 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 costs breaks down to a savings of \$84 per month for each individual in this subset, or \$434,000 over a 12-month period for the relatively low number of 431 individuals.

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

***Recommendation:** A \$10 million, five-year strategic investment to bolster the \$125 million in senior housing capital funding is an extremely low-cost way to ensure that New York's growing senior population is being taken care of while also saving money for the State. The 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. It ultimately represents a modest investment that will improve seniors' quality of life, save Medicaid dollars, and help the State implement its ambitious Olmstead Plan to serve people in the least restrictive settings appropriate to their needs.*

## **VII) Cannabis Regulation**

The proposed Cannabis Act includes several provisions intended to protect medical cannabis patients and individuals engaged in legal activities under the Act from discrimination and adverse employment actions. Specifically:

- Certified medical cannabis patients are deemed to have a "disability" and are protected under the Human Rights Law, Civil Rights Law, and hate crimes sections of the Penal Law.
- Adverse employment actions based on conduct allowed under the Cannabis Act are prohibited unless the employer establishes that the lawful use of cannabis has impaired the employee's ability to perform his or her job. An employee may be considered impaired when there are "specific articulable symptoms while working that decrease or lessen the employee's performance."
- Schools and landlords are prohibited from refusing to enroll or lease to or otherwise penalizing a person based on conduct authorized by the Cannabis Act unless failing to take such action would jeopardize federal funding or licensure; the organization has adopted a cannabis code of conduct based on a religious belief; or the action is a prohibition on smoking, and the premises are registered on the smoke-free housing registry.

The legislation does, however, provide an exemption to allow an employer to take adverse employment action for the possession or use of intoxicating substances during work hours. It also provides that employers are not required to commit any act that would violate federal law or that would result in the loss of a federal contract or federal funding.

We are concerned about the impact of the above prohibitions on federally regulated LTPAC providers and affordable senior housing properties financed by the U.S. Department of Housing and Urban Development (HUD). As providers of services for vulnerable individuals, our members also fear being unable to protect patients, residents, and clients from employees whose judgment or coordination may be impaired by cannabis. While we appreciate the provisions aimed at protecting federally regulated and funded entities, we are not certain that these provisions are clear or broad enough. We are also concerned that senior services providers that are not federally regulated or funded will be even more limited in their ability to protect residents and clients from impaired caregivers.

***Recommendation: Clarify and broaden the exemptions from prohibitions on adverse employment actions for federally funded or regulated entities and for providers of services to vulnerable individuals.***

### **Conclusion**

As this testimony illustrates, there are a number of concerns and unanswered questions relative to how the Executive Budget would affect elderly and disabled New Yorkers, and the not-for-profit and public providers that serve them. We are very concerned that the Executive Budget offers insufficient opportunity or investments for LTPAC providers and plans while imposing new cuts, costs, and mandates. We urge the Legislature to remedy this by ensuring that the final enacted budget includes infrastructure and workforce investments and additional Medicaid funding to accommodate increased costs to providers and the MLTC plans that pay them. LeadingAge New York looks forward to working with the Legislature and Executive on the 2019-20 budget and the State's ongoing reform initiatives.

*Founded in 1961, LeadingAge New York is the only statewide organization representing the entire continuum of not-for-profit, mission-driven, and public continuing care including home and community-based services, adult day health care, nursing homes, senior housing, continuing care retirement communities, adult care facilities, assisted living programs, and Managed Long Term Care plans. LeadingAge New York's 400-plus members serve an estimated 500,000 New Yorkers of all ages annually.*