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Testimony to the New York State Legislature
Joint Hearings of the Senate Finance and
Assembly Ways & Means Committees

2024-2025 Executive Budget

Topic: Health

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Thank you for the opportunity to provide testimony on the Fiscal Year 2024-2025 Executive Budget ("Executive Budget"). The Center for Elder Law & Justice ("CELJ") has been serving the Western New York region for over 40 years, providing free civil legal services to older adults, persons with disabilities, and low-income families. CELJ's primary goal is to use the legal system to assure that individuals may live independently and with dignity. CELJ also advocates for policy and systems change, particularly in the areas of housing, elder abuse prevention, nursing home reform, and consumer protection. Currently CELJ provides full legal representation in ten counties of Western New York.[1] CELJ's Free Senior Legal Advice Helpline is open to all of New York State. CELJ operates a main office in downtown Buffalo, with three additional offices in Cattaraugus, Chautauqua, and Niagara counties.

The title, and arguably the theme of the Executive Budget "Our New York, Our Future" places emphasis on the importance of making the State a safer, more affordable, and more livable place. It is essential that the final budget includes older adults and invests in policies to help older adults age with independence, autonomy, and dignity. Failure to fully invest in a long-term care ("LTC") system that enables older adults to age in place in the most integrated setting of their choosing will lead to the collapse of LTC in the State and force older adults into settings that cut them off from the community. Furthermore, it is important that the budget does not reduce access to quality care and services for persons who are lower income and/or whose care is covered by Medicaid.

Unfortunately, the proposed Executive Budget does not make the needed investment to ensure older adults age in place with independence, autonomy, and dignity. While the State is currently engaged in the development of its Master Plan for Aging and the Most Integrated Setting Coordinating Council ("MISCC") is set to release an Olmstead plan this year, the proposed Executive Budget's failure to invest in aging and home and community-based services and

[1] Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Livingston, Niagara, Orleans, Steuben, and Wyoming Counties

supports, and the proposed legislative proposals highlighted below, are counterintuitive to making the State "Age Friendly."

The budget does include $7.5 billion in funding over the next three years to implement the recently CMS approved Section 1115 Medicaid Waiver Amendment ("1115 Waiver") to support a comprehensive series of actions to advance health equity, reduce health disparities, and strengthen access to primary and behavioral health care across the state." However, the 1115 Waiver fails to intentionally include older adults and support investments in their caregivers.[2]

Aging is an equity issue and the impact of structural discrimination compounds one's health over time.[3] The long-standing history of structurally racist policies and practices that contribute to inequity in health care and significant health disparities were reflected by the pandemic's disproportionate impact on persons of color, especially in nursing homes.[4] These disparities exist today. For example, in assessing the quality of care provided by nursing homes located in Erie County, CELJ found that persons of color were more likely to reside in consistently underperforming nursing homes.[5]

We urge the Legislature to fight for a budget that ensures every older adult, regardless of race, disability, geographic location, and income, is able to age with independence and dignity. The 2024-2025 final budget must invest in older adults and their caregivers. Failure to do so will continue the State's longstanding preference to place older adults and younger adults with disabilities into institutionalized settings and continue the health disparities and other challenges faced by their caregivers.

I. Support Budgetary Actions that Promote Autonomy, Dignity and Access to Quality In Adult Care/Assisted Living and Nursing Homes.

A. Reject Executive Budget Assisted Living Resident Quality Proposal (HMH Part F section 2) and Implement Quality Proposals Across all Adult Care Facility Levels of Care.

B. Support Consumer Protections in Adult Care Facilities and Require Transparency.

1. Support Consumer Protections in all Adult Care Facilities.

2. Mandate DOH Publish Adult Care Facility Inspection Reports Online.

C. Support Programs that Enable Older Adults to Age in Place within the Adult Care

[2] CELJ submitted comment to DOH on May 20, 2022 and CMS on October 19, 2022 urging the waiver to be intentional and address the needs of the State's aging population.

[3] *See* Justice in Aging, *Older Women & Poverty* (Dec.2018), available at http://justiceinaging.org/wp-content/uploads/2018/12/Older-Women-and-Poverty.pdf . *See also Kilaru* AS, Gee RE. Structural Ageism and the Health of Older Adults. *JAMA Health Forum.* 2020;1(10):e201249. doi:10.1001/jamahealthforum.2020.1249

[4] *See* Chidambaram, Neuman, et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, Kaiser Family Foundation, Oct. 27, 2020, available at https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/ , last accessed January 19, 2024; see also Rebecca J. Gorges, *Factors Associated With Racial Differences in Deaths Among Nursing Home Residents With COVID-19 Infection in the US,* JAMA Network Open. 2021;4(2):e2037431. doi:10.1001/jamanetworkopen.2020.37431, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776102 , last accessed January 19, 2024.

[5] For example, in assessing the health inspections of all 35 nursing homes in Erie County with their corresponding total weighted health score, 7 of the 10 worst performing nursing homes had the highest percentages of person of color as residents. Data and analysis are available by request.

Facility Levels of Care Structure.

1. **Support: HMH Part F Section 1 to Make the Special Needs Assisted Living Residence Voucher Program Permanent.**
2. **Reject: HMH Part L sections 2 and 6 to Repeal the Enhanced Quality of Adult Living Program and the Enriched Housing Subsidy Program.**

D. Reject Executive Budget Proposal HMH Part Q sections 8-10: Medication Aides in Nursing Homes and Ensure Nursing Home Operators are Meeting Staffing and Legal Obligations.

E. Increase the Personal Needs Allowance for Residents in Nursing Homes

F. Support Increased State Investment in the Long Term Care Ombudsman Program (LTCOP)

II. Support Home & Community Based Services and Implement Policies that Eliminate Institutionalization Bias.

A. Support Home Care Savings and Reinvestment Act.

B. Support Fair Pay for Home Care

C. Repeal the Harmful Changes to the Medicaid Program Enacted through Prior Budgets.

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I. Support Budgetary Actions that Promote Independence, Autonomy, Dignity, and Access to Quality in Adult Care/Assisted Living and Nursing Homes.

A. Reject Executive Budget Assisted Living Resident Quality Proposal (HMH Part F section 2) and Implement Quality Proposals Across all Adult Care Facility Levels of Care.

The Executive, as set forth in HMH Part F section 2, is proposing legislation that would implement quality measures and reporting for Assisted Living Residences (ALRs). The proposal would create a ranking system for ALRs and would allow for the DOH to grant "Advanced Standing" classification to the top scoring ALRs which would provide an extended surveillance schedule to facilities with that classification. The Executive also seeks to permit facilities that have the ALR licensure to seek accreditation from a national agency which would then exempt these facilities from inspection by the DOH for the duration of their accreditation, at the discretion of the Commissioner.

For reasons detailed below, we urge the Legislature to reject this proposal and offer recommendations for the Legislature and Executive's consideration in advancing and improving quality of care and life for older adults who reside in all Adult Care Facilities (ACFs), not solely ALRs.

Overview of ACF structure: not every ACF has the ALR licensure; every resident deserves quality services, protections, and consumer information.

There are five types of ACFs set forth in the SSL.[6] Two form the basis of what many refer to as 'assisted living' in the State and are licensed by the DOH: Adult Homes (AHs)[7] and Enriched Housing Programs (EHPs).[8] All ACFs operate as either an AH or EHP and offer the lowest level of services. Beyond this basic licensure, an ACF can obtain higher-level licensure and certifications to provide additional services: ALR and Assisted Living Program (ALP).

An ALR[9] is an ACF that is licensed as an AH or EHP that has additionally been approved by the DOH to provide a higher level of care. An ALR can also receive an Enhanced Assisted Living (EALR) certification to allow for residents to 'age in place' and/or a Special Needs Assisted Living (SNALR) certification that allows the ALR to serve residents with cognitive impairment.
AHs and EHPs (and thereby ALRs) may be licensed by the DOH to participate in the ALP. The ALP serves individuals who are medically eligible for nursing home placement, but serves them in a less medically intensive, lower cost setting. The ALP provides personal care, room, board, housekeeping, supervision, home health aides, personal emergency response services, nursing, physical therapy, occupational therapy, speech therapy, medical supplies and equipment, adult day health care, home health services, and the case management services of a registered professional nurse.[10] The ALP is not governed by the ALR statute and regulations.[11]

The Executive is proposing to establish quality measures only in the PHL § 4656, which only covers ACFs with the ALR licensure. Not every ACF has an ALR license. For example, Erie County has 34 ACFs that are not part of a continuing care retirement community. Of the 34, 10

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[6] *Adult-care facility* shall mean a family-type home for adults, a shelter for adults, a residence for adults or an adult home, which provides temporary or long-term residential care and services to adults who, though not requiring continual medical or nursing care as provided by facilities licensed or operated pursuant to article 28 of the Public Health Law or articles 19, 23, 29 and 31 of the Mental Hygiene Law, are, by reason of physical or other limitations associated with age, physical or mental disabilities or other factors, unable or substantially unable to live independently. SSL § 2(21); 18 NYCRR § 485.2(a).

[7] *Adult home* shall mean an adult-care facility established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults unrelated to the operator. SSL §2 (25); 18 NYCRR § 485.2(b).

[8] *Enriched housing program* shall mean an adult-care facility established and operated for the purpose of providing long-term residential care to five or more adults, primarily persons 65 years of age or older, in community-integrated settings resembling independent housing units. Such program shall provide or arrange the provision of room, and provide board, housekeeping, personal care and supervision. SSL §2(26); 18 NYCRR §485.2(c).

[9] "Assisted living" and "assisted living residence" means an entity which provides or arranges for housing, on-site monitoring, and personal care services and/or home care services (either directly or indirectly), in a home-like setting to five or more adult residents unrelated to the assisted living provider. An applicant for licensure as assisted living that has been approved in accordance with the provisions of this article must also provide daily food service, twenty-four hour on-site monitoring, case management services, and the development of an individualized service plan for each resident. An operator of assisted living shall provide each resident with considerate and respectful care and promote the resident's dignity, autonomy, independence and privacy in the least restrictive and most home-like setting commensurate with the resident's preferences and physical and mental status. PHL § 4651(1).

[10] SSL § 461-I Assisted living program.
[11] PHL § 4651 (Definitions) states "Assisted living and enhanced assisted living shall not include…(e) assisted living programs approved by the department pursuant to SSL § 461-l". (PHL § 4651-1(e)).

are AH or EHP only (798 beds) and of these 4 have the ALP (214 beds).[12] Older adults and persons with disabilities who reside in an ACF with only the base AH or EHP licensure deserve to have quality standards and consumer protections like ALRs.

Each type of ACF offers differing levels of services and tailored quality measures must be considered. A5790A would require the DOH to report to the legislature on the development of a quality scoring system for ACFs by January 15, 2025. CELJ suggests that quality measures and scoring system is developed for AH, EHP, and the ALP concurrently with the ALR. Every ALR has the base AH or EHP license. In addition, each level of care within the ACF systems has its unique services based on the licensure/certification.

Quality measures must be developed with residents and their representatives.

The Executive is proposing that ALRs report annually on quality measures to be established by the DOH. While the proposal is currently specific to ALRs, and needs to be expanded to include all ACF types, quality measures must not be developed without the involvement of residents and their representatives. It is essential that residents are involved, there are public forums, and draft quality measures are published for public comment. A5790A would require the DOH consult with consumer representatives, including the long term care ombudsman program (LTCOP). CELJ suggests that this language is strengthened to require opportunity for public comment across all ACF levels of care, not solely ALRs.

Extended surveillance schedule for "Advance Standing."

The DOH is already required to survey ACFs with the "department's highest rating" at least once every eighteen months.[13] Otherwise, all other ACFs shall be inspected no less than annually. Currently there is no consumer-facing publicly available information that would provide the basis for the "department's highest rating."

The Executive is proposing a separate rating system for ALRs only, set forth in PHL § 4656. As stated above, this excludes ACFs with only the base AH or EHP licensure, and ACFs with the AH or EHP licensure only that participate in the ALP. The ALR Statute (Article 46-B of PHL) is clear that it does not apply to AH, EHP, or ALP.[10] If a rating system is to be implemented specifically for ALRs, a similar rating system must be implemented for ACFs that do not have the ALR certification. While A5790A would require DOH to report to the legislature on the development of a quality scoring for ACFs by February 15, 2025, since all ALRs have AH or EHP as their base licensure, CELJ recommends such quality scoring should be done the same time as ALR.

Accreditation is not a substitute for oversight.

CELJ strongly opposes the Executive proposal that would allow for ALRs to operate with zero to limited oversight by the DOH so long as they maintain an accreditation from a nationally recognized accrediting agency. Achieving an accreditation from a nationally recognized agency

[12] Health Facility Certification Information: https://health.data.ny.gov/Health/Health-Facility-Certification-Information/2g9y-7kqm/data

[13] SSL §461-a(2)(a)(1).

should accomplish nothing more than serve as a marketing/recruitment tool for ALRs to attract new residents. In addition, there are ALRs that participate in the ALP. Residents who participate in the ALP are a vulnerable population as they are medically eligible for nursing home placement. Removing DOH oversight in favor of a national accreditation agency is opening the door to abuse, neglect and other harm.

CELJ however supports the language in A5790A that allows for ALRs to seek accreditation but would not exempt ALRs from DOH oversight. Such language could be strengthened to require the DOH post the data reported by the accreditation agencies to the DOH.

B. Support Consumer Protections in Adult Care Facilities and Require Transparency

1. Support Consumer Protections in all Adult Care Facilities

The proposed Executive Budget and A5790A both would require ALRs post various information that is of benefit to the consumer (prospective/residents and their families), including the monthly service rate, admission/residency agreement, and a summary of all service fees. The Executive proposal would also require the ALR post the staffing complement of the residence.

CELJ supports these proposals, however the State can go further and mandate this for all ACFs by incorporating these requirements into the SSL. A5485/S5472 for example, would amend SSL 461-c to require every AH and EHP to post the admission/residency agreement on the facility's website. This language can be strengthened by incorporating the Executive and A5790A consumer protection/information requirements. While ALRs do provide higher level of services/supports to its residents, we are seeing AHs and EHPs starting to charge residents for added services they thought were included in the monthly rent. It is essential that the proposed consumer protections are implemented into the SSL so that every resident has basic consumer protections regardless of the level of care.[14]

2. Mandate DOH Publish Adult Care Facility Inspection Reports Online

There is greater public transparency and oversight for nursing homes than for ACFs. This is in part due to Medicare & Medicaid being the primary payers for nursing home care. Oversight and transparency of ACFs is mainly based on state law and as such it is imperative that the Legislature take action.

While the resident consumer protections proposed under the Executive Budget are important, the State can go further by mandating the DOH publicly post the results of adult care facility inspections online at the NYS Health Profiles website: https://profiles.health.ny.gov. DOH includes the survey reports for nursing homes on the Health Profiles website, but only the regulatory violation for adult care facilities.

This information is not helpful to prospective residents or their families when deciding on whether to apply for admission to an ACF. There are no details as to the violation, nor is there a published

[14] For national coverage on this issue, *see* https://www.nytimes.com/2023/11/19/health/long-term-care-assisted-living.html

plan of correction. Compare to the NYS Health Profiles-Nursing Homes where such information is available to current and prospective residents and their families.

We urge the Legislature and the Executive to implement through the Budget, funding and legislation that would mandate DOH upload inspection reports for ACFs.

C. Support Programs that Enable Older Adults to Age in Place within the Adult Care Facility Levels of Care Structure.

Older adults have the constitutional and fundamental right to live in the least restrictive setting and have access to needed services and supports which support them to age with independence, dignity, and maintain their autonomy. Compared to nursing homes, ACFs are designed to be a social model that offers various services and supports (based on the level of care) in an environment that offers socialization, structured activities, and integration with the community. It is essential that the State implements a budget that facilitates older adults to age in place within the ACF structure and not be evicted from their home solely due to running out of funds to pay for their care.

1. *Support: HMH Part F Section 1 to make the Special Needs Assisted Living Residence Voucher Program Permanent.*

CELJ supports the Executive's proposal to transition the Special Needs Assisted Living Residence ("SNALR") Voucher program from a pilot to a permanent program. However, it is important that this program is fully funded such that older adults living with a dementia who qualify can remain in their home for as long as possible, and not be discharged to a nursing home only because they lack the funding to remain in the SNALR. Transfer trauma is a major concern with this population and the state must take measures to reduce unnecessary relocation of persons with dementia solely because of their inability to pay for their care.

2. *Reject: HMH Part L sections 2 and 6 to repeal the Enhanced Quality of Adult Living program and the Enriched Housing Subsidy Program.*

CELJ opposes the Executive's proposal to discontinue the EQUAL program (SSL § 461-s) and Enriched Housing subsidy program (SSL § 461-b(1)(c)). It does not make sense that the State would subsidize the cost for persons with dementia to remain in their SNALR, while at the same time repealing programs that help others age in place in their homes. It is discrimination based on disability.

The EQUAL program is a way to improve the quality of life for ACF residents who are in the greatest need as directed by the residents. Specifically, the EQUAL program is a grant that is available to ACFs who provide housing and services to residents receiving SSI. Residents in these ACFs do not have access to the same quality services, food, activities, and environment, when compared to primarily private pay ACFs. Under this program, it is the residents who decide what the awarded funds should be used for including, but not limited to: air conditioning in resident rooms, furniture, televisions, computers, transportation for resident services, and other activities and equipment the residents determine as through the resident council.

The EQUAL program, when administered properly, improves resident quality of life, encourages resident participation in their daily lives and promotes autonomy. We provide two examples through our partnership with the NYS Region 15 LTCOP:

- An ACF in the City of Buffalo was awarded EQUAL program funds and the residents decided to use those funds to purchase microwaves for resident use and upgrade the automatic doors in the building. As a result of resident involvement in the EQUAL program process, participation in resident council has substantially increased and more residents are engaged in using their voice and offering suggestions to the ACF. For example, the residents are planning an eclipse watching party in April 2024.

- Residents in two ACFs in Chautauqua County that are operated by a not-for-profit, where over half the residents in one ACF are recipients of SSI or a decreased monthly fee due to income and asset level, and in the other, over 85% of residents are low income and recipients of SSI have benefited from the EQUAL program. In working with the residents, EQUAL program funds were used to support resident quality of life improvements including:
    - Updating common space furniture and 20 year old wall covering;
    - Conversion of a space from an unused nook to a kitchen area where residents can cook if they choose;
    - Provide shopping trips at no cost to the resident by offsetting transportation costs;
    - Install awnings to promote outdoor activities; and
    - Install sidewalks for safe mobility and connection to the surrounding community.

<u>The EQUAL program helps residents age in place with independence, autonomy, dignity, and remain connected with the community.</u>

The Enriched Housing subsidy program provides funds to qualifying not-for-profit operators who provide services to individuals receive SSI benefits. The purpose of this program is to enhance the quality of care to improve service delivery to eligible residents and assist in meeting resident needs. While we always call for transparency and accountability for how such funds are spent (i.e. to the benefit of the residents and not the operator), these funds are necessary such that the needs of lower income residents are met.

ACFs are not mandated to accept residents whose income is SSI/SSP nor are they required to keep residents who run out of funds. It is important that the EQUAL program and Enriched Housing subsidy program remain and are funded. If not-for-profit ACFs begin to limit admissions of individuals who are unable to pay the private pay rate, where are these individuals going to go? What about residents whose funds/resources are depleted? Older adults who need the services of an ACF should be afforded the opportunity to age in place in their ACF (as appropriate) and not be forced into a nursing home or other inappropriate setting like a hotel or shelter due to exhaustion of funds/resources. It does not make sense for a budget to prioritize aging in place for the SNALR program (which we support), while cutting necessary programs for lower income persons who reside in ACFs.

<u>CELJ urges the Legislature to reject these proposed cuts and restore funding to these essential programs that help lower income older adults reside in their home; ACF</u>**.**

D. Reject Executive Budget Proposal HMH Part Q sections 8-10: Medication Aides in Nursing Homes and Ensure Nursing Home Operators are Meeting Staffing and Legal Obligations

While there are nursing home operators who do place resident care and safety at the forefront of financial decision-making, too many do not. The Legislature has implemented various reforms to address the failures of those operators to provide safe and quality care to all residents: Minimum Nurse Staffing Law (Chapter 156 of the Laws of 2021); Certificate of Need and Related Party Contracts (Chapter 102 of the Laws of 2021, amended by Chapter 141), the FY 2021-2022 Budget enacted PHL 2828-minimum direct spending requirements, and others. These reforms are in the process of being implemented and the nursing home lobby has been hard at work to weaken these necessary reforms. CELJ urges the Legislature and the Executive to reject the further weaking of these essential laws.

Specifically, CELJ urges the Legislature to reject the Executive's proposal to authorize certified medication aides to administer routine and prefilled medications in nursing homes.[15] While promoted by supporters as a no-cost strategy address staffing concerns, if implemented, the quality of care will decline and resident safety will be adversely impacted.

Nursing home operators are required under federal and state law to ensure resident care needs are met based on the individual's plan of care, this includes medication administration and management from licensed nursing staff. Resident acuity has increased over the past decade, and persons living in nursing homes are more medically and socially complex. Instead of increasing CNA and RN workload, the State should first ensure nursing home operators are meeting their federal and state legal obligations. The State can start by ensuring nursing home operators are meeting the minimum nurse staffing standards set forth under PHL 2895-b.

There is limited research on the issue of medication assistants in nursing homes, and that research has mixed results. For example, one study evaluated the impact of the use of medication assistants in a rural eastern Washington State nursing home. It found that while the number of LPNs scheduled to administer medications slowly declined, as the number of medication assistants increased, the number of inspection deficiencies more than doubled from 2017 to 2019.[16] Another study, from 2013, found mixed results regarding the potential benefits/harms of having CNAs distribute medication. Specifically, it found that where nursing homes reduced RN/LPN staffing levels, and used medication aides, there were increases in the numbers of residents who needed help with ADLs, who lost continence, and who were depressed/anxious.[17]

NYS ranks 35th in direct RN staffing, 45th in total nurse staffing, and 5th for the highest usage of contract staffing (16.3%) in the United States.[18] The State must place greater efforts and emphasis

[15] CELJ also opposes A8299: while one of the reasons used to support the bill is NY's OPWDD system uses DSPs to administer medications, typically the medical care needs of that population are less complex than persons who reside in nursing homes.

[16] Crogan NL, Simha A.. Impact of Medication Use on Nursing Home Staffing Levels and Inspection Results. Gerontology & Geriatrics. Sept 17, 2020; https://austinpublishinggroup.com/gerontology/fulltext/ggr-v6-id1044.pdf

[17] Walsh JE, Lane SJ, Troyer JL. Impact of medication aide use on skilled nursing facility quality. Gerontologist. 2014 Dec;54(6):976-88. doi: 10.1093/geront/gnt085. Epub 2013 Aug 22. PMID: 23969257

[18] https://data.cms.gov/quality-of-care/payroll-based-journal-daily-nurse-staffing

on ensuring each nursing home operator is meeting federal and state requirements on RN and other direct nurse staffing before adding any additional burdens on already overworked RNs and CNAs.

CELJ further opposes A2800 and other efforts to further dilute the minimum nurse staffing standards in nursing homes. While it is important that nursing homes have physical, occupational, and recreational therapists and assistants, these, along with any other proposed staff minimum standards, must be in addition to the minimums set forth under PHL 2895-b.[19]

The DOH has the oversight and enforcement authority to ensure nursing home operators are properly utilizing private and public funds on resident care and the State can do more to hold bad actors accountable. For example, PHL 2803-x requires nursing home operators:

- Disclose common or familial ownership of any corporation, other entity or individual providing services to the operator or the facility;
- Notify DOH and LTCOP prior to executing a letter of intent or other contractual agreement related to the sale, mortgaging, encumbrance, or other disposition of the real property of the facility and the consulting, operations, staffing agency or other entity to be involved in the operations of the facility.
- Notify residents and their representatives, staff and their representatives and LTCOP within 5 days of executing such agreements.

These disclosure requirements, along with operator submitted costs reports, provide the DOH with the necessary information to fully review and assess how funds are being spent (and potentially misspent) and cross reference to staffing levels and quality of care. Furthermore, the DOH has the information needed to assess small to stand-alone not-for-profit nursing home operations and work with those operators to improve their finances and support of quality care and life services.

E. <u>Increase the Personal Needs Allowance for Residents in Nursing Homes.</u>

CELJ urges the Executive and the Legislature to include a substantial increase in the personal needs allowance (PNA) for nursing home residents in the Budget. The PNA is the monthly sum of money residents who are covered under chronic care Medicaid are allowed to retain from their income. The PNA, currently $50, was set back in 1981 and has never been increased or adjusted for increased cost of living.[20]

If a resident uses chronic care Medicaid to pay for their stay, the nursing home must provide nursing services, dietary services, certain activities programs, room/bed, maintenance services, routine personal hygiene items and services, and medically related social services. Medicaid does not pay for personal items and services that persons residing in the community can access that improves quality of life. Such items and services include: cards to send to family, a meal out with

[19] There should be no question as to the benefits, and the need of higher nurse staffing standards, even higher than what PHL 2895-b requires. For example, *see* Harrington C, Schnelle JF, McGregor M, Simmons SF. The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Serv Insights*. 2016;9:13–19. Published 2016 Apr 12. doi:10.4137/HSI.S38994 – that documented over 150 staffing studies have been done, and that the strongest positive relationships are found between RNs and quality, and that total nurse staffing is directly related to quality.
[20] For residents whose income is SSI, the PNA is $55, for veterans $90.

friends or participate in an ice cream truck social at the nursing home, clothing, internet, books, beauty/barber services and more.

While A8396/S7786 that would increase the PNA to $128.[21] the increase does not go far enough, nor does it include cost of living increases so that residents are not left with pennies and no means to purchase personal items which often connect them to the community. $50 in 1981 is the equivalent of $172.14 today.[22] Given this, **we urge the PNA to be increased to at least $150 to be adjusted annually to reflect the consumer price index.**

Only allowing an older adult to retain $50 of their income, with the balance going to the nursing home, is an affront to basic dignity and quality of life principles. Increasing the PNA is a simple and straightforward way the State can directly improve the quality of life of older adults who live in nursing homes through the Budget.

F. Support: Increased State Investment in the Long-Term Care Ombudsman Program (LTCOP)

The LTCOP advocates for residents of nursing homes, adult care facilities and family type homes. Ombudsmen provide information and assistance to long-term care residents and their families in an effort to attain quality care. Ombudsmen are specifically trained to investigate complaints and resolve problems. As the chief advocate for long-term care residents in both nursing homes and adult care facilities, LTCOP can play a significant role in raising the level of care provided by these facilities and ensure each resident is treated with the dignity they deserve.[23]

LTCOP is responsible for providing a 'regular presence' in these homes. However, decades of severe underfunding by the State is preventing LTCOP from fully fulfilling its responsibilities under both State law and the federal Older Americans Act. As a result, LTCOP is reliant on volunteer ombudsmen to try to carry out its mission. Volunteer ombudsmen serve an essential role and function within LTCOP. However, volunteers are only required to provide 2-4 hours per week to a facility. While some provide more, it is not enough. Due to the complex issues and environment residents are facing, paid staff are needed.

The legislature recognized the importance of LTCOP by negotiating a $2.5M add into the FY 2023-24 and 2022-23 budgets. Unfortunately, the Executive did not include the FY 2023-24 budget legislative addition into this year's proposal. CELJ urges the legislature to again fight for additional funding in the final budget.

With the prior budget increases from the State, LTCOP has been able to recruit, train and retain

[21] $140 if income is SSI, $196 for veterans.

[22] https://data.bls.gov/cgi-bin/cpicalc.pl?cost1=50&year1=198104&year2=202312 The Federal Benefit Rate (FBR), which is used to calculate Supplemental Security Income (SSI), is updated annually based on the changes in the Consumer Price Index (CPI). CPI is calculated by the US Bureau of Labor Statistics and measures chances in prices paid by US consumers for a variety of different goods and services. The PNA for nursing home residents should be updated annually based on the CPI as well to acknowledge the changes in pricing over time

[23] For example, *see:* The Impact of Long-Term Care Ombudsman Presence on Nursing Home Survey Deficiencies Berish, Diane E. et al. Journal of the American Medical Directors Association, Volume 20, Issue 10, 1325 - 1330

more staff and volunteer ombudsmen, which has in turn lead to greater coverage.[24] However, more funding is needed to ensure the program can quickly ramp up coverage efforts. A $15 million investment into LTCOP for the program to hire 235 full-time employees to conduct regular and consistent weekly visits. It is time the program move away from a volunteer-based model to one that is professionally staffed and supplemented by volunteers.

II. Support Home & Community Based Services and Implement Policies that Eliminate Institutionalization Bias

In order to fully support older adults to age with independence, dignity and autonomy, and reform LTC in the State, home and community-based services must be prioritized. This means implementing a budget and policies that make home care the first available choice and supporting formal and informal caregivers.

A. Support: Home Care Savings and Reinvestment Act.

CELJ strongly supports S7800/A8470, the Home Care Savings and Reinvestment Act, that would replace the failed Managed Long Term Care (MLTC) model with a managed fee-for service program that will ensure older adults have access to home and community based services. A managed fee-for service model, whereby a care management entity would be paid to develop a care plan and authorize services, would ensure older adults and persons with disabilities who need long term services and supports actually receive said services.

There are many reasons for the state to move in this direction:

- Plans are incentivized to deny care. Plans are paid the same per member per month premium for every member. This model was doomed to fail from the beginning because by definition, members are those with chronic conditions, aka high needs. MLTCs, in order to make a profit, deny needed home care and delay approvals for months.[25]

- Plans place barriers to members returning to the community after entering a nursing home for short-term rehabilitation/care. The carve-out of nursing home care from the MLTC benefit package, implemented in August 2020, exacerbates the incentive for MLTCs to limit access to high needs older adults. For example, we have seen MLTCs refuse to reinstate or increase home care for clients who needed the home care to return home.

- There is a lack of accountability and transparency. The State has failed to ensure that MLTC plans are properly following the law and model contract requirements. For example, in 2022, the NYS Comptroller found that the State paid $2.8 billion in premiums to MLTC plans that provided little or no services, and another $701 million for consumers who had died, moved to

[24] In according to data from https://aging.ny.gov/transparency

[25] *See* Mis-Managed Care: Fair Hearing Decisions on Medicaid Home Care Reductions by Managed Long Term Care Plans, June-December 2015, by Medicaid Matters NY and NYS Chapter of National Academy of Elder Law Attorneys (July 2016), available at https://medicaidmattersny.org/mltc-report/. The report was featured in a story in the New York Times, Nina Bernstein, *Lives Upended by Disputed Cuts in Home-Health Care for Disabled Patients*, July 21, 2016, available at https://www.nytimes.com/2016/07/21/nyregion/insurance-groups-in-new-york-improperly-cut-home-care-hours.html?_r=0.

Assisted Living, or were otherwise not eligible for MLTC.[26] CELJ, along with other consumer advocates, called on the DOH to adopt long term care access standards recommended by CMS, and to post a publicly available quality dashboard with performance metrics such as the maximum wait time for home care services to be initiated after authorization.[27] CELJ also called on DOH public report plan specific data on the numbers and outcomes of appeals, rate of admission of MLTC members to a nursing facility from the community by length of stay, successful transitions to the community, and more.[28] Furthermore, while the Legislature passed a bill that would have required transparency about home care usage, A1926/S1683, the Governor vetoed the bill.

While the Executive, under HMH Part H section 9, seeks to achieve some authority over MLTC plans, by authorizing DOH to impose liquidated damages for managed care organizations who fail to comply with the model contract, based on current and past experience with State oversight failures, CELJ doubts this proposal would have a major impact. While CELJ supports that proposal, replacing the failed MLTC model with managed fee-for service would help to ensure the State upholds its Olmstead obligations and would save the State millions in dollars that is currently being wasted with MLTC.

B. <u>Support Fair Pay for Home Care in Executive Budget.</u>

The State has an obligation to ensure older adults and persons with disabilities are provided with the services and supports to live in the least restrictive setting; their community homes. Shortages within the home care workforce are a major contributing factor to older adults and persons with disabilities being unlawfully institutionalized. Including Fair Pay for Home Care[29] in the FY 2024-2025 Budget, helps to address this issue by ensuring aides are paid 150% of the regional minimum wage. The homecare workforce deserves to be paid a living wage, and the Fair Pay for Home Care Act will accomplish this. This investment is needed to support older adults and persons with disabilities to age (and work) with independence, autonomy, and dignity.

To effectuate comprehensive LTC reform, the State must realign such that nursing homes are the option of last resort (or actual individual choice), and not the first. This cannot be achieved until the State's home care delivery system is stabilized and reliable.[30]

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[26] New York State Comptroller, *Medicaid Program — Oversight of Managed Long-Term Care Member Eligibility*, Aug. 5, 2022, *available at* https://www.osc.state.ny.us/files/state-agencies/audits/pdf/sga-2022-20s52.pdf.

[27] *Consumer Advocate Statement on New York State Comptroller Report of Aug. 5, 2022: Medicaid Program – Oversight of Managed Long Term Care Member Eligibility* (Nov. 2022, available at https://medicaidmattersny.org/wp-content/uploads/2022/11/OSC-MLTC-report-consumer-advocates-statement-11.2.22-final.pdf, citing CMS, *Promoting Access in Medicaid and CHIP Managed Care: Managed Long Term Services and Supports Access Monitoring Toolkit*, June 2022, *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-access-toolkit.pdf.

[28] CELJ October 10, 2022 Annual Comment on NYS DOH 1115 Medicaid Demonstration Waiver.

[29] S3189 (May).

[30] *See Sterling et al. "Utilization, Contributions, and Perceptions of Paid Home Care Workers among Households in New York State." Accessed https://academic.oup.com/innovateage/advance-article/doi/10.1093/geroni/igac001/6499014?login=false „See also:* Jacobal-Carolus, Luce, Stephane, Milkman, Ruth. "The Case for Public Investment in Higher Pay for New York State Home Care Workers-Estimated Costs and Savings-Executive Summary., Accessed

Instead of investing in the home care workforce, the Executive, at HMH Part G is proposing to discontinue wage parity for personal assistants in the CDPAP in NYC, Nassau, Suffolk, and Westchester Counties. While this is outside of CELJ's coverage area, we urge the Legislature to reject the proposal. Wages for persons who provide home care services to older adults and persons with disabilities must be made a priority. Without a healthy and financially sound workforce, there can be no home and community based services and supports.

Fair Pay for Home Care must be included in the FY 2024-2025 Budget. This is a needed investment not only for the State's aging population, but their caregivers. All the efforts underway with the Master Plan on Aging and the upcoming release of the Olmstead Plan will mean nothing unless substantial investment is made in the home care workforce.

C. Repeal the Harmful Changes to the Medicaid Program Enacted through Prior Budgets.

The FY 2020-2021 Budget amended SSL to set new minimum requirements for eligibility for PCS and CDPAP services for eligibility to enroll in a Medicaid MLTC plan. Under these enactments, applicants have to require assistance with physical maneuvering for 3 ("more than two"), Activities of Daily Living, except for applicants with dementia or Alzheimer's. For applicants with dementia or Alzheimer's, only supervision with more than one ADL is needed.

These amendments create irrational and discriminatory distinctions between Medicaid consumers with different types of disabilities. These irrational and discriminatory distinctions are arbitrary and violate federal regulation.[31] Furthermore, these amendments will force older adults and people with disabilities inappropriately into nursing homes. This outright violates the Americans with Disabilities Act and the Olmstead integration mandate.

While the implementation of these amendments has been delayed due to the Public Health Emergency Maintenance of Effort requirements, that delay is scheduled to end. We urge the legislature to act now and avoid unnecessary harm to older adults.

CELJ supports S328 and urges the Legislature and the Executive to repeal these harmful changes.

In addition, the FY 2020-2021 Budget implemented Medicaid cuts to access to home care services through a 30-month lookback. While also not yet implemented due to the Public Health Emergency, if implemented, would delay receipt of Medicaid covered home care services for older adults and persons with disabilities, and will cause unjust institutionalization and further strain on familial caregivers. When a Medicaid applicant is in a nursing home, they are receiving care and services. Medicaid, if approved, will cover the care retroactively. However, when a Medicaid applicant is in the community, a lookback will delay the approval process leaving the individual without

https://static1.squarespace.com/static/58fa6c032e69cfe88ec0e99f/t/6022ae8312cfd1015354dbee/1612885635936/Executive+Summary+CUNY+REPORT.pdf

[31] 42 C.F.R. §440.230(c): The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.

essential home care services that are needed for the individual to remain in their home. CELJ urges the Legislature and the Executive to repeal this harmful change.

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Thank you for the opportunity to submit this testimony. CELJ is available to answer any questions and provide additional information.

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