Joint Legislative Public Hearing on Health/Medicaid

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Introduction

My name is James W. Clyne, Jr., and I am the president and CEO of LeadingAge New York. Thank you for the opportunity to testify on the health and Medicaid aspects of the SFY 2014-15 Executive Budget.

My comments today will focus on a few broad themes: (1) adjusting the Medicaid cap to reimburse providers adequately for increased Medicaid enrollment and costs of care; (2) ensuring that aging services providers have access to resources for critical infrastructure investments, such as health information technology, telehealth and senior housing; (3) rejecting new mandates and providing an appropriate level of support for existing ones, including wage parity, the UAS-NY assessment system, and managed care contracting with home health agencies; (4) restoration of arbitrary funding cuts that jeopardize the sustainability of essential providers; and (5) assuring actuarially-sound premiums for managed long term care plans and rationalizing the transition to mandatory managed long term care. Left unaddressed, these issues could derail efforts to redesign the Medicaid program in a manner that protects the wellbeing of frail elderly New Yorkers and people with disabilities.

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 (MLTC) plans. LeadingAge NY's 600-plus members serve an estimated 500,000 New Yorkers of all ages annually. This broad representation gives LeadingAge NY a unique understanding of the potential impact of the 2014-15 Executive Budget on the entire system of services for seniors and people with disabilities.

Our members are playing a critical role in new models of care and payment being advanced by the state and federal governments, such as health homes, accountable care organizations, managed care for medically-complex beneficiaries, and hospital readmission reduction initiatives. They are helping to manage chronic conditions, provide nursing and rehabilitation therapies after an acute episode and on a long-term basis, and provide assistance with activities of daily living and social supports for frail elderly and medically-complex patients who are at risk of avoidable and expensive hospitalizations. As the state moves to allocate billions of dollars to transform the delivery system, it is critical to recognize the important role played by aging service providers that furnish long term and post-acute care and social

supports to a high-risk population. Investment in their services is essential to the success of efforts to reduce avoidable hospitalizations and ensure better health and better care at a lower overall cost.

Medicaid Global Spending, Trend Factor and Conditional Restoration of the 2% Cut

The proposed budget continues and extends through March 31, 2016 authorization for both the Medicaid global spending cap and the "super-powers" granted to the Commissioner of Health to reduce spending if expenditures exceed projections. Several factors entirely out of the control of the provider community could cause the cap to be breached (e.g., an expansion of Medicaid enrollment due to the impact of the health exchange or "Marketplace" or an economic downturn), and yet it is the providers that would cope with the effects of reduced payments in the face of added expenses. Furthermore, the manner in which the administration develops spending projections for each category of service (which is not well understood) could have a bearing on whether a certain type of provider could face a non-uniform cut if the cap is exceeded.

Under the Executive Budget, the annual cap on state share Medicaid expenditures would increase from $16.4 billion in 2013-14 to $17.1 billion in 2014-15, for a less than 4 percent increase. The Governor's budget would further establish the Medicaid global cap for SFY 2015-16 in law at $17.9 billion.

These increases are based on 10-year average growth rates in the medical component of the consumer price index, which is a measure of price inflation in health care. However, the cap does not merely operate as a limit on allowable price increases in health care services. Instead, the cap acts as a limit on total state share Medicaid spending through the Department of Health which is affected by a complex array of variables including changes in: (1) Medicaid enrollment; (2) patient acuity; (3) composition of services; and (4) payment arrangement (i.e., fee for service vs. managed care). Medicaid spending is also affected by policy decisions that increase the expense of providing health care, such as the wage parity law for home health workers. Yet, the cap is not adjusted to accommodate of these factors. Providers should not be at risk of being arbitrarily penalized for macroeconomic factors that negatively impact on the global spending cap.

Ironically, although the global cap is adjusted based on an inflationary index, the Executive Budget provides no trend factor (i.e., inflationary) adjustments to provider and managed care plan payments. Under existing law enacted last year, trend factor adjustments to Medicaid reimbursements have been eliminated through March 31, 2015. The trend factor freeze affects hospitals, nursing homes (except

pediatric facilities), adult day health care programs, certified home health care agencies (CHHAs), long term home health care programs (LTHHCPs), personal care providers, assisted living programs (ALPs), hospice and clinics.

We are pleased to see that the budget includes a proposal to eliminate the 2% across-the-board cut to all Medicaid service sectors that has been in effect since April 1, 2011. Under the proposal, this cut would end on March 31, 2014. However, various provider sectors, including nursing homes, LTHHCPs and ALPs agreed in prior years to alternative savings mechanisms, such as increased provider taxes for nursing homes and LTHHCPs and reductions in EQUAL for the ALPs, in lieu of a 2% Medicaid rate cut. The Executive Budget leaves open the possibility that these alternative mechanisms could be continued after April 1, 2014.

At the same time, the budget would create, for the first time, a program to share global cap savings with Medicaid providers and managed care plans. We are pleased that the Executive Budget includes this proposal. SFY 2013-14 Medicaid expenditures through November 2013 were $59 million below global spending projections, suggesting this could become a reality for Medicaid providers. This would be welcome relief for providers which have seen no cost-of-living increase in over five years. Unfortunately, despite the best efforts of providers to improve efficiencies and reduce unnecessary utilization, increases in Medicaid enrollment, rising patient acuity and several new mandates may consume much of the room under the cap, and are unlikely to leave enough savings for providers to experience any meaningful relief.

Recommendation: *The Legislature should adjust the $17.1 billion Medicaid global spending cap for SFY 2014-15 to provide sufficient funding for recipient enrollment growth, increases in patient acuity in fee-for-service and managed care settings, elimination of the two percent across-the-board cut, and instituting quality payments and performance-based inflationary adjustments. As Medicaid redesign proceeds and funding shifts among service categories, the Legislature should also continue to closely monitor the development of spending projections by service category as well as actual spending trends by service sector.*

Health Care Capital Investments

a) Capital Restructuring Financing Program and Health Care Facility Restructuring Program

LeadingAge NY was pleased to see provisions in the Executive Budget to improve access to capital for health care facilities. Capital investment in our health care infrastructure is critically important as the state moves to transform the delivery system; yet options for accessing capital among our cash-strapped senior services providers have been extraordinarily limited.

The proposed budget would address this problem by (i) allowing not-for-profit nursing homes and clinics to borrow money through the Health Care Facility Restructuring Program; and (ii) establishing a $1.2 billion, five-year program under the joint administration of DOH and the Dormitory Authority of the State of New York (DASNY) to provide bond financing of capital projects that enhance the "quality, financial viability and efficiency of the health care delivery system." This new program would permit funds to be disbursed to hospitals, nursing homes, diagnostic and treatment centers and mental health clinics for projects involving closures, mergers, consolidations, restructuring, improvements to infrastructure, development of primary care service capacity, and promotion of integrated delivery systems.

This proposal, while laudable, is too narrow in scope. It would exclude home care agencies and assisted living programs and does not explicitly support investments in health information technology and telehealth. The new models of care and payment being advanced under the MRT and the Affordable Care Act demand robust health information technology systems to support the sharing of health information across the continuum, performance measurement, and management of risk-based payments. Although communication and coordination among a variety of providers is key to the success of these new models of care and payment, public investment in health information technology and exchange for the long-term/post-acute care sector has been minimal. Similarly, investment in home-based telehealth applications that support cost-effective patient care through remote patient monitoring and medication management has not been a priority of either the federal or state government.

As the state pursues its goals of reducing avoidable hospitalizations and overall health care spending, by ensuring that care is coordinated across settings and more individuals are served in the community, added investments in health information technology, health information exchange and telehealth

applications for long-term/post-acute care providers are critically important. Without such investments, the state's ability to achieve its health care goals may be compromised.

Recommendation: *The Legislature should support the expansion of the $1.2 billion Capital Restructuring Financing Program to include Assisted Living Programs, Certified Home Health Agencies and Licensed Home Care Services Agencies. Eligible projects under the program should include health information technology and telehealth projects. The proposed program provides a preference for applicants approved to participate in the Delivery System Reform Incentive Program. Since DSRIP projects are expected to be limited to specified models, the Capital Restructuring Financing Program should be open to projects that do not qualify for DSRIP, as well as those that do.*

b) Private Equity Investment in Health Care Facilities

In another effort to improve access to capital for health care facilities, the Executive Budget includes a private equity demonstration program. The proposal would authorize a "pilot program" under which up to five business corporations would be established as health care facility operators. Operators of facilities under this pilot would be exempt from the prohibition on corporate ownership of stock, but would be limited to no more than 35 stockholders. Although institutional investors would be permitted, the corporations' stock could not be traded on a public or over-the-counter exchange. The corporations would be authorized to operate "hospitals" as defined in the Public Health Law (which includes nursing homes and clinics), as well as home care agencies and hospices.

LeadingAge NY remains very wary of any arrangements that would have the practical effect of allowing the principals of a publicly-traded corporation to establish a New York affiliate and offer health care services. We remain strongly opposed to allowing publicly-traded corporations to operate nursing homes and home care agencies in the state.

In other states that allow these ownership structures, these corporate entities are much less accountable to the state and local communities and more accountable to shareholders. As a result, serious quality of care lapses have more often been associated with these corporately operated providers than with community-based providers such as those that characterize New York's health care system. For example, according to a July 2011 report from the U.S. General Accounting Office, nursing homes owned by private investment firms had more total deficiencies, were more likely to have been cited for a serious deficiency, and had lower total nurse staffing ratios than other facilities.

Recommendation: *The Legislature should carefully review this proposed pilot program, prohibit operators established under the pilot from operating nursing homes, carefully circumscribe the use of any such ownership structure to compelling situations involving public health and safety, and thoroughly evaluate the outcomes of any such pilot.*

Investing in Affordable Housing

LeadingAge NY applauds the Executive Budget's critical $100 million investment in affordable housing, and its $18.4 million increase in funding for the MRT supportive housing initiative. These new funds create a significant opportunity to address the growing need for low-income senior housing and support services, but the Executive Budget does not include a specific earmark for senior housing. Last year, $3 million was allotted through the MRT supportive housing workgroup for a senior supportive housing pilot project to keep seniors in the community and out of institutional settings for as long as possible. While this represents an important first step, it does not come close to meeting the need.

New York State faces a significant and growing gap in the supply of affordable senior housing, as well as long term services and supports, due to the steep growth in the number of senior citizens. LeadingAge NY issued a report entitled "Senior Housing in New York State" that details the growing need for senior housing and supportive services to promote healthy aging-in-place and reduced dependence on the Medicaid program. The report reveals that New York's population aged 65 and older will grow by 40 percent between 2010 and 2040. Approximately 25 percent of New Yorkers in this age group have income below 150 percent of the poverty level. According to the report, affordable senior housing is a vitally important element of the infrastructure needed to support the goals of Medicaid redesign, while enhancing resident quality of life and promoting independence.

Recommendation: *State lawmakers should support programs that fund capital and supportive services in senior housing to preserve and update existing affordable senior housing properties; provide gap funding for new senior housing construction to include supportive housing building features; and infuse supportive services into existing affordable senior housing. The Legislature should earmark a portion of affordable housing and supportive housing investments for senior housing development.*

Mandate Relief and Adequacy of Rates

a) **Wage Parity**

Effective March 1, 2014, home care agencies and Medicaid managed care plans will be required to increase significantly the compensation paid to home health aides under the state's Home Care Worker Wage Parity law passed in 2011. The law establishes a minimum wage for home health aides who perform Medicaid-reimbursed work for certified home health agencies (CHHAs), long term home health care programs (LTHHCPs) and managed care plans within New York City and the counties of Nassau, Suffolk and Westchester. The Executive Budget proposes $300 million to assist with this mandate. While we applaud the Governor for recognizing that this mandate is unaffordable to providers in a climate of shrinking revenues, managed care plans and providers estimate the real cost at more than $600 million.

Recommendation: *The Legislature should increase the Governor's $300 million proposed allocation, in order to cover fully the cost of this mandate, ideally with funds outside of the Medicaid global spending cap.*

b) **Nursing Home Standard Wage**

The Executive Budget would require that all managed care contracts include a provision requiring a standard rate of compensation be paid to employees who provide inpatient nursing home services including nurses, nurse aides, orderlies, therapists and any other occupations designated by DOH and the Department of Labor. The standard rate would be required to include a basic hourly cash rate and a supplemental benefit rate which would be annually determined by these two state agencies. It is unclear from the Executive Budget proposal what these rates would be and how they would be determined.

Given the state's plan to enroll Medicaid beneficiaries in need of nursing home care into managed care plans beginning in March of this year, the standard wage requirement would eventually apply to nearly all Medicaid-covered nursing home services. A nursing home that "materially" fails to comply would risk having its Medicaid admissions suspended, as well as incurring other penalties and contract violations. With no additional reimbursement proposed in the Executive Budget for these requirements, nursing homes and Medicaid managed care plans would bear the financial burden of yet another potentially major unfunded mandate.

LeadingAge NY's mission-driven members work hard to offer their employees fair and competitive compensation and benefits. The lack of specificity of this proposed mandate makes it difficult to quantify its impact, but it would presumably increase nursing home expenses at a time when Medicaid reimbursement already fails to cover the cost of providing care. Absent additional funding to support the associated increased wages, this law will ironically force providers to cut direct care staff, threatening the viability of many programs. These requirements would also place added financial pressure on managed long term care plans, as they would bear responsibility for paying rates to facilities that support the required compensation levels.

Recommendation: *The Legislature should reject this proposal outright, unless the state is prepared to identify additional resources to cover fully the associated compliance costs in Medicaid fee-for-service and capitated rates of payment.*

c) Managed Care Contracting for Home Health Services

DOH has just issued a policy directive requiring all skilled home health services delivered under contracts with Medicaid managed care plans to be provided by a home health agency that meets the federal Conditions of Participation (i.e., a CHHA or LTHHCP, rather than a licensed home care services agency (LHCSA)). The impact of this policy, both in terms of cost and the ability of Medicaid beneficiaries to maintain relationships with existing caregivers is certain to be significant. With the additional staffing and assessment requirements that CHHAs and LTHHCPs must meet, we expect the cost differential between LHCSA and CHHA or LTHHCP contracting to be substantial.

Recognizing the challenges associated with this new directive, the Executive Budget allocates $17 million in SFY 2014-15 to adjust managed care premiums to reflect the increased costs to plans of complying with this requirement. Given the current volume and expected growth of home care services furnished under managed care, it will be critically important to quantify accurately the added compliance costs and adjust managed care premiums appropriately to ensure that that premiums are adequate to support the services Medicaid beneficiaries need to remain in the community.

Recommendation*: The Legislature should allocate sufficient funds to ensure managed care premiums are adequate to cover the increased cost of shifting contracts from LHCSAs to CHHAs and LTHHCPs.*

d) Nursing Home Case Mix Index Cap

The Executive Budget includes an onerous provision that would cap each nursing home's increase in its case mix index (CMI) (a measure of resident acuity) at 2% in any six-month period for Medicaid payment purposes. The proposed cap is arbitrary and entirely at odds with state and federal policies that encourage nursing homes to serve people with more intensive needs. Efforts to reduce avoidable hospital use, to serve more people in community-based settings, and to require nursing home residents to enroll in Medicaid managed care plans will invariably lead to nursing home CMI increases, as lower acuity residents receive the supports they need to return to the community and higher acuity residents are retained rather than hospitalized. Furthermore, CMI increases are already subject to audit. Accordingly, this ill-advised proposal should be rejected.

Recommendation*: The Legislature should reject this 2% CMI cap and reimburse nursing homes for their legitimate increased costs of care.*

e) UAS-NY Implementation

DOH has required managed long term care (MLTC) plans, long term home health care programs (LTHHCPs), adult day health care (ADHC) programs and assisted living programs (ALPs) to adopt a new patient assessment tool called the Uniform Assessment System for New York (UAS-NY). This new electronic assessment, which must be conducted by a nurse in the patient's residence, requires significant additional nursing and patient time to complete, as well as investments in technology and training. The UAS-NY has turned into a significant unfunded mandate for both plans and providers. In addition, duplicative regulations have forced frail elderly and disabled individuals to sit through redundant multi-hour assessments, performed by both managed care plans and their network providers.

Recommendation*: The state should quantify the costs associated with UAS-NY implementation and allocate funding for managed care plans and providers through the state's Balancing Incentive Program funding award and/or other sources to offset these new costs. It should also eliminate duplicative assessments.*

Vital Access Provider Funding

LeadingAge New York supports the Vital Access Provider (VAP) expansion as proposed by the Execute Budget, which would include additional funding and include licensed home care services agencies (LHCSAs) among the providers eligible for funding. The VAP program is provided as discretionary grants

and is intended to assist essential community providers (hospitals, nursing homes, clinics and home health providers) proposing, or affected by, facility closures, mergers, integration or reconfiguration of services.

The final SFY 2013-14 budget provided a total of $182 million in VAP funding, including $30 million from discontinuing the financially disadvantaged nursing home funding program. The Executive Budget would increase total VAP funding to $194 million in SFY 2014-15, inclusive of a $40 million allocation to add LHCSAs to the list of eligible provider types for VAP funding.

Recommendation*: The Legislature should support the expansion of the VAP program and ensure that the state distributes the $30 million dedicated to disadvantaged nursing homes.*

Managed Long Term Care, PACE and Fully Integrated Duals Advantage (FIDA) Programs

LeadingAge NY has long been a proponent of the major themes of Medicaid redesign: expanding care management; recalibrating Medicaid benefits; revisiting reimbursement systems and incentives; streamlining regulations; empowering patients/residents and engaging them in their care; and aligning with federal policy objectives. With the inception of the MRT philosophy of "care management for all" and the decision to transition nearly all Medicaid beneficiaries, including the frail elderly and those with disabilities, into managed care, LeadingAge NY's managed long term care plan and provider members are playing a critical role in the MRT's reforms. (For purposes of this testimony, the term "managed long term care" also includes PACE and FIDA).

The adequacy of premiums remains an ongoing concern for both managed long term care plans and providers. The mandatory enrollment of higher risk cohorts of patients, the recently- enacted wage parity requirements, and the home health contracting requirement have created very real concerns regarding the adequacy of managed care plan rates. Beginning March 1st, the nursing home population will begin transitioning into managed care, and it is not clear that the rate to be paid for nursing home level of care enrollees will be adequate to cover the costs of those residing in nursing homes. If enacted, the proposed standard wage mandate is likely to exacerbate the problem.

In addition, aggressive timeframes for managed care transitions, a lack of timely guidance on key operational issues, and inconsistent directives on other issues have led to an unacceptable level of uncertainty in the operations of managed care plans and providers. Budgeting and planning in this

environment has become extremely difficult, as plans and providers are unsure how to allocate resources, how to operationalize shifting policies, and even which providers they may use for home health services.

Recommendation*: The Legislature should ensure timely and actuarially-sound managed care rate updates that reflect the acuity of the enrolled population and costly new mandates. The state should partner more closely with the managed care plans and providers to provide timely guidance on key operational issues and ensure an efficient transition that minimizes disruptions for Medicaid beneficiaries.*

Adult Care Facilities and the Assisted Living Program

Adult Care Facilities (ACFs), Assisted Living Programs (ALPs), and Assisted Living Residences (ALRs) are critical services for seniors in New York. While each category of licensure offers something slightly different, they all provide an option for seniors who cannot remain in their own homes, but do not need the continual skilled nursing services of a nursing home. These options are popular with seniors as they provide more home-like settings that foster independence. We must ensure that ACF and assisted living are true options for low-income seniors. Without ACFs and assisted living programs that serve low-income seniors, many more New Yorkers would need nursing home care, at a significant cost to the Medicaid program.

a) Enhancing the Quality of Adult Living (EQUAL)

The Enhancing the Quality of Adult Living (EQUAL) program provides funding for ACFs that serve recipients of Supplemental Security Income (SSI) or Safety Net Assistance, and is distributed based on the financial status of the facility, resident needs, and size of the facility. This funding is critical as SSI does not cover the full cost of providing care. EQUAL supports quality initiatives in facilities that serve Medicaid-eligible individuals who, without the support of the ACF or ALP, would likely be in a nursing home. The Executive Budget funds EQUAL at $6.5M, the same level as last year, which represents a six percent reduction over years prior to 2013-14.

Recommendation: *While we appreciate that the Executive Budget's proposed level-funding for the EQUAL program at $6.5M, last year's EQUAL funds were cut by approximately six percent in the final agreement. The Legislature should increase EQUAL funding to its historic level of $6.9M.*

b) SSI Enriched Housing Subsidy

The SSI Enriched Housing Subsidy is funded at approximately $475,000, essentially the same level as last year. The program pays $115 per month per SSI recipient to certified operators of not-for-profit certified enriched housing programs. Again, this funding is critical; if Enriched Housing Programs cannot afford to accept Medicaid-eligible individuals, many will likely enter nursing homes.

Recommendation: *Once again, we appreciate the Executive Budget's proposed level-funding for the SSI Enriched Housing Subsidy. However, last year's funds were cut by five and a half percent in the final agreement. The Legislature should increase this modest subsidy to its historic level of $502,900.*

c) Reappropriations

Over the past few years, we have been monitoring various reappropriations for EQUAL, the SSI Enriched Housing Subsidy, and the now defunct QUIP and EnAbLE programs. All of these funding programs support facilities that serve low-income individuals. These programs are modest investments that can have a significant return. We have fought hard to ensure that funding, which through prior budget processes has been promised to ACFs, is ultimately paid out. While we have had some success, some of this funding was vetoed by the Governor last year. A fraction of these past funds is reappropriated in this year's budget.

Recommendation: *The Legislature should ensure that the decisions that were made in past years' enacted budgets are executed. The Legislature should reappropriate the $11.7 million owed for past year's EnAbLE grants and ensure they are distributed this year. This funding allowed for spending on air conditioning in resident rooms, improving the quality of food services, and providing generators. Certainly, the extreme weather events over the past few years highlight the importance of generators, and yet some facilities – particularly those that serve a low-income population – simply do not have the funds to purchase them.*

d) Assisted Living Programs

The assisted living program (ALP) provides an assisted living option for Medicaid beneficiaries who are medically-eligible for nursing home care. In the face of annual budget cuts and increased requirements and costs, existing ALPs are struggling to stay open. The ALP has not received a trend factor increase in years. Rather, ALPs have experienced annual reductions in their Medicaid rate, while operating costs have risen. The implementation of the Uniform Assessment System (UAS-NY) has introduced significant

new costs for training, nursing staff, and technology. The training of each individual who works on the assessment takes an average of twelve hours, and the assessments themselves require approximately two hours of nursing time. All of these factors make it increasingly difficult to operate an ALP successfully under the current reimbursement structure.

Despite the challenges that ALPs are currently facing, there is a growing demand for Medicaid assisted living options, and insufficient resources to satisfy it. Many existing ALP providers want to expand their programs to meet their community's needs. Others are seeking to develop new programs for low-income seniors in their communities.

Recommendation: *We are pleased that the Executive Budget proposal restores the two percent cut to the ALP Medicaid rate. We request a restoration of this funding through the Medicaid rate, as opposed to the elimination of the EQUAL cut. Unfortunately, the two percent adjustment will not be sufficient to address the increased expenses associated with UAS-NY implementation. We ask the Legislature to provide additional financial support to address this need.*

e) Application Streamlining and the ALP 6,000 Bed Initiative

LeadingAge New York applauds DOH for undertaking a collaborative initiative with LeadingAge NY and other stakeholders to streamline the application process for ALPs, ALRs and ACFs. This, along with recent legislation and various proposals in the Executive Budget, will help move the process along for applicants wanting to develop or expand these services.

We understand that the transition to a managed care environment raises important policy issues for the ALP, and DOH resources are limited. For these reasons, we support the proposal to extend by two years the initiative to expand the ALP by 6,000 beds. Nevertheless, the Department's lack of sufficient staff in this area suggests that even the two-year extension of the ALP bed initiative will be insufficient. With approximately 300 applications pending, and more to come, it is taking *years* to process applications, resulting in unnecessary costs to the providers and the communities they are trying to serve.

Recommendations: *The Legislature and the Executive should adopt the proposed recommendations to further streamline the application and related processes, and extend the ALP 6,000 bed initiative by two years, while actively working to provide DOH with additional resources to processes applications.*

Adult Day Health Care

Mandatory enrollment into managed long term care plans has brought significant challenges to adult day health care (ADHC) programs. Since 2012, we can attribute 20% closure of programs to the inherent inflexibility of adult day health care regulations as managed long term care expands. This number is growing every day. The Adult Day Health Care Council and LeadingAge NY sought to address many of the regulatory issues by rewriting sections of ADHC regulations. For two and one-half years we have relentlessly advocated for the hybrid option or what is now called "the unbundled services/payment option." The proposed regulations allow ADHC programs to provide less than the full package of services and negotiate a payment accordingly. We have made compromises and met every demand from the state. The time has come for DOH and the Governor's office to advance these regulations for emergency rule making.

Recommendation: *The Legislature should press DOH and the Governor to quickly advance the proposed regulations allowing the unbundled services/payment option for Adult Day Health Care.*

Character and Competence Review of Applicants to Operate Health Care Facilities

LeadingAge NY supports the budget's proposal to streamline "character and competence" reviews of applicants for establishment as operators of hospitals, nursing homes and diagnostic and treatment centers by reducing the "look-back" period for consideration of their compliance records from ten years to seven years. This proposal would also give the Public Health and Health Planning Council (PHHPC) the discretion to approve an applicant for establishment, even if the applicant had experienced recurrent violations of regulations, provided that the applicant demonstrates that the violations cannot be attributed to any action or inaction of the applicant.

Recommendation*: The Legislature should approve this proposal. In the not-for-profit context, the current law prevents beneficial mergers, consolidations, and certain affiliations, based on violations that may be remote in time or that relate to a different facility that happens to share a board member with the applicant. The PHHPC should be given greater discretion to determine when an establishment action should be barred.*

Continuing Care Retirement Communities (CCRC)

One small, but critically important, segment of the long term care continuum of services completely missing from the Executive Budget is the Continuing Care Retirement Community (CCRC). In previous

testimony, LeadingAge NY highlighted the plight of the CCRC industry in New York as an example of how excessive and burdensome statute and regulation have stifled innovation in senior services.

The CCRC combines housing, health care and an insurance component to allow seniors to invest in the community and age in place with dignity, comfort and security. Throughout the rest of the nation, this model has proven to be extremely popular with consumers who want to commit their own resources towards their housing and care needs as they age. Other states, including our neighboring states, can boast of dozens of CCRCs meeting the market demand. New York has only a dozen (i.e., a total of 12) CCRCs in the entire state. With so few CCRCs, we are "exporting our seniors" to other states where the CCRC operators are welcoming them with open arms. We are not just losing seniors to the Sunbelt; we are losing them to neighboring states.

Anecdotally, the CCRC approval process in New York can easily take from 18 to 24 months and involve an application that is several inches thick. In Pennsylvania, the standard application approval time is 90 days and the application is less than 50 pages. This is emblematic of the daunting task that any developer faces in trying to build a CCRC in New York. New York's Insurance Regulation 140 presents a similarly burdensome regulatory impediment for operators of CCRCs.

We need to revisit the state's approach to regulation of CCRCs. All of New York's CCRCs are non-profits dedicated to a mission of providing the highest level of amenities, services, and care to their community residents. When we force our seniors to relocate to other states, we also export dollars and economic activity. Most of the economic activity generated by our CCRCs stays right here in New York and is a boon to local communities.

Recommendation*: The State should adopt statutory and regulatory changes that would allow for new CCRC development and allow current operators to innovate and expand. The State should also consider providing low-cost financing options to encourage CCRC investment.*

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 agencies that serve them. At the same time, there are several proposed initiatives that have the potential to advance population health, improve the patient care experience and reduce the cost of

services. LeadingAge NY looks forward to working with the Legislature and Executive on the 2014-15 budget and the state's ongoing reform initiatives.

Thank you again for the opportunity to testify today. I would be happy to answer any questions you may have on our testimony.