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New Yorkers Want to Age in Place. A Fragmented Healthcare System Is Preventing That, Say Experts

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Many New Yorkers want to age in place, but doing so can be challenging, with the healthcare system built around care in institutions such as nursing homes and assisted living. That poses a looming challenge in a city where the population is getting older. The 65-and-over population increased by 6.4% from April 2020 to July 2023, while the city's total population declined by 6.2%, according to the Office of the New York State Comptroller.

To gain a greater understanding of the factors underlying that challenge and find future solutions, Crain's Content Studio partnered with the law firm Sheppard Mullin to host "The future of aging in New York," a breakfast conversation on November 19.

"While most of us want to age in our own homes, in our own communities, with dignity and control, the systems around us often push us in the opposite direction," said Fred P. Gabriel, publisher/executive editor of *Crain's New York Business*, who moderated the discussion in New York City.

Gabriel spoke with Adam Herbst, healthcare partner at Sheppard Mullin; Dr. Mitchell Katz, president and CEO of NYC Health + Hospitals and Dan Savitt, president and CEO of VNS Health, a provider of senior care, in-home skilled clinical care and Medicare/Medicaid health plans, to discuss how reforms are shaping the delivery and financing of long-term care, Medicaid, housing and home-based services statewide.

Shifting from an institution-focused approach

As the panelists described it, New York has a mix of robust programs to support the aging population, but they were not designed to work together to support aging in place. Misaligned financing models, a lack of integration among Medicare, Medicaid and service providers, and a shortage of home health aides are making aging in place difficult, according to the panelists. Medicaid, administered through the New York State Department of Health, covers long-term services and supports, while Medicare covers medical care—leaving older adults navigating two disconnected systems.

“We don’t need more pilots or additional regulation. New York already has strong models,” said Herbst, pointing to the Program of All-Inclusive Care for the Elderly (PACE), naturally occurring retirement communities (NORCs), assisted living programs and Social Care Networks. “The real work is scaling what works and aligning Medicaid, Medicare, housing, and community supports so people experience these solutions consistently. Alongside these challenges, New York’s Master Plan for Aging and the development of Social Care Networks reflect a coordinated effort to finally integrate long-term care, housing, prevention, and social supports at a statewide scale.”

Social Care Networks are designed to strengthen the delivery of social care services to Medicaid recipients.

“Home health deserts”

One obstacle to keeping elderly people in their homes is the complexity of their needs, which, in addition to intermittent nursing care, includes non-medical necessities, such as shelter, housing and transportation, noted Dr. Katz. “For many people, the best option is a skilled nursing facility, even though they would rather stay home,” said Dr. Katz.

Meanwhile, reduced or flat reimbursements contribute to “home health deserts” in underserved communities such as the Bronx, Brooklyn, Queens, Upstate New York and rural areas, Savitt said. “It's going to continue to be that way until we start to recognize as a healthcare industry the importance of putting money into the hands of the people that can deliver care at the right time at home,” he said.

A shortage of home healthcare professionals has exacerbated the situation. “We have maintained large numbers of vacancies that we'd be happy to hire people for, but it's not possible to hire them,” Dr. Katz said. “They're not available in the market.”

Recent federal actions around immigration have contributed, reducing the number of documented immigrants providing home health care, he added. “People of different visa statuses that were previously allowed to work are no longer being allowed to work,” he said.

Unpaid caregivers are filling in the gap, but they need solutions and respites, noted Herbst. “That requires us to utilize technology,” he said.

Skimpy reimbursement

The current reimbursement system does not allow the industry to raise wages to incentivize workers to choose assignments in underserved areas that require extra travel time, according to Savitt. “The system just can't handle these things,” he said.

Ideally, it would make sense to set up shared services in NORCs, said Dr. Katz. “It would be nice if there was a world in which we could create those shared services in a non-institution setting so that aides could be shared, nurses could be shared, physical therapists could be shared with less transport,” Dr. Katz said.

However, that would require coordination between government agencies to provide funding, Savitt said.

Overreliance on emergency departments

A shortage of home health care resources is leading to greater reliance on hospitals by the elderly, higher mortality rates and higher costs, according to Savitt. While older people who qualify for Medicaid can go to a skilled nursing facility, those who don’t qualify are on their own, he noted.

“Emergency departments (EDs) have become the last stop for older adults who lack stable housing or caregiving supports—not because EDs are designed for these needs, but because the broader system fails to catch people upstream,” Herbst added.

Tackling social determinants of health

Factors such as the lack of social support for elderly people who live alone have contributed. Some challenges can be solved with straightforward solutions like providing stair ramps to walkups and help with tasks like meal preparation—but many of these are not being utilized, according to Dr. Katz. “The various services that are necessary to maintain life and dignity don't exist because they're not medical services,” he said.

After the panel, Herbst noted that even as the event spotlighted where the system is breaking down, there are also models that work. For instance, he said, in New York, PACE programs, health systems, and community-based organizations have teamed up to build shared care-management teams, real-time communication pathways, and smoother hospital-to-home transitions.

The 1115 waiver, which lets states test innovative models under Medicaid, is one route to replicating successes in aligning care teams, sharing data, coordinating benefits and designing needed services, he added.

“The 1115 waiver can be a catalyst for this work—giving communities the tools to integrate medical, social, and housing supports upstream so that older adults remain healthy, stable, and connected where they live,” Herbst said.

Reference:

https://www.osc.ny.gov/files/press/pdf/report-22-2025.pdf