November 1, 2019

Donna Frescatore
Deputy Commissioner and Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

Via E-Mail
Re: DSRIP Phase 2 Draft Application

Dear Ms. Frescatore:

I am writing on behalf of LeadingAge New York to provide comments on the Department's draft application to extend and renew its Delivery System Reform Incentive Payment Program (DSRIP). As you know, LeadingAge New York is a statewide organization that represents the continuum of not-for-profit long-term/post-acute care (LTPAC) providers, senior services, and provider-sponsored managed long term care (MLTC) plans. Our members include providers of senior housing, non-medical senior services, home care agencies, adult day health care programs, assisted living facilities, hospice programs, nursing homes, and MLTC, PACE, FIDA, Medicaid Advantage Plus (MAP), and Medicare Advantage D-SNP plans.

We were pleased see long-term care recognized as an "additional high priority area" in the Department's draft DSRIP application. However, the application lacks detail on the implications of that designation and the allocation of funds to address it. If long-term care is a high priority, resources must be dedicated to support and incentivize the reforms that the Department seeks. In an environment of declining or flat reimbursement rates, rising costs, and workforce shortages, real reform cannot be achieved without upfront investment and incentives. Specifically, since approximately 40 percent of New York's Medicaid spending under the global cap is allocated to long-term care, 40 percent of DSRIP funding should similarly be dedicated to long-term care initiatives. The recommended uses and methods of allocating these funds are set forth in more detail below.

I. Workforce: *Dedicate $1.4 Billion to LTPAC Workforce Initiatives*

Workforce recruitment and retention are the top priorities for LeadingAge New York members. The draft DSRIP application correctly highlights the major demographic shift taking place in New York State and the workforce crisis this shift has created. We applaud the Department's recognition in the application of initiatives that will support nursing students and aide trainees, such as subsidies and stipends for participating in aide certification and nursing programs and loan forgiveness programs for nursing students. We also wholeheartedly support subsidies for

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work barrier removal including child care and transportation for LPNs and aides. We agree that, although workforce shortages are present statewide, needs are particularly acute in rural areas.

While we commend the application's reference to these initiatives, we are concerned that the application does not appear to dedicate funding to fund them or to address directly the LTPAC workforce shortage. Instead, it implies that LTPAC workforce initiatives and funding will be funneled through the PPSs, which will be charged with identifying system reforms and workforce needs.[1] As previously noted, the PPSs are largely governed and managed by large hospital systems (plus a large physician group and a collaboration of FQHCs). Although there are isolated exceptions, such as the Staten Island PPS's long-term care apprenticeship program, PPSs have not dedicated even modest funding to LTPAC providers or LTPAC workforce to date. There is no reason to believe that they would allocate a greater proportion of PPS funding to LTPAC workforce under the second phase of DSRIP, unless the Department dedicates funding for this purpose.

Accordingly, of the $1 billion allocated for workforce development in the draft application at least 40 percent, or $400 million, should be dedicated to LTPAC workforce development. In addition, we request that an additional $1 billion drawn from the DSRIP Performance allotment be allocated to LTPAC workforce initiatives. These funds should be allocated based on regional need as grants to LTPAC providers, educational institutions, and other entities involved in workforce development, for recruitment and retention initiatives that include expansion of aide certification and nursing programs, apprenticeship programs, stipends and financial aid for aide trainees and nursing students, job-related supports (e.g., transportation, child care, peer mentoring[2]), career ladder programs, and wage subsidies.

II. DSRIP Performance: *Require DSRIP Performance Initiatives to Incorporate LTPAC Leadership and Investment*

The draft application allocates $5 billion to "DSRIP Performance" without specifying the permitted uses of these funds. It appears that the application would link these funds to continuing with the promising practices identified in the draft application. Unfortunately, since there were only 6 long-term/post-acute care focused projects out of approximately 40 in the first phase of DSRIP, there are comparatively few DSRIP LTPAC practices to choose from in the second phase. Indeed, the body of the application contains no LTPAC promising practices. LTPAC practices are identified only in the appendix, and only two are listed – one focusing on INTERACT in nursing homes and one focusing on hospice.

a. 40 Percent of Funds Should Be Allocated to LTPAC Models

We request that 40 percent of this $5 billion allotment -- i.e., $2 billion -- be targeted at LTPAC. As noted above, we ask that $1 billion of these funds be allocated to LTPAC workforce initiatives. The remaining $1 billion should be invested in:

[1] The application states: "Additional programs that DSRIP fueled through the PPS workforce collaborations should continue to identify the system reforms needed to support the aging population and the workforce needs that will be required."

[2] Hegeman, CR. Turnover Turnaround. Health Progress. 2005 Nov-Dec;86(6):25-30. Paraprofessional Healthcare Institute, Introducing Peer Mentoring in LTC Settings, May 2003.)

(i) Innovative care models to serve consumers with complex conditions, including:
   a. Expanded use of nurse practitioners and physician assistants in nursing homes to lead clinical interventions that promptly identify and address changes in condition and avoid negative outcomes such as hospital admissions and ED visits, including ER diversion programs and restorative care units;[3]
   b. INTERACT training and implementation support for nursing homes and home care agencies;
   c. Expansion of palliative care and hospice services through eMOLST and advance care planning education for clinicians and consumers;[4]
   d. Comprehensive post-acute care management in the home through home care agencies and in adult day health care programs, and transitional care management from post-acute care in nursing homes to home-based care, in order to reduce rehospitalization rates and optimize outcomes;[5]
   e. Inter-disciplinary, palliative care models for people with dementia, such as Comfort Matters®;[6]
   f. Telehealth interventions across the LTPAC continuum to improve outcomes and prevent avoidable hospital use, including in home care, assisted living, adult day health care and nursing home settings.[7]

(ii) EHR adoption and upgrades and health information exchange; and

(iii) Supporting and funding the use of advanced aide roles in nursing homes and home care, including medication technicians and patient care technicians in nursing homes.[8]

(iv) Funding resident assistants or service coordinators in affordable senior housing developments (described in detail on p.7-8).

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[3] NPs and PAs enable nursing home staff to respond immediately to changes in patient status and provide residents and families with additional confidence in the ability to manage their conditions outside of the hospital. This model has achieved reductions in hospitalizations in I-SNPs. See MedPac, Report to Congress, Mar. 2013. M. Perry, et al. "To hospitalize or not to hospitalize? Medical care for long-term care facility residents." Kaiser Family Foundation, Oct. 2010. Available at: http://kff.org/health-costs/report/to-hospitalize-or-not -to-hospitalize-medical/.

[4] Use of MOLST is associated with higher rates of hospice use and lower rates of in-hospital death. eMOLST enables portability of MOLST forms and access by providers across the continuum. Jennings LA. Use of Physician Orders for Life Sustaining Treatment among California Nursing Home Residents. *J Gen Intern Med.* 2016. Fromme. Association between Physician Orders for Life-Sustaining Treatment for Scope of Treatment and in-hospital death in Oregon. *J Amer Ger Soc*. Jul 2014.

[5] This could be coupled with a post-acute bundle for non-duals in mainstream managed care or duals in integrated plans.

[6] The Comfort Matters® model is supported by CaringKind, formerly the Alzheimer's Association New York City Chapter. It is a person-centered, team-based approach that was developed by the Beatitudes Campus in Arizona, which provides training and accreditation to participating facilities. Although it has been primarily implemented in nursing homes, the model can be adapted to any setting. https://caringkindnyc.org/palliativecare/

[7] Chess D. Impact of After-Hours Telemedicine on Hospitalizations in a Skilled Nursing Facility. *Am. J. Managed Care*. Aug. 2018. Grabowski. Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings for Medicare. *Health Affairs.* Feb. 2014. Rabinowitz. Benefits of a Telepsychiatry Consultation service for rural nursing home residents. *Telemed J eHealth*. Jan-Feb 2016. AHRQ. Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews. 2016.

[8] Paraprofessional Healthcare Institute, Raise the Floor, 2016. Walsh. Impact of Medication Aide Use on Skilled Nursing Facility Quality. *The Gerontologist*. Aug. 2013.

Like the promising practices highlighted in the draft application, these initiatives align closely with federal priorities. They are aimed at reducing avoidable emergency room use and hospital admissions, they build scale and support communication along the continuum to facilitate value-based payment arrangements, they enable efficient and effective use of a scarce workforce, and they strengthen efforts to optimize dignity and quality of life among older adults with complex medical conditions and functional limitations.

b. Require LTPAC Focus and Leadership in Value-Driving Entities

The draft application appears to rely on the creation of value-driving entities VDEs to carry out the promising practices selected for the second phase of DSRIP, but provides little detail on the nature of such entities or their activities. They appear to be performing provider systems (PPSs) or subsets of PPSs or other entities that collaborate with managed care plans, providers and community-based organizations CBOs) to implement high-priority DSRIP promising practices. The application requires all VDEs to "bring MCOs in the region into the management and operational structure," but merely suggests that "ideally, Value-Driving Entity governance would include additional representation from community-based providers, including primary care, behavioral health and long-term care." It does not require VDEs to engage these providers in their leadership or operations.

We recommend that, if VDEs are to be the platform for DSRIP 2.0, they should be required to include LTPAC providers in their governance structure. In addition, MLTC plans (i.e., MAP, PACE and partially-capitated plans) should be included in VDE management and operations to the same extent as mainstream MCOs. VDEs should be required to participate in at least one long-term care project. We also urge the Department to authorize and fund the creation of specialized LTPAC VDEs. Notably, the State has funded the creation of network infrastructure for PPSs and behavioral health care collaboratives. It has not made similar investments in the creation of LTPAC networks.

The application establishes as the single goal of VDEs the sustainability of their DSRIP projects through VBP contracts by the close of the third year of the DSRIP extension. As described in more detail below, the LTPAC sector faces greater challenges than the acute and primary care sectors in succeeding under risk-sharing arrangements, especially in the absence of Medicare gainsharing. We urge the Department to seek an agreement with CMS to enable LTPAC-focused VDEs share in the Medicare savings they generate.

III. Additional High Priorities: *Ensure that the High Priority Designation for Long-Term Care Drives Additional Funding and Engagement*

a. Greater Specificity in Proposals and Dedicated Funding is Needed

We appreciate the characterization of long-term care as an "additional high priority area" in the draft application. However, the practical implications of this designation and of the proposals set forth in this section of the application are difficult to discern and require further elaboration. Moreover, the draft application does not specify the amount of funding dedicated to this high priority area.

Instead, the application implies that this high priority area will be funded through VBP arrangements led by VDEs. It provides that "[f]urther exploration of bundling and value-based payment options for this sector will be married to continued exploration of new managed care delivery models to further strengthen and integrate the broader continuum of care for patients needing longer-term services and supports." It goes on to state that "[c]ollaborations of Value-Driving Entities, MCOs, and CBOs would target a specific high-need population for activities . . . and would initially use available data (including QE data) to define the population and the opportunity(ies) for improvement.

Although the long-term care section of the application appears to rely on VDEs, the application does not require VDEs to include LTPAC providers or MLTC or PACE plans in their leadership and does not require VDEs to engage in long-term care projects. The application's emphasis on VDEs that are self-sustaining through VBP arrangements implies that the principal source of funding for this high-priority area will be shared savings. However, the application overlooks the structural, financial, programmatic challenges that LTPAC providers have faced in pursuing VBP arrangements.

b. Success under VBP for LTPAC Providers Requires a Leadership Role and Medicaid/Medicare Integration

Our members support value-based payment as a mechanism for improving quality and outcomes and enhancing the efficiency of the delivery system. Many have been active participants in Medicare bundled payment arrangements and in I-SNP and MLTC VBP arrangements. All are continuously working to integrate their services with acute care, other post-acute services, primary care, and physician services. However, they have faced significant challenges in succeeding financially under VBP models — not because they have failed to achieve savings or to satisfy quality metrics. On the contrary, studies of the Medicare Bundled Payents for Care Improvement Program (BPCI) have shown that the reductions in Medicare episode payments generated by these models are derived principally from reductions in post-acute care, especially in skilled nursing facility utilization and length of stay.[9]

Rather, LTPAC providers are challenged in succeeding financially under these models because of the way the models are typically structured. The bundled payment and accountable care organization models under Medicare are typically led by hospitals or large physician practices. Thus, CMS shares any savings generated (including savings generated by the post-acute sector) with the ACO or bundle leads – the hospitals or physician practices. The lead entities do not generally pass on a share of those savings to their post-acute partners.

In Medicaid's partially-capitated MLTC program, it is difficult to generate savings due to a number of factors. These include the exclusion from the MLTC benefit package of hospital services, programmatic limitations on the ability to control utilization, and mandated rate pass-throughs. As a result, VBP arrangements under Medicaid MLTC are predominantly pay-for-performance contracts, rather than shared savings or shared risk arrangements. The State has not yet provided any funding for MLTC or PACE performance incentives under VBP, although a

[9] "CMS Bundled Payments for Care Improvement Initiative Models 2-4: Year 5 Evaluation and Monitoring Report," prepared for CMS by The Lewin Group, Oct. 2018.

payment for performance on potentially avoidable hospitalizations has been promised in SFY 2020-21.

Accordingly, if the State's intention is to address the long-term care priority area through gainsharing under VBP arrangements, we are pessimistic that LTPAC providers will experience a measurable increase in resources, given current programmatic constraints.

The prospects for successful VBP arrangements for LTPAC providers are improved when Medicare and Medicaid funding streams are aligned or integrated. With integrated funding, Medicare savings achieved through the expenditure of Medicaid funds on high-quality long-term services and supports can be shared with the State and reinvested in the long-term care delivery system. Moreover, through the shared savings that can be generated in integrated models, plans and providers have greater opportunities to implement innovative care models, such as leveraging service-enriched affordable senior housing or assisted living facilities as platforms for care delivery. We believe that MAP and PACE plans sponsored by non-profit, long-term care (LTC) providers can play a key role in strengthening integration and innovative VBP arrangements with LTPAC providers. These plans offer a more person-centered approach to care management than mainstream managed care plans, have strong relationships with providers along the continuum of LTPAC, and have been committed partners in the State's long-term care policy initiatives. Further, our analysis of quality data of plans that serve the vast majority of MLTC members has shown that MLTC plans sponsored by non-profit LTC providers achieve better results on quality measures than other plans.[10]

c. Invest in Health IT and Health Information Exchange in the LTPAC Sector

The LTPAC sector is further hindered in its ability to succeed under more sophisticated VBP arrangements by lack of public investment in IT infrastructure to engage in data collection, analytics, and health information exchange. The suggestion in the draft application that Value Driving Entities, CBOs and MCOs would initially rely on "available data (including QE data)" to define the attributed population and opportunities for improvement is well-intentioned but misguided. It overlooks the fact that LTPAC providers are under-represented among providers contributing data to QEs due to very limited public funding for EHR adoption and health information exchange among LTPAC providers.

d. Seek Clarification of Federal Medicaid Managed Care Conflict of Interest Regulation to Allow HCBS Risk Sharing with Plans

Federal Medicaid managed care regulations and related waiver provisions governing "conflicts of interest" in care planning hinder the ability of home and community-based services (HCBS) providers to participate in VBP arrangements that involve any form of risk sharing.[11] In order

[10] LeadingAge New York analysis of NYS Department of Health, *Consumer's Guide to Managed Long-Term Care*, New York City, 2018. In the New York City region, where the vast majority of MLTC members are enrolled, the average star rating of partially-capitated plans operated by non-profit, long term care provider organizations is 3.9, compared to an average of 2.8 for other plans.
https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/.

[11] 42 CFR 438.208(c), referencing §441.301(c)(1) and (2).

for HCBS providers to accept risk, they must be authorized to assess their attributed beneficiaries, stratify them by condition and needs, and develop service plans to manage their utilization based on their needs. Moreover, beyond managing utilization to succeed in VBP arrangements, many home care agencies or their affiliates have assumed care planning functions under delegation agreements with MLTC plans in an effort to bring care management closer to the beneficiary, his/her caregivers, and local services. If the State and federal governments truly want to align incentives and transfer increasing levels of risk from MLTC plans to providers, the Medicaid managed care conflicts of interest regulation must be interpreted or waived to permit HCBS providers to develop service plans and manage utilization.

When negotiating the next iteration of the Terms and Conditions, the State should seek clarification from CMS that, like Health Homes, HCBS providers (e.g., home care agencies) operating under managed care contracts may provide delegated care management services to the MLTC members they serve and may incorporate care management into VBP arrangements.

IV. Interim Access Assurance Fund: *Expand Eligible Facilities to Include Nursing Homes*

Consistent with the designation of long-term care as a high priority area, we request that the Interim Access Assurance Fund be opened up to nursing homes. Like safety net hospitals, New York's nursing homes are struggling to survive in the face of rising costs and Medicaid rates that fall short of costs by an average of $64 per day, according to national study. As a direct result of serving a predominantly Medicaid population (well above the 30 percent threshold required of safety net hospitals), the average nursing home operating margin was -1.1 percent in 2017, with 41 percent of facilities incurring an operating loss. At the same time, nursing homes are struggling with reductions in nursing home utilization driven by Medicare alternative payment mechanisms, increased use of home care services, and competition from critical access hospitals that strive to improve occupancy by retaining Medicare beneficiaries in swing beds. The impact of the recent change in the Medicaid case mix index methodology has deepened nursing homes' distress, and several have indicated that they are at risk of closing.

Like safety net hospitals, many nursing homes are focusing resources on right-sizing their facilities and developing new services. They are developing services that address the needs of medically-complex residents and expanding assisted living and other forms of non-institutional care. However, revenue losses from nursing home services, without additional transition funding, may permanently destabilize some essential providers. In order to avoid closures that would force older adults to seek nursing home care far from family and friends, we urge the Department to make IAAF funding available to nursing homes.

V. Social Determinants of Health: *Invest in Resident Assistants in Affordable Senior Housing*

We commend the State's goal of addressing the social determinants of health and integrating non-medical supports into the health care delivery system. However, the State's efforts to address social determinants of health (SDH) through managed care VBP arrangements have not been well-suited to the partially-capitated MLTC program or the needs of older adults. Several

of the SDH interventions highlighted by the Department are either targeted at younger cohorts (e.g., home-based pre-natal and peri-natal services, safe places to exercise) or are covered MLTC benefits (e.g., home-delivered meals) that are not permissible as SDH interventions. Further, the use of managed care VBP as the funding mechanism for SDH interventions assumes that significant savings will be generated to sustain them. In the context of a fully-capitated plan, such savings may be generated through reduced hospital use. However, these savings are not available in the partially-capitated program. Thus, the SDH intervention requirement is not adequately funded in the partial cap program.

One way in which the State could more effectively address social determinants of health among low-income, older adults is by supporting the use of resident assistants or service coordinators in affordable senior housing. This cost-effective model helps residents by: (1) establishing relationships with community-based services and organizations; (2) assisting residents in applying for public benefits; (3) arranging for educational, wellness, and socialization programs; (4) facilitating access to services such as housekeeping, shopping, transportation, meals-on-wheels; (5) establishing resident safety programs; and (6) advocating for residents. As noted in our earlier letter, rigorous studies have shown that these programs reduce utilization of hospital services.[12]

We recommend that the extension of the MRT Waiver include funding for resident assistants in affordable senior housing developments. A modest investment of $10 million over five years could be used by both existing and newly-created affordable housing developments, such as those created under HCR's new "Senior Housing Program," which was designed to facilitate the disbursal of the $125 million in new funding for senior housing. Pairing resident assistant services with senior housing creates an efficient and effective model for aging in place. It generates Medicaid savings to by helping low-income seniors to avoid or delay accessing more costly levels of care, such as assisted living or nursing homes.

VI. DSRIP Data Collection and Sharing

Phase 2 of DSRIP should expand the data available concerning PPS investment in LTPAC and the beneficiaries receiving LTPAC services. The first phase of DSRIP made available an unprecedented array of data available to managed care plans, PPS staff, and providers. However, there were gaps in data collection and dissemination with respect to the LTPAC sector. For example, Medicaid data was made available to mainstream managed care plans, PPS analytics staff, and certain PPS providers through the DSRIP dashboards and MAPP tools to enable population health assessments and planning and performance improvement interventions. Unfortunately, these data were not made available to MLTC or PACE plans or LTPAC providers.

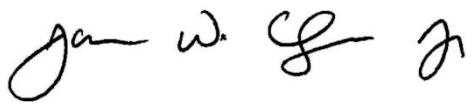
[12] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* Oct. 2018.

Similarly, data collected concerning the distribution of funds to PPS participating providers does not separately identify funds distributed to home care agencies. Instead, these providers appear to be included in a broader category of HCBS providers. Moreover, this category was not separately reported until the third year of DSRIP. For purposes of transparency, policy development, program design, and public input, it is important for stakeholders to understand where the DSRIP funds are budgeted and spent.

To advance the high priority goal of long-term care reform, the Department should collect more specific data from PPSs about investments and incentive payments to LTPAC providers and make available data to LTPAC providers, PACE programs, and MLTC plans to support DSRIP projects and promote population health improvement.

Thank you very much for your consideration of these comments. Please don't hesitate to contact me at 518-867-8383 with any questions.

Sincerely yours,



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