August 17, 2017

Mr. Daniel Sheppard
Deputy Commissioner
Office of Primary Care & Health Systems Management
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Health Care Facility Transformation Program: Statewide II Request for Applications

Dear Mr. Sheppard:

We are writing on behalf of LeadingAge New York and the Adult Day Health Care Council (ADHCC) in response to your July 19th letter seeking input on the Request for Applications (RFA) for the next round of capital grants under the Health Care Facility Transformation Program (HCFTP): Statewide II.

LeadingAge NY represents nearly 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout New York State, including nursing homes, home care agencies, adult care and assisted living facilities, managed long term care programs, retirement communities and senior housing facilities. The ADHCC is a statewide membership association representing over 90 percent of the medical model adult day health care (ADHC) programs operating in New York State.

General Comments

Within the LTPAC services sector, significant investments are needed for facility upgrades, renovations to comply with federal home and community-based settings requirements, program restructuring, and service development, as well as to expand the deployment of health information technology (HIT), health information exchange (HIE), and telehealth services.

Many of the state's nursing homes and other LTPAC facilities were built in the 1970s and 1980s, and are inefficient, outdated, institutional in nature and/or not configured to meet the needs of patients who need complex care, memory support and behavioral health services. With an excess of nursing home beds in some areas of the state, providers are seeking to "rightsize" their facilities and/or offer needed nursing home alternatives such as assisted living.

Nursing homes seek to introduce or expand specialty programs such as restorative care units, neurobehavioral services, neurodegenerative units, in-facility dialysis and outpatient therapies. Providers also seek to create more home-like environments through the establishment of Green Houses/small houses and neighborhoods within existing facilities.

Still other providers seek to continue unique missions – such as serving rural communities – through merger or affiliation with other LTPAC providers.

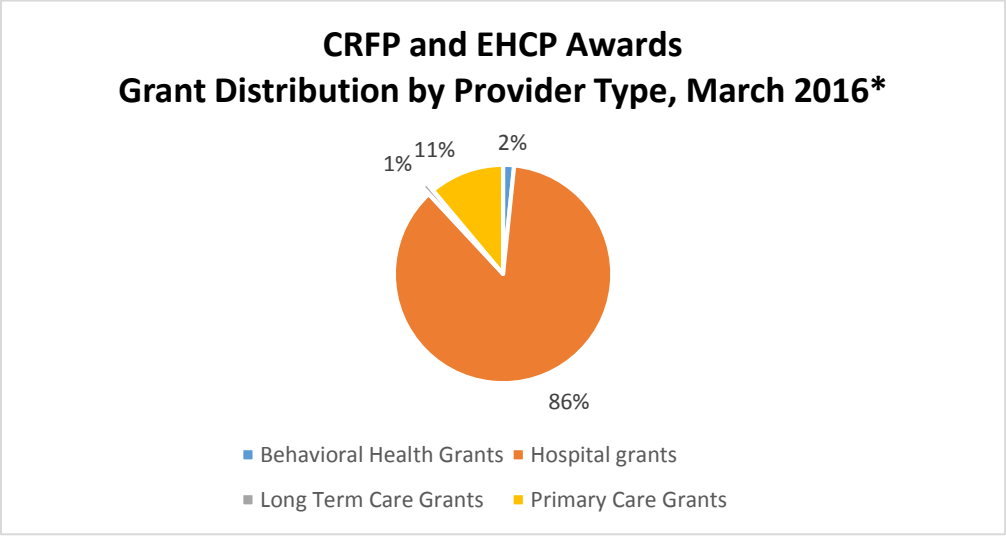
However, years of losses from serving Medicaid beneficiaries (the predominant payer) and Supplemental Security Income (SSI) beneficiaries prevent these organizations from accumulating the capital needed to make these transformational investments.

Investments are also needed in ADHC programs, assisted living capacity, adult care facilities and hospices. These facilities and programs are essential in keeping frail elderly people out of more expensive residential settings and minimizing avoidable hospital use. However, they receive limited support for the capital costs of developing new capacity, updating existing facilities, and creating added services.

The need for investment in electronic health record adoption and health information exchange is particularly pressing. LTPAC providers have not had access to federal HIT meaningful use incentives and only negligible access to state funding for needed capital. As a result, LTPAC providers lag behind hospitals and physician practices in electronic health record adoption and in health information exchange. Beginning in 2018, LTPAC providers with certified electronic health records will be required by state regulation to connect to the State Health Information Network of New York and engage in secure bi-directional health information exchange. This will be a costly endeavor for many LTPAC providers, both in terms of upfront outlays and continuing expenses.

In spite of the compelling need for strategic investments in LTPAC services, acute and primary care providers have consistently been awarded the vast majority of funding available under recent grant opportunities. Exhibit I below illustrates that acute and primary care providers were awarded 97 percent of the Capital Restructuring Financing Program and Essential Health Care Provider Program funding, with LTPAC providers receiving only 1 percent.

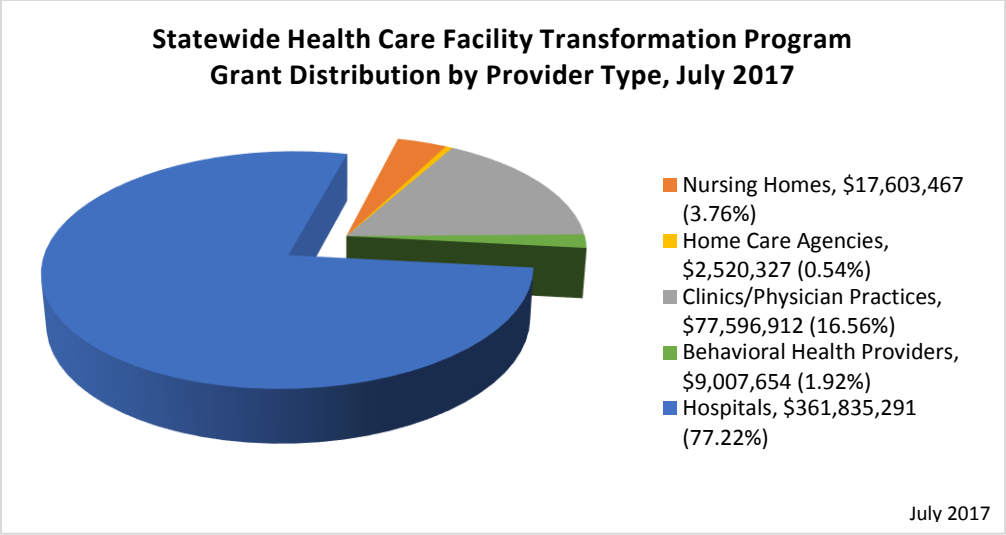
Figure I



Note: Awards are categorized based on the licensure or principal services of the awardee.

This trend has been continued with the HCFTP Phase I, with 94 percent of funding awarded to hospitals, clinics and physician practices. DSRIP funding distributions have also been heavily weighted towards hospital and primary care.

Figure II



Efforts to meet key objectives around DSRIP performance, value-based payment, population health management, and changing LTPAC needs and preferences will be compromised if LTPAC providers are unable to achieve HIT and HIE milestones or to make other critically needed investments to improve efficiencies, update services in response to changing demands, and optimize quality. Accordingly, we strongly recommend that the majority of the remaining HCFTP funds be invested in the LTPAC system.

Program Eligibility and Related Criteria

The Commissioner has the authority under Public Health Law (PHL) § 2825-e(3) to designate "other purposes and community-based providers." Utilizing this authority, the Commissioner should include assisted living programs, ADHC programs, hospices, assisted living residences, adult homes and enriched housing providers as eligible community-based health care providers for purposes of the $75 million allocation.

PHL Section 2825-e(5) spells out the criteria the Commissioner will consider in determining awards. The second criterion listed relates to alignment with DSRIP project goals and objectives. If alignment with DSRIP is in fact being considered in making recommendations on HCFTP projects, we believe that the Department should also consider DSRIP funding already received or anticipated to be received by the applicant in these recommendations. In addition, the seventh listed criterion relates to the extent to which the project benefits Medicaid enrollees and uninsured individuals. Future awards should place greater emphasis on applicants that have, relative to other providers, high proportions of Medicaid and/or SSI beneficiaries.

Program Administration

The remaining $204 million of program funds should be awarded based on a new RFA that is issued with reasonable lead time (i.e., within 2-3 months) and a reasonable application period to ensure that small providers and those that were unable to timely submit for Phase I are given ample time to develop applications. Applicants that were unsuccessful based on the recent awards should be eligible to have their existing applications reconsidered or to resubmit.

Projects should be evaluated based on a more formalized structure/scoring method, so that applicants that do not receive awards can receive debriefings on their proposals enabling them to improve their future funding prospects, and that all parties can be sufficiently assured of an objective evaluation process.

The Department should consider capping each project award at a total dollar amount (e.g., $10 million) and/or as a specified maximum percentage of the total funds awarded in each geographic region. This would help to ensure there is a sufficiently broad distribution of awards to projects of different sizes and types.

Program award announcements should be made in a timely manner. Phase I awards were announced approximately one year after the applications were submitted. Many of these projects entailed construction or other time sensitive events (e.g., mergers), and delays of this length can significantly affect project costs and the feasibility/timing of major restructuring efforts. The award announcement process needs to be more timely, and any related processes (e.g., Certificate of Need) should be commensurately timely and responsive.

Conclusion

Thank you for the opportunity to provide input on the HCFTP, Statewide II. If you have any questions on our comments, please contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President
LeadingAge New York

Anne Hill
Executive Director
Adult Day Health Care Council