LeadingAge New York

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Re: Follow-Up on 1115 Medicaid Waiver Concept Paper
Via E-Mail

Dear Mr. Friedman and Ms. Montgomery:

I am writing to follow up on our meeting a few weeks ago regarding the 1115 concept paper. It was interesting to hear the presentation on the concept paper at the recent PHHPC meeting. The presentation elaborated on the Department's plans surrounding various elements of the paper and suggested that the Department is fairly committed to the framework laid out in the concept paper. Accordingly, rather than expanding on proposals we've previously submitted to the Department as we had discussed, we've attempted to adapt the framework laid out in the concept paper to accommodate the needs of older adults and the continuing care system that serves them.

As an initial matter, I want to reiterate the need for state policy to prioritize long-term care in major Medicaid policy initiatives in New York State. The unique needs of older adults and the bifurcated (Medicare/Medicaid) financing and organization of the health care services they use are not considered from the outset. As a result, MLTC plans and long-term care services have often been required to fit into molds designed for other services and populations. The results have been wasted resources, inefficiencies, and limited improvements in access or quality for older adults. The DSRIP, value-based payment, and social determinants of health initiatives under the prior waiver all suffered from a lack of early and concerted consideration of the beneficiaries who receive long-term care services and the providers and managed care plans that deliver or arrange for them.

In order to rebuild and revitalize our long-term care system in the wake of this devastating pandemic, we will need a multi-pronged, inter-agency (e.g., DOH, SOFA, SED, DOL, SUNY, DASNY) effort that includes Medicaid dollars, other state and federal funds, regulatory reforms, and private and public sector engagement in workforce development. Adequate Medicaid funding must be the foundation of this revitalized long-term care system, and we would like to see the waiver support a thorough re-envisioning of our long-term care system. Our vision for the long-term care system echoes many of the

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themes implicit in the concept paper and is also reflected in many of the proposals set forth in a recent publication by the National Association of Medicaid Directors.[1]

Simply put, the State's policies and investments should promote the creation of a LTC system that prioritizes health equity across all dimensions and that:

- Promotes Access and Choice: Our long-term care system should provide Medicaid beneficiaries with access to an array of options suitable to varying levels of acuity and need, lifestyle preferences, and geographies. Those options should:
    - Make services available in the most integrated setting appropriate to the beneficiary's needs and preferences, including home care, adult day health care and assisted living.
    - Include nursing facilities that offer homelike environments, vibrant social, lives, and personal privacy (e.g., Green House, Eden Alternative, Comfort First, etc.), recognizing that some individuals will be unable to live in community-based settings due to their medical complexity and lack of informal supports. These facilities should have the resources to implement controls that mitigate the risks of airborne and other infectious diseases and to deliver advanced clinical care that reduces avoidable hospital use.
- Maintains a Well-Qualified, Appropriately Compensated, and Ample Workforce: Our long-term care system should have sufficient resources to enable recruitment, retention, and career development of the LTC workforce. This can only be accomplished through Medicaid rates that support competitive wages and recognize the skills, training, sensitivity, and dedication that LTC work demands. Recognizing the demographic challenges we face, our laws and regulations must optimize available personnel by allowing them to practice at the top of their scopes and by supporting cross-continuum certifications.
- Drives Quality and Value: Our policies should incentivize the delivery of high-quality, person-centered care, through financial incentives that are reliable, timely, additive, and non-punitive.
- Strengthens Integration: Our policies should support integration and coordination along the continuum of long-term services and supports and among the primary, acute, post-acute and LTC sectors, so that older adults can transition seamlessly from one setting to another.
- Targets High Priority Social Determinants of Health for Older Adults: The state should address the social determinants of health (SDH) for older adults through strategies tailored to their unique needs and preferences. It should expand and make effective use of existing community programs and services that serve older adults, rather than spending precious resources on new layers of administration and building new programs from the ground up. These strategies should include targeted investments to delay the need for higher levels of care and slow the growth rate of public expenditures. In particular, the state should expand support for unpaid, informal caregivers.

[1] Browning, L., Hammer, G. "Medicaid Forward: Long Term Services and Supports. Fall 2021. Accessed at https://medicaiddirectors.org/medicaid-forward-executive-working-groups/ .

To carry out this vision within the priorities and framework outlined in the concept paper we propose the following:

- HEROs: Ensure that HEROs include on their governing bodies MLTC/PACE plans and Area Agencies on Aging, as well as LTC providers representing the continuum of LTC, and require the HEROs to assess and address the needs of their regions' older adults and others who require LTC services and their caregivers;
- Social Determinants of Health: Given that many of the SDH interventions that are appropriate for the under 65 population are inappropriate for the older adult population or are already covered benefits under the MLTC plan (e.g., home-delivered meals, environmental supports, UAS community health assessment), authorize an approach to SDH interventions that utilizes existing infrastructure, does not require duplication of existing covered services, and to the extent it requires coverage of new services, provides adequate funding to support them. We are interested in discussing with you whether social determinants of health networks (i.e., IPAs) are feasible and add value in the context of services for older adults. In addition, we recommend that the waiver:
    - Address the social determinants of health for older adults through strategies tailored to their unique needs and preferences, without spending precious resources on new layers of administration and unnecessarily building new programs from the ground up. Engage Area Agencies on Aging, existing community-based health care providers, senior centers, other non-medical service providers, and affordable senior housing providers.
    - Make targeted investments to delay the need for higher levels of care among older adults and slow the growth rate of public expenditures.
    - Support unpaid, informal caregivers through training, respite services, and peer and emotional support.
    - Invest new resources in SDH interventions for dually-eligible LTC beneficiaries, and do not rely on reinvestment of savings from MLTC to fund them. Savings generated from reducing avoidable hospitalizations and other excess utilization do not accrue to MLTC plans, and MLTC plan premiums are already at the bottom of the rate range.
    - Ensure that any effort to adjust MLTC rates by "social care acuity" correlates with MLTC service risk and that risk adjustment also reflects the acuity presented by beneficiaries with dementia who require high personal care hours, but do not necessarily require extensive physical assistance, such as turning and positioning.
    - Dedicate funding to partnerships of LTC providers, MLTC/PACE plans, and community services to support transitions of care along the acute/post-acute/long-term care continuums and transitions from nursing homes to the community. Provide MLTC/PACE plans with a payment incentive for supporting community transitions that can be shared with participating providers.
- Value-Based Payment: In developing VBP arrangements for MLTC/PACE plans, acknowledge that unique arrangements must be tailored for MLTC and for PACE, recognizing that:
    - VBP arrangements cannot be funded with reinvested savings. New financial resources must be provided, especially in light of the state's decision to pay premiums at the bottom of the actuarial rate ranges. Further, savings generated through MLTCs generally accrue to Medicare and cannot be captured for Medicaid VBP incentives.

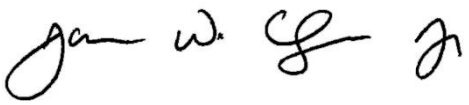
    - Global budgets for the dually-eligible LTC population are generally infeasible, except in the context of the MAP or PACE plan, and single providers generally do not have the overall census, much less the volume of enrollment in a single plan to accept a global budget. Further, in the context of a PACE program or provider-sponsored MLTC plan, the state has already effectively implemented global budgets for the LTC benefit package.
- Supportive Housing: Ensure that funding for supportive housing is allocated to affordable senior housing with services, not exclusively to short-term medical respite for homeless adults or OMH supportive housing for individuals with mental illness. This affordable senior housing model generates Medicaid and Medicare savings by providing low-income seniors with "light-touch" services that help them to prolong their independence and improve their quality of life. Rigorous studies have shown that affordable senior housing with supportive services reduces Medicare and Medicaid spending.[2]
- Pandemic Response Redesign: As part of the pandemic response redesign:
    - Provide financial incentives for nursing homes to enable the operation of more homelike and smaller facilities (e.g., Green House and small house models). Early research suggests that these facilities are more successful at preventing COVID infection than others. Health equity demands that Medicaid support access to smaller, more homelike nursing home settings that have a strong track record of infection prevention.[3]
    - Fund enhanced medical care and palliative care in nursing homes to enable nursing homes to retain residents and avoid hospitalization and accept discharged hospital patients earlier in their recovery.
    - Support staff-intensive models, like Comfort First, for nursing home residents with dementia who present high supervision and social engagement needs and high risks for transmission of COVID.
- Workforce Investment: Ensure that investments in WIOs and facility-based staff enable providers to pay competitive rates, offer work-related supports, and promote recruitment and retention of LTC staff, not just training to enhance the skills needed for VBP.
- Integration of Care: Invest in technologies and strategies that promote integration and smooth transitions along the care continuum. In addition, seek a waiver of the HCBS conflict of interest rule to enable integration and coordination of long-term services and supports, while promoting greater choice of providers and care management for consumers. The HCBS conflict of interest regulation, while well-intentioned, effectively prevents providers from creating efficiencies by sharing administrative services, creates barriers to effective care coordination within continuing care systems, and limits consumer choice. We can provide you with more information about this rather technical provision and its potentially counter-productive effects.

[2] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* October 2018. Li, G., Vartanian, K., Weller, M., & Wright, B. *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016. *Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.

[3] Waters, R. The Big Idea Behind A New Model Of Small Nursing Homes. *Health Affairs.* Mar. 2021.

Thank you very much for considering these additions to the concept paper. Please let us know if you need additional information on any of these proposals.

Sincerely yours,



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cc:
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