July 22, 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 and MRT Waiver

Dear Ms. Frescatore:

I am writing on behalf of LeadingAge New York to provide comments on the MRT Waiver and the second phase of 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 approximately 400 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, and Medicaid Advantage Plus (MAP) plans. Our members range from small, independent providers to large continuing care systems.

The State's efforts to transform the delivery system through the development of regional health care collaborations, supported by PPS 'integrators' and value-based payment models, have been impressive. Our members are proud to have been a part of the State's successful efforts to reduce avoidable hospital use by nearly 25 percent as of mid-2019 and to promote better health outcomes at a lower overall cost.

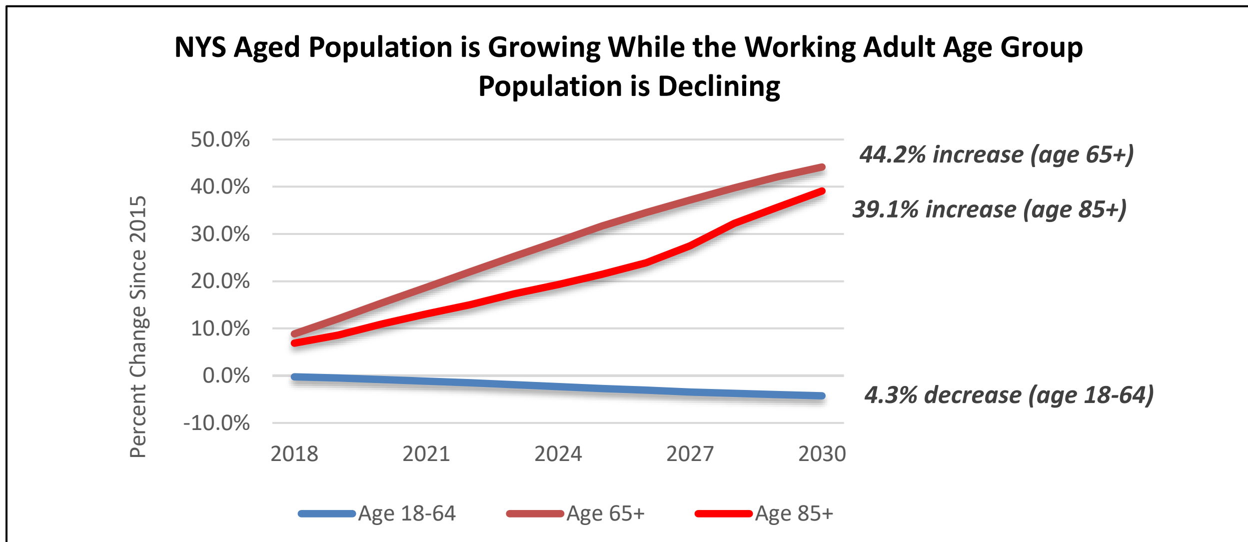
LeadingAge New York members have been eager participants in DSRIP Performing Provider Systems (PPSs), and many have expended significant administrative and clinical resources in participating in PPS committees and projects. As long-term/post-acute care providers, as well as sponsors of Medicare Advantage D-SNPs, MAP, PACE and MLTC plans, they have played a significant role in delivering care to individuals at high risk of avoidable hospital use. Through participation in Medicaid value-based payment arrangements under MLTC, Medicare bundled payment arrangements, Medicare I-SNP shared savings arrangements, and other alternative payment arrangements, our members are working to align financial incentives and add value to the health care delivery system.

Unfortunately, despite their efforts, most of our members report that they had little, if any, influence over the governance of the PPSs, the projects pursued, or the distribution of funds. Indeed, only 5 out of the 44 PPS projects on the project menu were targeted specifically at LTPAC providers and the people they serve. Moreover, our review of PPS funds flow reveals that only a minuscule fraction of PPS funding has been allocated to long-term/post-acute care.

The LTPAC sector is struggling to serve a growing number of older adults with complex medical conditions and functional limitations, amid a workforce shortage and Medicaid cuts, but it did not experience material financial benefits from the first iteration of DSRIP. As discussed in greater detail below, we look forward to working with the Department and CMS to ensure that, in the next phase, the LTPAC sector will participate proportionately in investments and reinvestment, that steps are taken to expand the LTPAC workforce (not merely train existing workers), and that regulations are rationalized to support efficient and effective delivery of LTPAC.

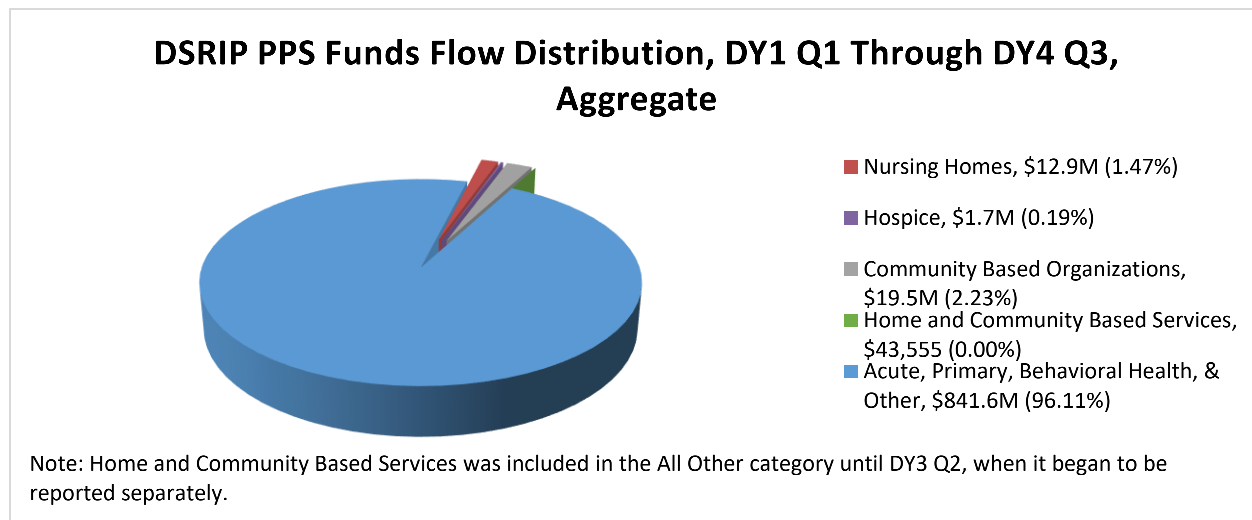
<u>The Need for Investment to Accompany Reforms in the LTPAC System</u>

New York State is in the midst of a major demographic shift that demands the same sort of visionary and concerted investment and reform in the LTPAC delivery system that the State has embraced for primary, behavioral health, and acute care under the first phase of MRT and DSRIP. Between 2015 and 2040, the number of adults age 65 and over in New York State will increase by 50 percent, and the number of adults over 85 will double. While the number of adults likely to need LTPAC is growing rapidly, the number of working-age New Yorkers able to serve them is dropping. By 2040, the number of adults between 18 and 64 for every adult over age 85 will drop from 28 to 14. We are already experiencing an LTPAC workforce crisis throughout most of the State, and that crisis is projected to deepen over the next twenty years.



Notwithstanding this demographic shift, the focus of investments under DSRIP, and the reinvestment of Medicaid savings through value-based payment (VBP), has to date been on primary, acute and behavioral health care services. With the benefit of upfront investments in infrastructure under DSRIP, the Roadmap has created opportunities for providers of primary, acute and behavioral health care services to reap the rewards of reinvested savings. It has not created the same opportunities for LTPAC providers.

Although several of our members were pleased and appreciative to receive PPS funding to support the adoption of electronic health record systems or integration with health information exchanges, through the third quarter of DSRIP Year 4, only **1.47** percent of PPS payments had been allocated to nursing homes, and only **0.19** percent had been paid to hospice programs. Home care allotments were not separately reported until DSRIP Year 3 when a "home and community-based services" category was added (which presumably includes home care); only **$43,555** was reported in that category through the third quarter of Year 4. [1]



Similarly, capital investment associated with DSRIP has been focused on the primary and acute care sectors, at the expense of LTPAC services. Only 1 percent of the Capital Restructuring Financing Program and Essential Health Care Provider grants were awarded to LTPAC providers. Of the Statewide Health Care Facility Transformation (SHCFT) capital grants, only 0.8 percent was awarded to LTPAC providers in 2016, and 4.3 percent was awarded to LTPAC providers in 2017. We were pleased to see 26 percent of the SHCFT Phase 2 grants go to LTPAC providers in 2019, but we are concerned that the shift of $300 million in Phase 3 funds to a second round of Phase 2 awards will result in a significant reduction in the proportion of funds allocated to the LTPAC sector.

Exacerbating the lack of investment in LTPAC capital and infrastructure, the sector has been hit with significant Medicaid cuts that have exceeded those imposed on any other sector, including mainstream managed care, pharmacy and hospitals. The SFY 2019-20 budget reduced Medicaid payments to long-term care providers and MLTC plans by $442 million (all funds).[2] These cuts were imposed on top of approximately $180 million in cuts enacted in 2018-19 that were continued or increased in 2019-20.[3] We appreciate the State's investment in a 1.5 percent trend

[1] LeadingAge New York analysis of DSRIP PPS Quarterly Reports, accessed at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm .

[2] This figure is net of adds and includes only reductions or increases in provider and plan payments. It does not include savings achieved through increased federal match or delays in implementation of new programs. It also includes the fiscal intermediary cut, as it will be implemented as a reduction in MLTC rates and will have ripple effects across the LTPAC sector.

[3] This figure is net of adds and reflects only budget cuts or investments that impact provider or plan payments or impose penalties. Budget initiatives that rely on maximization of federal funds, impact program eligibility, or shift

factor available to nursing homes – the first trend factor since 2007 -- to address rising wage and benefit costs. Unfortunately, that increase is likely to be entirely offset overall by the case mix index cut.

In the face of flat or declining funding, rising labor costs, and growing workforce shortages, the LTPAC sector is struggling to adapt to dramatic changes in the organization and financing of LTPAC services under both Medicaid and Medicare. LTPAC and senior services providers are expected to participate in a health care transformation, implementing innovative models of care and payment, and developing the physical, clinical, technical, and administrative infrastructure to do so. However, neither the State nor the federal government has made available sufficient funding necessary to develop the infrastructure in the LTPAC and senior services sector to do so. And, unlike hospital and physician services, LTPAC services are financed overwhelmingly with public funds – there is little ability to shift costs to commercially-insured or private pay patients and residents.

Moreover, despite the contribution of high-quality LTPAC to reductions in avoidable hospital use, and the investments in collaborative care models made by LTPAC providers, neither DSRIP nor the VBP Roadmap have driven reinvestment of savings in the LTPAC delivery system. The lack of reinvestment in LTPAC providers is largely attributable to two factors:

1. Most of the Medicaid beneficiaries served by LTPAC providers are dual eligibles, and most of the savings derived from reducing their hospital use accrues to Medicare, rather than to Medicaid;

2. The VBP models in mainstream managed care are led directly or indirectly by primary and/or acute care providers. Even when a mainstream managed care beneficiary receives high-quality post-acute care or long-term care that prevents avoidable hospital use and generates savings, the VBP contractor does not generally pass its share of the savings down to the LTPAC providers.

We ask that the next phase of DSRIP and the next extension MRT Waiver incorporate investments and reinvestments in LTPAC, along with the regulatory reforms and programmatic changes discussed below, in order to support the infrastructure that enables collaboration across the continuum for providers that serve older adults and people with disabilities, and to promote the expansion of the LTPAC workforce. We also urge you to consider the unique challenges facing rural providers of LTPAC and work with us to develop targeted strategies to address the needs of these essential providers**.**

Workforce

Given the aging demographics of New York State, we must build the LTPAC workforce and identify ways to use a shrinking pool of workers more efficiently and effectively. We recognize that the MRT waiver included significant funding for MLTC workforce. However, these funds have largely been invested in WIOs that provide training to enhance the skills of *existing*

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payment sources are excluded from the amount indicated. The $180 million does not include savings attributed to the nursing home benefit limit under MLTC.

workers. We need to invest in *recruitment* initiatives to expand the LTPAC workforce, such as the expansion of aide, LPN, and RN training programs especially in rural areas; subsidies and stipends for participating in aide certification and nursing programs; loan forgiveness programs for nursing graduates; and subsidies for car maintenance and day care for LPNs and aides. We also need to reexamine the availability and requirements of certification programs to ensure that we are optimizing access, avoiding unnecessary burdens on participants, and facilitating the ability to obtain and maintain certifications in multiple disciplines (e.g., PCA, HHA, CNA, PCT).

In order to maximize the efficiency and effectiveness of a scarce workforce, we also need to enable LTPAC professionals and paraprofessionals to practice at the top of their scope, to expand the use of patient care technicians in nursing homes, and to allow certified nurse aides to pass medications like their peers in OPWDD. We must allow nurses to practice nursing in all assisted living facilities, including the Medicaid Assisted Living Program (ALP), and enable ALP residents to access both ALP and hospice services concurrently.

Medicare-Medicaid Alignment and Data

As we've noted previously, LTPAC providers and MLTC plans are integral players in the health care continuum and serve an important role in reducing avoidable hospital use and generating savings for the Medicare and Medicaid programs. When the VBP Roadmap was first published, we welcomed the possibility that Medicare and Medicaid savings might be pooled and shared via New York's DSRIP waiver. Unfortunately, that opportunity did not materialize.

Our members have, however, been active participants in integrated managed care models that incorporate Medicare services with Medicaid long-term care services, including FIDA, Medicaid Advantage Plus, and Programs of All-Inclusive Care for the Elderly (PACE). We believe these programs present promising strategies to deliver financially- and clinically-integrated and person-centered care for beneficiaries with complex medical conditions and/or functional limitations. We also believe that MLTC plans sponsored by non-profit, long-term care (LTC) providers can play a key role in strengthening these initiatives. These plans offer a more person-centered approach to care management than mainstream managed care plans, use health care professionals as care managers, and have been strong partners in the State's LTC 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.[4] Through close personal contact with beneficiaries and their formal and informal caregivers and geographic proximity, plans sponsored by non-profit long-term care providers are able to conduct accurate assessments, make informed care management decisions, and create strong linkages with health and social services providers in their members' communities.

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[4] 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/.

As a result, although we support efforts to encourage enrollment in duals plans, we are concerned about the Department's proposal to implement default enrollment in the Medicaid Advantage and Medicaid Advantage Plus plans sponsored by mainstream Medicaid managed care plans. Because mainstream managed care plans are not sponsored by long-term care providers, we worry that this policy will deplete enrollment in MAP plans sponsored by long-term care providers, in favor of plans sponsored by mainstream managed care organizations that lack the same focus and experience in serving older adults and people with disabilities.

Finally, we are concerned about the lack of availability of Medicare claims data for purposes of MLTC care management and PPS performance initiatives. Without Medicare claims data, partially-capitated MLTC plans lack complete information about their members' hospitalizations and other health care utilization. Likewise, the State and PPSs lack sufficient information to evaluate PPS performance on avoidable hospital use by dual eligibles. This has led to the exclusion of dual eligible beneficiaries from the claims-based PPS performance measures, thereby reducing the incentive of PPSs to focus efforts on the needs of duals.

The siloes between Medicare and Medicaid drive inefficiencies, clinical fragmentation, and sub-optimal outcomes. We look forward to continuing to work with the Department and CMS to promote access to the Medicare data and to advance initiatives to integrate Medicare and Medicaid services and financing.

Supporting Consumers to Live in Independent Housing

With a rising proportion of our population over age 65 and limited funds and workers to address their needs, we need to expand access to cost-effective services and social supports in the community for older adults. The State's efforts to address social determinants of health have focused on a broad range of issues, but have not targeted older adults specifically. In fact, many are focused on younger age cohorts.

One way in which the State could 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.

Rigorous studies have shown that these programs reduce utilization of hospital services. One such study conducted of residents of Selfhelp Community Services in Queens with resident assistant services and a control group found that the hospitalization rate for Selfhelp residents was approximately 43% lower than for the comparison group (after controlling for age, zip code and other factors). In addition, the study found that the rate of hospital discharges for ambulatory care sensitive conditions among the Selfhelp residents was 30 percent lower than that

among the comparison group. An earlier study of Selfhelp residents demonstrated that the odds of visiting the emergency room were 53% lower for Selfhelp residents than for the comparison.[5]

We recommend that the extension of the MRT Waiver include funding for resident assistants in affordable senior housing developments. A $10 million investment 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.

Nursing Home Benefit Limit in Partially-Capitated MLTC

As part of the SFY 2018-19 budget, the State passed legislation to limit the nursing home benefit in partially-capitated managed long term care (MLTC) plans to three months for those enrollees who have been designated as permanently-placed in a nursing home. The State Plan Amendment to allow this change has not yet been approved. This change in coverage would eliminate duplication of care management services currently provided by both the nursing home and the MLTC plan. Moreover, by alleviating the associated administrative burdens on nursing homes and MLTC plans attributable to the current MLTC nursing home benefit, this proposal would help these providers and plans to better focus their limited resources on effective care management, discharge planning, and quality improvement initiatives for nursing home residents and community enrollees, respectively. We will continue to work with the State and CMS to support approval and implementation of this benefit limit.

Care Management Conflict of Interest Regulation

The State's VBP Roadmap envisions aligning provider and payer incentives by transferring increasing levels of risk from plans to providers. In order for 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. In addition to conducting care planning in the context of 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.

The 1115 Waiver's Terms and Conditions and federal regulations contain several unclear and inconsistent provisions that call into question the ability of providers to conduct care planning for the people they serve. We request that the next iteration of the Terms and Conditions clarify that, like Health Homes, HCBS providers (e.g., home care agencies) may provide delegated care

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

management services to the MLTC members they serve and may incorporate care management into VBP arrangements.

DSRIP Data Collection and Sharing

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 plans or LTPAC providers.

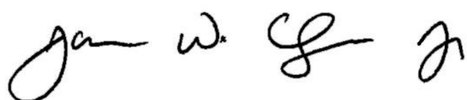
Similarly, data collected concerning the distribution of funds to PPS participating providers does not separately identify funds distributed to home care agencies. Instead, these providers appear to be included in a broader category of HCBS providers. Moreover, this category was not separately reported 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.

State Regulatory Reforms

In an era of growing demand for publicly-funded LTPAC services and shrinking public resources, a common-sense approach to regulation is required. LeadingAge New York has previously submitted to the Department a series of proposed regulatory reforms to support a more efficient and effective LTPAC delivery system. We will not reiterate those proposals here, but will continue to work with the Department to advance a regulatory framework that promotes high-quality, person-centered care, while eliminating unnecessary administrative burdens, expanding providers' ability utilize a scarce workforce, and reducing geographic disparities in regulatory oversight.

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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