LeadingAge New York

April 8, 2016

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Deputy Commissioner and Medicaid Director
Mark Kissinger
Director
Division of Long Term Care
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza Albany, New York 12210

Marc Berg, M.D., Ph.D.
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Via E-Mail

Re: Value-Based Payment MLTC Clinical Advisory Group

Jason Mark Marc Betsy
Dear Messrs. Helgerson, Kissinger and Berg and Ms. Lynam,

I am writing on behalf of LeadingAge New York in response to the request by the Value-Based Payment MLTC Clinical Advisory Group (the CAG) for regulatory reform recommendations. As you know, we submitted a letter to you on December 1 with recommended regulatory reforms, which is attached for your reference. These recommendations are essential to allow providers to optimize efficiencies and provide high-quality care, as they are asked to serve increasingly complex beneficiaries under value-based payment arrangements.

We would like to reiterate our recommendations of December 1 with a few updates:

- Enhanced Federal Medicaid Match for Health Information Exchange Investments: On February 29, CMS issued a letter to State Medicaid Directors that expands the scope of state health information exchange (HIE) activities eligible for a 90 percent federal match. Although these funds are not be available to support the purchase of electronic health record systems, the 90 percent match is available for activities to connect long-term/post-acute care (LTPAC) providers with physicians and hospitals. We urge the Department to explore this opportunity as a source of funding to support connections between LTPAC providers and Regional Health Information Organizations and to expand HIE between LTPAC providers and others. A copy of the CMS letter is attached.

- Naturally-Occurring Retirement Communities: The NORC recommendations contained in the December 1 letter were addressed through budget legislation enacted earlier this month.

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- Written Physician Orders Timeframe: Proposed regulations addressing the issue set forth in the December 1 letter are pending.

Please refer to the attached letter from December 1 for the remainder of our regulatory reform recommendations.

As you develop the on-menu options for VBP in MLTC, we ask you to include the following:

- On-menu options that involve pay-for-performance arrangements with new funding for performance incentives.

- A community-based option that would allow attribution of beneficiaries to medical-model adult day health centers, as well as home care agencies.

- An on-menu option that includes less than the entire benefit package. Specifically, plans and providers should be permitted to agree to exclude services such as podiatry, optometry, and dental from their VBP arrangements. Moreover, we understand that DOH will be moving to carve all Medicaid services into the MLTC benefit package in this state fiscal year. This will further complicate VBP arrangements, if they are supposed to include all MLTC benefits.

- On-menu options that do not demand the creation of a new "integrator" entity (e.g., an IPA or ACO) to serve as an intermediary between the plans and providers. As explained more fully below and in the attached letter, we question the wisdom of requiring, in every case, the creation of a new administrative entity (either an IPA or ACO) to perform such functions as contracting, care management/coordination, distribution/recoupment of payments and quality assurance. In many respects, the IPA or ACO envisioned would replicate functions currently performed by plans and providers, while adding administrative expenses to a system that is already experiencing funding shortfalls.

  In addition, we understand that you envision the IPA or ACO engaging in care coordination or care management of attributed members. It is important to recognize that MLTC members today may already have 3 or more care managers: an MLTC care manager, a health home care manager, and a Medicare ACO/PCMH care manager. In addition, after a hospital discharge, the members may have a hospital-assigned care coordinator to prevent readmissions. When the State begins to enroll participants in the Nursing Home Transition and Diversion Waiver and the Traumatic Brain Injury Waiver into MLTC plans, these beneficiaries may also have service coordinators and RRDC specialists. We question whether additional care management will add value.

We continue to believe that the only way to realize significant shared savings under current programmatic constraints is to pool Medicare and Medicaid dollars for duals in long-term care settings. Margins in Medicaid are already too thin, and the ability to manage price and utilization is too limited, to generate significant savings. Moreover, it is also important to acknowledge that, even if Medicare spending is pooled with Medicaid, and Medicare savings are realized through reductions in

hospitalizations, the overall savings will be reduced by the additional Medicaid-reimbursed nursing home days and personal care days that will substitute for Medicare-reimbursed hospital days.

We gather that little progress has been made in discussions with CMS concerning Medicare-Medicaid alignment. In an effort to support the State's and our members' goals for VBP, we have searched for existing models of VBP arrangements in long-term care that involve only the Medicaid-covered services. After reviewing the literature, speaking with consultants who have national practices, interviewing the CEO of a national network of long-term/post-acute care providers, and querying the national LeadingAge organization and its state affiliates, we have been able to find only pay-for-performance arrangements and arrangements that involve both long-term care and acute care benefits. Thus, New York State will be building long-term-care-only, shared risk models from scratch.

In the absence of existing long-term-care-only, shared savings models, we urge you to pay close attention to the policy and operational challenges facing plans and providers, as the State moves forward with implementing Medicaid VBP in the LTPAC sector. Please keep in mind that MLTC plans are severely restricted in their ability to reduce utilization of services or prices paid to providers, due to State and federal policy decisions. We have every reason to believe that *providers* operating under VBP arrangements will be similarly constrained in their ability to manage utilization. Even if *a provider* (rather than a plan), operating under a VBP arrangement, seeks to reduce or modify the level of services delivered, we assume that State and federal fair hearing and aid continuing rights would apply. Likewise, the ability to reduce provider payment rates is limited by mandated wage provisions in home care and by benchmark rate provisions in nursing home care.

Operational considerations, in addition to the policy environment, raise significant barriers to the State's MLTC VBP plans. The LTPAC sector is, unfortunately, far behind hospitals and physician practices in terms of (i) developing scale through organizational affiliations, such as IPAs; (ii) adopting EHRs and engaging in HIE; and (iii) building population health management capacity. As far as we know, only a small portion of the nursing homes and home care agencies statewide are involved in IPAs. Those IPAs typically involve only one or two types of provider or service. They do not typically involve the continuum of long-term care providers along with podiatrists, dentists, etc. Creating or joining these entities will require providers to invest upfront dollars that they simply don't have, well in advance of realizing any shared savings. As the State moves to include all Medicaid benefits (e.g, behavioral health, ambulatory care, acute care, labs, imaging, prescription drugs, etc.) in the MLTC benefit package, the composition of these IPAs and their integration activities become increasingly complex.

Moreover, as you know, in order to contract jointly on behalf of their participating providers, without running afoul of antitrust laws, IPAs must be clinically and financially integrated. This alone is operationally daunting – particularly in a large IPA with multiple provider-types and specialties. This integration and the ability to succeed will require centralized data and analytics, robust cost accounting and financial management systems, and HIE capacity. All of this infrastructure must be built and integrated into business processes for these IPAs and their participating providers. The State's information systems will have to advance as well. Today, for example, the State must resort to surveys of plans and providers in order to calculate the number of permanently-placed nursing home residents

enrolled in MLTC plans, whose institutional Medicaid eligibility is pending, because existing systems don't capture those data.

Given all of these challenges, in the short run, we urge you to focus on pay-for-performance incentives with new incentive funding and to consider on-menu options that do not demand the creation of an expansive new administrative layer.

Thank you for the opportunity to provide these comments and the attached recommendations. Please don't hesitate to contact Dan Heim or me with any questions.

Sincerely yours,

Karen Lipson
Executive Vice President for Innovation Strategies

cc: Jonathan Noonan
Dan Heim
Sean Doolan

LeadingAge New York

December 1, 2015

Via E-Mail

Re: Value-Based Payment MLTC Clinical Advisory Group

Dear Messrs. Berg and Kissinger and Ms. Lynam,

I am writing on behalf of LeadingAge New York in response to the request by the Value-Based Payment MLTC Clinical Advisory Group (the CAG) for regulatory reform recommendations. The Regulatory Impact Subcommittee made a similar request last month. In this letter, we reiterate our November 24th recommendations to that Subcommittee and include some additional recommendations.

As an initial matter, we would like to invite you to meet with the LeadingAge New York Managed Long Term Care/PACE Cabinet to discuss the provider-sponsored managed long term care/PACE model, the beneficiaries served, and the challenges facing plans and providers under payment reform. In addition, we would like to share some of our concerns regarding the fundamental assumptions that appear to form the basis for the development of the State's evolving MLTC VBP policy.

Our members recognize the importance of value-based payment (VBP) to achieving the Triple Aim and the State's DSRIP goals. However, it is important to be realistic about the challenges associated with VBP in the long-term care sector. It is difficult to reduce spending and manage utilization within the MLTC benefit package alone, due to the intensive needs of the members, extensive fixed costs borne by LTPAC providers, required payment rates, continuity of care policies, and fair hearing rights. While savings is available from avoided hospitalizations, those costs (and savings) are, as you know, borne by Medicare. Moreover, a reduction in acute care expenses is likely to lead to an increase in Medicaid-funded long-term care expenses, as hospital days replaced by nursing home days or personal care visits. Finally, the success of VBP arrangements relies heavily on data and analytics and health information exchange. Unfortunately, there has been little public investment in information technology and health information exchange in the LTPAC sector. As a result, many LTPAC providers lack the infrastructure necessary to succeed in a VBP environment.

Further, we question the wisdom of an MLTC VBP policy that requires the creation of a new administrative entity (either an IPA or ACO) to serve as an intermediary between providers and plans, performing such functions as contracting, care management, distribution of payments and quality assurance. We understand the State's interest in leveraging these administrative entities in order to build sufficient scale to support risk-based arrangements. And, in some markets, long term care providers are organizing IPAs and MSOs to support such arrangements. However, an IPA, MSO or ACO should not be essential to VBP in every market nor essential to every payment arrangement. It is important to recognize that the MLTC itself is a risk-bearing vehicle that assumes responsibility for "total [long-term] care for a subpopulation" on a capitated basis. It can engage in performance-based or risk-based payment arrangements directly with providers. In many respects, an IPA or ACO would effectively replicate the role of the MLTC. Significantly, we do not believe that there is sufficient funding in the current MLTC premiums to support a new administrative layer.

Given these constraints, we believe it is important at the outset to focus MLTC VBP efforts on performance-based arrangements that reward providers for high-quality care. Notably, the State's VBP Roadmap supports

this emphasis by elevating such arrangements to Level 1 for the MLTC sector and exempting MLTCs from the goal of tying at least 35 percent of total managed care payments to VBP arrangements at Level 2 or higher by 2019.

In addition to raising these fundamental concerns, we would like to submit the following regulatory reform recommendations:

Cross-Sector Reforms

- **Capital Reimbursement for EHRs and Other Technology in Nursing Homes and Assisted Living Programs:** All of the value-based payment (VBP) models require electronic health records (EHRs), health information exchange along the continuum, and robust data and analytics. However, long-term/post-acute care (LTPAC) providers have been excluded from federal EHR incentive payments and have received very little funding from state grants to support investment in health information technology. Other grants have been limited to narrowly-defined capital expenses that, as a practical matter, typically exclude health information technology. To encourage nursing homes and assisted living providers to invest in health information technology, Medicaid reimbursement regulations should be amended to permit software licenses and EHR leases purchased by nursing homes and ALPs to be reimbursed as capital, rather than as operating expenses.

- **Adjust UAS Scoring of Cognitive Deficits and Behavioral Health Conditions:** As VBP arrangements gain traction and transfer higher levels of risk to providers, risk measurement and adjustment will become critical. However, the tool most likely to be used to measure and adjust risk – the UAS – is widely understood to understate beneficiary risk when a beneficiary has severe dementia, cognitive impairment, or mental illness. Because risk points for judgment and behaviors have been eliminated in the UAS, the UAS risk score routinely under-values the risk associated with these beneficiaries and thereby their needs and expected resource use. For example, we understand that a beneficiary with dementia or severe mental illness whose judgment is so impaired that he or she requires round-the-clock personal care would receive a risk score between 6 and 40, while a beneficiary with quadriplegia, who also requires round-the-clock care, would score between 35 and 90. The undervaluing of risk scores for beneficiaries with these conditions will impair the ability of plans and providers to evaluate and effectively mitigate the risk associated with VBP arrangements. The State should modify the UAS scoring methodology to account more accurately for cognitive impairment and behavioral health conditions.

Home and Community-Based Services

- **Implement the Advanced Home Health Aide (AHHA) model.** Certifying Advanced Home Health Aides will help people with complex conditions to remain in the community, permit more efficient deployment of a limited supply of visiting nurses, and support home health aide recruitment and retention efforts. As value-based payment (VBP) arrangements encourage the delivery of services to beneficiaries with complex medical conditions in community settings, while reducing the overall cost of care, AHHAs can play a critical role. In addition, this initiative would provide for an expanded career ladder in the home health aide field, supporting recruitment and retention efforts. This proposal is especially important, given severe home care nurse and aide workforce shortages in certain regions of the State. This proposal would also support implementation of the recently approved Community First Choice State Plan Amendment.

AHHAs would be trained to administer certain medications (e.g., eye drops) and to flag changes in health status early to prevent a possible hospitalization or emergency room visit. Like aides in residences for people with developmental disabilities, and personal assistants in the Consumer Directed Personal Assistance Program, AHHAs should be permitted to perform these tasks. Legislation to implement this proposal was introduced as part the Executive Budget in the past two years, but was not enacted.

- **Modernize the Naturally Occurring Retirement Community (NORC) Supportive Services Program:** With expanded access to community-based services, providers and plans can work together to reduce the overall cost of care. NORCs and Neighborhood NORCs provide low-cost access to a range of services. However, statutory requirements governing NORC funding should be updated including the minimum number of older adults and required density of older adults in the host community, the local match requirements; the size of the grant awards, and the mandatory and optional services. Allowing for the modernization of this program will expand the number of programs and services being delivered, save Medicaid dollars, and allow for a greater number seniors to remain independent in the community.

- **Extend the Timeframe for Securing Written Physician Orders in Home Care:** We support the Department of Health's efforts, in collaboration with stakeholders, to extend the deadline for home care agencies to secure written physician orders from 30 to 365 days. This will align State regulations with federal Certified Home Health Agency (CHHA) regulations and reduce inconsistencies between CHHA and licensed home care services agency regulations. It will reduce the burdens associated with managing compliance with multiple sets of inconsistent regulations and will provide home care agencies with a reasonable period to obtain written documentation from physicians. Reducing unnecessary administrative burdens will facilitate efforts to reduce the overall cost of care and increase resources available to focus on clinical activities.

Nursing Homes

- **Nurse Practitioners and Physician Assistant Services in Nursing Homes:** Success under VBP arrangements will require nursing homes to implement robust clinical protocols to avoid hospitalizations, re-hospitalizations and emergency department visits. Nursing homes will increasingly be expected to retain residents who experience an acute exacerbation to the extent medically appropriate and to care for higher acuity residents after discharge from the hospital. Active engagement of mid-levels in these activities will be valuable to these new models. However, outdated nursing home regulations prevent NPs and PAs in nursing homes from practicing within the full scope of their professional licenses. In particular, regulations should be amended to clarify that NPs and PAs are permitted to conduct the initial health history and physical for new residents and to sign nursing home admission orders.

- **Eliminate the Patient Review Instrument (PRI):** Hospitals conduct the PRI assessment prior to discharge from the hospital to a nursing home. The PRI assessments tend to have minimal value due to hospital discharge staff's lack of familiarity with the patient and absence of a hospital purpose for the PRI. Upon admission to the nursing home, a complete assessment is conducted by the nursing home using the Resident Assessment Instrument. Under managed care and emerging VBP arrangement, there is significant pressure to reduce nursing home utilization. Accordingly, the PRI is no longer necessary to prevent inappropriate utilization.

- **Revise Medicaid Reimbursement Rules to Permit Payment for Remote Consults with Psychiatrists and other Specialty Physicians.** This would increase the ability of facilities to meet the specialized needs of their residents in an expeditious manner and reduce emergency department visits and hospital admissions.

- **Modify Training Required of "Paid Feeding Assistants:"** New York regulations require feeding assistants who support nursing home residents at meals to undergo more extensive training than federal regulations require. As a result, many nursing homes continue to use certified nursing assistants (CNAs) to assist some residents at meals who might otherwise be fed by a paid feeding assistant. If State regulations were aligned with the federal requirements, nursing homes could expand their use of feeding assistants and allow CNAs to focus on higher level tasks. This would alleviate an unnecessary administrative burden and facilitate efforts to reduce the overall cost of care.

Adult Care Facility/Assisted Living (ACF/AL)

- **Update Admission and Retention Standards for ACFs.** As the combined force of managed long term care and VBP arrangements encourage the diversion and transition of beneficiaries from nursing homes, adult care facilities and assisted living programs will serve an increasingly frail and complex population. However, the current admission and retention standards for ACFs are based on outdated notions of the level of care that may be provided in the community. These regulations should be updated accordingly. (See, e.g., 18 NYCRR 487.7 and 488.4.)

- **Allow ACF/AL Nurses to Perform Nursing Tasks.** Currently, there are many ACFs, Assisted Living Programs, Assisted Living Residences, and Special Needs Assisted Living Residences that employ licensed practical nurses (LPNs) and/or registered nurses (RNs). Unfortunately, these nurses are not permitted to perform nursing tasks in these ACF settings due to statutory limitations in New York related to the corporate practice of the professions. By allowing nurses in ACFs to perform tasks within their scope of practice, Medicaid beneficiaries living in ACFs would receive more proactive, preventive services that can prevent emergency department visits and hospital admissions. Nurses working in ACFs could also help to avert declines in health status that trigger nursing home placement, thereby saving money for the state, the federal government and the consumer. Like nurses employed by nursing facilities and hospitals, nurses employed by ACFs should be exempt from the corporate practice of the professions prohibition and permitted to practice their profession in those settings.

- **Allow ACFs and Assisted Living Facilities to Utilize Advanced Home Health Aides.** Building on the home health recommendation above, the AHHA should also be used in ACF and assisted living settings.

- **Allow Access to Hospice services in the Assisted Living Program (ALP).** Currently, DOH prohibits a Medicaid beneficiary from residing in the ALP and accessing the hospice benefit at the same time. This limits access to critical services and supports. We recommend the elimination of this barrier. Aside from the clear benefits to the beneficiary, doing so is also likely to reduce hospitalizations and emergency room visits for ALP residents.

- **Eliminate Barriers to Hospice in ACFs and Assisted Living Residences (ALRs).** Separate from the specific Medicaid issue of the ALP, State regulations impede the provision of hospice services in other ACF and ALR settings. Barriers relate to the need for nursing and assessments and administration of medication when a

resident cannot participate in the self-administration of medication. Empowering nurses who are employed by ACFs and ALRs to perform nursing tasks will partially address this issue. However, other policy changes are needed to provide ACF and ALR residents with the same access to hospice services as other people living in the community.

Adult Day Health Care

- **Adopt Billing Codes for Unbundled Services Payment Option.** ADHC programs provide a low-cost, community-based setting for beneficiaries with complex medical conditions and functional limitations. The Department of Health has adopted regulations to "unbundle" the all-inclusive adult day health care (ADHC) rate to permit managed care plans to contract for discrete services within the ADHC setting based on the needs of the registrant (patient). However, managed care plans and ADHCs have been hindered in contracting for unbundled ADHC service by the absence of managed care billing codes for these services. We recommend that the Department accelerate its work with plans and ADHC providers to adopt billing codes for these services. The implementation of the unbundled services option for ADHCs paves the way for innovative payment arrangements involving a variety of service packages.

Thank you for the opportunity to provide these recommendations. Please don't hesitate to contact Dan Heim or me with any questions.

Sincerely yours,

Karen Lipson
Executive Vice President for Innovation Strategies

cc: Jonathan Noonan
Dan Heim
Sean Doolan