April 18, 2016

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

Marc Berg, M.D., Ph.D.
KPMG, LLP (US)
15 Broadway
Albany, New York 12207-2974

Via E-Mail

Re: Value-Based Payment Roadmap Update

Dear Messrs. Helgerson and Berg:

I am writing on behalf of LeadingAge New York to provide comments on the June 2016 Annual Update to the New York State Roadmap for Medicaid Payment Reform.

We commend the State for its comprehensive vision for transformation of the delivery system and the payment models that sustain it. We also appreciate the State's extensive efforts to engage stakeholders in the development of the Roadmap through subcommittees and clinical advisory groups (CAGs).

We are concerned that the unintended effect of the Roadmap, together with DSRIP Performing Provider System (PPS) funding priorities, is to further deplete funding of long-term/post-acute care (LTPAC) services. Clearly, the focus of State and federal Medicaid investments under DSRIP, and the reinvestment of Medicaid savings through value-based payment (VBP), is on primary, acute and behavioral health care services. With the benefit of upfront capital and infrastructure investments and incentive payments under DSRIP, the Roadmap creates feasible opportunities for providers of primary, acute and behavioral health care services to reap the rewards of reinvested savings. The same cannot be said of LTPAC providers.

While the State has moved quickly to address the infrastructure, capital and operating needs of primary, acute and behavioral health care providers, it has not invested resources to address the same challenges confronting LTPAC providers. The LTPAC sector is struggling to adapt to dramatic changes in the organization and financing of LTPAC services under both Medicaid and Medicare, in the face of flat funding, rising labor costs, and workforce shortages. 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 the funding necessary to develop the infrastructure in the LTPAC and senior services sector to do so.

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

As you know, based on the funds flow projections submitted by each of the PPSs, only 4.2 percent of PPS payments are projected to be allocated to nursing homes over the five-year waiver period, and only 1.1 percent is expected to flow to hospice programs. Only 3.6 percent of the PPS payments is projected to be distributed to community-based organizations over five years – presumably a portion of these funds would be allocated to home care agencies.

Similarly, capital investment associated with DSRIP has been focused on the primary and acute care sectors, to the exclusion of LTPAC services. Only 1 percent of the Capital Restructuring Financing Program and Essential Health Care Provider grants were awarded to LTPAC providers.

The State's VBP Roadmap proposes to use payment reform to create a pathway for reinvestment of the savings realized by DSRIP in the delivery system. However, we are concerned that the payment models currently proposed will not result in the reinvestment of any savings in the LTPAC delivery system. In fact, they may result in further depletion of funding in LTPAC, if penalties are imposed on managed long term care (MLTC) plans that are not able to ramp up their VBP contracts quickly enough to meet the State's ambitious goals.

As we've noted previously, MLTC plans and their network providers play an important role in reducing avoidable hospital use and generating savings for the Medicare program. The best way to realize significant savings for reinvestment under current programmatic constraints is to pool Medicare and Medicaid dollars for duals in long-term care settings. Unfortunately, the Roadmap Update does not reflect progress on the State's proposal to align Medicare and Medicaid incentives and pool savings.

We appreciate the State's willingness to reward MLTC plans and providers for reducing avoidable hospitalizations through a pay-for-performance arrangement that would qualify as a Level 1 VBP arrangement. ***However, if the performance incentives are funded solely through withholds from rates, rather than new funding, the proposed arrangement will not create any new revenue for the LTPAC system and will not address existing funding shortfalls for the sector. Moreover, a VBP arrangement funded exclusively through withholds runs the risk of further destabilizing struggling providers, and runs counter to the basic assumption that VBP will make new revenues available for investment and operational support.***

We also appreciate the Roadmap's recognition that "[p]ayment reform principles should include operational feasibility." However, we question whether operational feasibility has been considered in the MLTC arena. As we've indicated to the MLTC CAG, by requiring that any on-menu VBP arrangement for MLTC plans include "[a]ll services covered by the associated managed care plans," the Roadmap demands that providers contract through a large, multi-specialty IPA or ACO that includes not just LTPAC services, but also dental, optometry, podiatry, and soon all Medicaid services. While IPAs and other affiliations are growing in the LTPAC sector, they typically do not involve the entire continuum of care. It is unlikely that such multi-specialty entities could come together and integrate sufficiently to engage in joint contracting for the entire benefit package within the three-year time frame anticipated, particularly in the absence of any public investment in this infrastructure.

Given the complexity of creating the on-menu options for MLTC plans envisioned by the Roadmap, we expect that providers and plans will advance off-menu proposals. This may result in administrative burdens for the State, providers, and plans and delay implementation of VBP arrangements.

With these fundamental concerns in mind, we would like to raise the following more granular issues:

- On page 18, the Roadmap contains a key chart describing the various VBP models and levels. The "Total Care for Subpopulation" row identifies "FFS with bonus/withhold for quality" should qualify as Level 0. However, in the box on page 19, the Roadmap states that pay-for-performance arrangements for reductions in avoidable hospitalizations would qualify as Level 1. These two pages are inconsistent, and our understanding all along had been that such MLTC payment arrangements with LTPAC providers would be treated as Level 1. Without this interpretation, the 80-90 percent VBP Level 1 penetration goal for 2019 appears to be unattainable.

- We appreciate the State's commitment to transparency in the managed care contracting process. We assume that this commitment extends to the MLTC contracts as well. In addition, it is important to incorporate the lengthy CMS approval process in contract planning in order to avoid retroactivity and facilitate the attainment of VBP goals.

- The Roadmap references attribution of MLTC members to a home care provider or nursing home (depending on the residential status of the member). However, this anticipates a recommendation of the MLTC CAG, which has not yet issued recommendations. We recommend that MLTC VBP on-menu options permit attribution to adult day health care programs, as well as home care agencies, for members who live in the community. Once Assisted Living Program (ALP) residents are enrolled in MLTC plans, the home care agencies associated with ALPs should receive attribution of their residents as well.

- We are concerned about the proposed penalties on MLTC plans (which can be passed down to providers) for failing to meet threshold percentages of VBP payments at Level 2 or higher beginning in 2019 (we are assuming that pay-for-performance would qualify as Level 1). MLTC pilots are not anticipated until 2017. Given the complexity of the on-menu arrangements proposed, and the lack of public investment in the necessary infrastructure to date, it is unrealistic to expect significant engagement of MLTC plans and providers in risk-sharing arrangements by 2019.

Finally, we applaud the Roadmap's recognition that housing is health care. The Roadmap's commitment to offering a "stable, safe, and accessible housing environment" is commendable. In addition to prioritizing housing for homeless New Yorkers with mental illness, we ask that the State also commit to developing affordable housing with supports for senior citizens. With current waiting lists for affordable senior housing of 7 to 11 years in many communities, a substantial expansion of capacity is needed to address growing demand. Housing with supportive services for seniors can help seniors to age in place and delay or avoid nursing home placement.

We would like to reiterate the comments and regulatory reform recommendations we have advanced in the MLTC CAG and have attached them for your reference. Thank you for the opportunity to provide these comments. Please don't hesitate to contact Dan Heim or me with any questions.

Sincerely yours,

Karen Lipson

Executive Vice President for Innovation Strategies

cc: Mark Kissinger
Margaret Willard
Dan Heim
Sean Doolan