October 31, 2014

Jason Helgerson
New York State Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Comments on Capital Restructuring Financing Program

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our comments on the Department of Health (DOH) announcement of the availability of funds under the Capital Restructuring Financing Program (CRFP). We appreciate the opportunity to provide input on this program.

LeadingAge New York is concerned that long term and post-acute care (LTPAC) providers will have only limited access to grants under this program, in spite of the fact that there are significant and pressing needs for strategic capital investments in these services. LTPAC providers received only limited funding through the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) for facility and program development and health information technology (HIT) deployment, and have not been eligible for other HIT funding support including meaningful use incentives. As a result, LTPAC services are often delivered in physical plants that need upgrades; electronic health record (EHR) adoption is far from universal; and development of new services and programs has lagged changing local community needs.

Our fundamental concerns about LTPAC access to CRFP grants are twofold: (1) whether awards to Delivery System Reform Incentive Payment (DSRIP) program participants will take precedence over those to non-DSRIP applicants; and (2) with DSRIP Performing Providers systems (PPS) leads primarily being hospitals, we are concerned that there is a strong unlikelihood that LTPAC participants in DSRIP will have adequate access to capital through this avenue.

DSRIP vs. Non-DSRIP Awards

According to the CRFP announcement, "Awards totaling up to $1.2 billion over seven years will support capital projects that help strengthen and promote access to essential health services including projects that will improve infrastructure, promote integrated health systems and support the development of additional primary care capacity. *The grant program will complement awards granted by the Delivery System Reform Incentives Payment program, DSRIP.*" [Emphasis added]

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

The CRFP is authorized by Public Health Law Section 2825. This statute provides for distribution of CRFP funds for two types of capital grants to providers and practitioners, namely those that: (a) qualify for payments under DSRIP; or (b) are DSRIP non-qualifying and non-participating applicants. The enabling statute does not purport to prioritize one type of grant over another and, in fact, was enacted prior to the announcement of an agreement with the federal Centers for Medicare and Medicaid Services on the terms and conditions that would apply to DSRIP.

However, the wording of the CRFP announcement provides that funding priority will be given to applications that are made through DSRIP. At this point in time, it is unclear what proportion of the State's LTPAC providers will be invited to join PPSs; indeed many safety-net eligible providers that have been left out of PPS formation to date and other LTPAC providers that serve Medicaid recipients and yet, have not been designated as safety net eligible. The latter group of service providers is arguably less likely to be invited to join PPSs than listed safety-net providers.

Accordingly, much of the state's LTPAC service infrastructure may not be participating in DSRIP even though it serves the safety net population. Given this reality and other state policy initiatives that will require significant capital investments in LTPAC services (e.g., Olmstead compliance, care management for all, etc.), non-DSRIP participants should be given meaningful and timely access to CRFP funding.

Capital Access Through DSRIP

The vast majority of the DSRIP Emerging PPS lead applicants are acute care hospitals and hospital systems. We are concerned that the capital needs of lead applicants will take precedence over those of other participating providers including LTPAC providers. Furthermore, if PPSs are disproportionately selecting projects that do not directly involve LTPAC services, LTPAC providers may be even less likely to benefit from CRFP awards.

Any serious effort to reduce avoidable hospital use must involve LTPAC services, given relatively high rates of avoidable hospital admissions and readmissions among seniors and people with disabilities. Successful management of chronic disease and disability to avoid unnecessary hospital use among elderly and disabled individuals in facility- and community-based settings requires the active engagement of LTPAC providers.

Given these concerns and realities, we recommend that the CRFP grant application expressly require the PPS lead applicant to address how the application supports the transformation of delivery of LTPAC services to meet the needs of the community, and that this element of the application be expressly considered and prioritized in the scoring process. In addition, bonus points in the application process to include LTPAC providers in capital project funding proposals would help bolster this effort.

LTPAC Capital Needs

Following years of limited state capital grants for LTPAC services, the need for strategic capital investments in this area has grown considerably. Among the major categories of need are the following:

1. ***HIT and telehealth applications.*** To date, providing funding for technology applications in LTPAC service settings (e.g., electronic medical records, telehealth and remote monitoring capabilities) has not been a priority of either the federal or state governments. However, as the state pursues its goals of containing Medicaid costs, ensuring that the care of every Medicaid recipient is coordinated across settings and serving more individuals in community settings, added investments in technology in LTPAC facilities and community-based programs will be essential. Furthermore, recently proposed regulations would require certain LTPAC providers to connect to the Statewide Health Information Network for New York at considerable cost, with no funding identified. LeadingAge NY recommends that funding priority be given through the CRFP to promote deployment of a range of technology applications in nursing homes, assisted living facilities, home care programs and other senior services settings. LTPAC providers participating in DSRIP Domain 2 projects will need capital investment to achieve the HIT and information exchange requirements.

2. ***Service reconfiguration and capacity development:*** As the state transitions the LTPAC Medicaid population to managed care and other systems changes occur, the delivery system also needs to change. However, capital grants for reconfiguring LTPAC services and developing new capacity are largely non-existent, even though, for example, additional nursing home rightsizing and increases in assisted living capacity would result in Medicaid savings. CRFP funding should also be available to incentivize the construction of needed affordable assisted living and other cost-effective LTPAC service alternatives.

3. ***Facility modernization.*** Many of the physical plants used to furnish LTPAC services are also dated and in need of significant renovation or even replacement. Nursing homes are the only provider type that is subject to equity requirements of up to 25 percent through the Certificate of Need (CON) process, a large obligation that is difficult to meet. CRFP funding should be available on a priority basis to support cost-effective LTPAC service reconfiguration projects that meet changing community needs and improve quality of care and quality of life for residents/patients.

Other Comments and Questions

Based on our review of the CRFP announcement, we have other comments and questions which are listed below:

1. Will program funding be allocated equally over each of the six years (i.e., $200 million per year) or in some other fashion? Given the compelling capital needs that exist, a strong case can be made for accelerating the availability of funds.

2. Will there be a specific allocation of funds by region? If so, how will this be determined? What assurances will there be that rural and underserved areas will have adequate access to grant funds?

3. Will there be a specific allocation of funds by relevant program agency (i.e., DOH, OMH, OPWDD and OASAS)? If so, how will this be determined?

4. Will DOH establish minimum and maximum amounts of funding to be awarded to individual applicants under the program? If so, how will this be determined?

5. How much time will be allotted for submission of applications? When will the first round of program awards be announced?

6. What will be the length of the contract period during which an awardee must expend the funds?

7. Will refinancing, restructuring or discharge of capital debt be considered an eligible expenditure?

8. If a provider is part of a PPS and the PPS submits an application for CRFP funding which does not incorporate the provider's capital project, is the provider eligible to separately apply for CRFP funding as a non-participating entity?

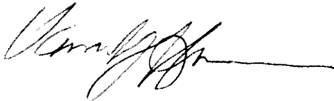
9. Will any CRFP funding preference be given to providers that receive funding in the future through the Vital Access Program?

10. Will there be opportunities for public input on the request for applications, the process by which applications will be reviewed, and the criteria by which applications will be judged?

11. Will there be any flexibility in certain regulations regarding the establishment of projects for these new projects, which would expedite becoming operational? If so, would this flexibility be available only to projects named in DSRIP applications?

Thank you for your consideration of our concerns and recommendations. If you have any questions regarding our comments, please do not hesitate to contact us at (518) 867-8383.

Sincerely,



Daniel J. Heim
Executive Vice President

cc: Courtney Burke, Executive Chamber
Paul T. Williams, DASNY
Greg Allen, NYSDOH
Mark Kissinger, NYSDOH
Dan Sheppard, NYSDOH
Charles Abel, NYSDOH
Jim Introne, NYSDOH