October 29, 2014

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

RE: DSRIP Application Comments

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am writing to share our comments on the Delivery System Reform Incentive Payment (DSRIP) Application documents. We appreciate the opportunity to provide input into this process. Below are some overarching themes, followed by specific comments on the application documents.

1. ***The Role of LTPAC Providers in DSRIP:*** As we have previously indicated, we remain concerned about the significance of the role that Long Term and Post-Acute Care (LTPAC) services will play in DSRIP. We see the involvement of LTPAC providers as being essential to achieving DSRIP objectives, and ask the Department of Health to reinforce this reality in the application documents and elsewhere. This complex initiative is evolving at a rapid pace, and without this guidance, Performing Provider Systems (PPSs) may fail to form networks with sufficiently robust LTPAC services. One way in which these opportunities could be highlighted is by naming them in the application documents, particularly in the "Scale of Implementation Sections".

2. ***Need for Investment in Health Information Technology (HIT) and Exchange:*** A consistent theme throughout our comments is the need for strategic investments in technology for LTPAC providers. The electronic health record (EHR) and Health Information Exchange (HIE) requirements in the Domain 2 projects are concerning as these providers have not had access to capital opportunities to establish the necessary platform. We anticipate that there will be multiple other needs for the Capital Restructuring Financing Program dollars available, and we can't presume or rely on that funding as the way in which all providers in the project achieve that level of connectivity. We wholeheartedly believe that this level of connectivity will be essential, but fear it is not possible without further state investment.

3. ***Skilled Nursing Facility (SNF) Bed Reduction:*** There are multiple references in the application to reducing SNF bed capacity, including the opportunity to increase the application score as a result. We note that SNF bed reduction is not necessarily the only mechanism to achieve DSRIP objectives, and in some cases, may be short-sighted. As we seek to keep people out of the hospital, nursing homes will play a key role in providing an alternative to subacute placements

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in hospitals. In addition existing SNF beds/infrastructure can be transformed to a more acute-care (and in some cases less acute) setting without forgoing valuable and much needed residential infrastructure.

4. ***Managed Care and Managed Long Term Care:*** While the application acknowledges a role for managed care (and presumably, managed long term care (MLTC) plans), it remains unclear exactly how managed care/MLTC would be integrated into PPSs and Integrated Delivery Systems. Given the significant efforts underway to enroll Medicaid recipients into managed care and MLTC, it is important that providers and managed care plans obtain clarity on this role to ensure the efforts are complimentary and not duplicative or at odds with one another in any way.

Below we provide comments first on the Organizational Application, and then on the Project Application.

Part 1: Organizational Application

Section 1: Waivers

The application, as drafted, requires waivers to be project-specific, and requires a high level of detail. To increase process efficiency, perhaps there could be some agreed-upon blanket waivers that would be useful industry-wide in order to achieve DSRIP objectives. In addition, we recommend that PPSs have an additional opportunity in the development of the work plan process in the spring and beyond, as the needs and barriers become clearer. There are likely several factors that haven't been considered or may not be encountered until work plan implementation is underway.

Section 2: Governance

The Project Advisory Committee (PAC): There should be some bolstering of this structure to ensure LTPAC providers have a voice. For example, the application should require the PPS to explain the role/mechanism of providers with the PPS and identify a process for ensuring partnering provider roles.

Oversight and Member Removal: It is important to build in some protections for LTPAC providers in the "progressive sanctions" and procedures for member removal from a PPS.

Section 3: Community Needs Assessment

While we understand that Community Needs Assessments are under way and the timeframe is short, we urge that PPSs consider the entirety of healthcare and supportive services in a community that can help individuals remain healthy in the community.

Healthcare Provider Infrastructure: The Community Needs Assessment requires an assessment of health care and community resources capacity. The health care category should explicitly include adult day health care (ADHC) programs, hospices, and End-Stage Renal Disease (ESRD) services.

Community Resources Supporting PPS Approach: Additionally, the community resources category should explicitly include senior housing, senior centers, Naturally Occurring Retirement Communities (NORCs), home-delivered meals, and independent living centers.

Community Population Health & Identified Health Challenges: We suggest that this include "Leading Causes of Disability" in assessing the health of the population.

Section 5: PPS Workforce Strategy

This section focuses on how the existing workers will be impacted in terms of the need for redeployment, retraining, as well as potential reductions to workforce as a result of transformation of the delivery system. Unfortunately, it ignores workforce shortages, particularly the unique challenges faced in rural and other underserved areas. The section also fails to address how to meet the needs of an aging population as the ratio of potential caregivers to frail elderly individuals shrinks, including the paraprofessional aide workforce. These issues should be incorporated in the strategy.

Section 6: Data Sharing, Confidentiality and Rapid Cycle Improvement

LTPAC providers have not been able to access funding for EHR adoption, are not eligible for meaningful use incentives, and have not been actively engaged in all RHIOs. Building the software connections to connect to RHIOs costs money and will require upfront investment. These providers will need financial assistance to accomplish the objectives of data sharing and connectivity.

Section 8: DSRIP Budget and Flow of Funds

Other Safety-Net providers should be added to second bullet describing the flow of funds to PPS partners, including adult care facilities (ACFs), assisted living programs (ALPs), licensed home care services agencies (LHCSAs), and ADHC programs. It is crucial that these services are considered in this planning process.

As drafted, this gives significant power to the PPS leads, with no protections to ensure downstream providers receive any incentive funds. This section should include an explanation of how the funding distribution plan was developed to ensure all partnering providers within the PPS will be receiving necessary funding to facilitate and recognize achievement of collective goals. Providers that help PPSs achieve incentive funds should share in the benefits.

Lastly, it should be noted that details may become clearer after the PPS develops its implementation plan. Is there any opportunity to make adjustments at that time?

Section 9: Financial Sustainability Plan

We raise concern about financially fragile or tenuously stable providers taking on risk. Assumption of risk by these providers could have significant implications for other PPS providers.

Section 10: Bonus Points

We recommend that bonus points be offered to incentivize PPS leads to ensure capital funds flow to downstream providers. This would help ensure that all safety-net providers can meet Domain 2 HIT and exchange requirements. Many ACFs, ALPs, home care providers and nursing homes do not currently have EHRs and will need significant access to capital funding to make this successful. Bonus points would help the PPS achieve the objectives of the Domain 2 projects and create a truly integrated delivery system.

Further, the application process could build in more incentives to engage diverse LTPAC providers. The initial round of attribution highlighted gaps in that so many people were not attributed to any PPS.

This, and discussions with providers, suggest that this reflects a need to further engage SNFs and other LTPAC providers. Incentives to involve LTPAC providers could improve attribution results and support transitions to more integrated service delivery systems.

Part 2: Project Application, Domains 2, 3, and 4

Below are our comments on specific projects:

2.a.i: Integrated Delivery System:

The PPS is expected to use existing Health Home or ACO infrastructure to develop a comprehensive health management strategy. While Health Homes serve all regions of state, they were designed to focus on individuals with behavioral health needs and typically do not incorporate LTPAC providers. In addition, ACOs do not serve all regions of the state and, as a Medicare-driven model to date, do not incorporate long-term care. Medicaid managed care, MLTC, and the Program for All-inclusive Care for the Elderly (PACE) population health management infrastructure can and should also be deployed to support the development of these systems in order to achieve the objective to "…create an integrated, collaborative, and accountable service delivery structure that incorporates the full continuum of services."

The EHR and HIE requirements relative to this and other Domain 2 projects do not recognize unique challenges for LTPAC providers. As noted above, these providers have not had access to capital opportunities and meaningful use incentives. The few providers that already have systems in place may also have struggles in connecting with other providers in the region. For these reasons, we believe an additional targeted investment in HIT for LTPAC providers is needed.

For a PPS to evolve into a truly integrated delivery system that is capable of providing the full scope of Medicaid services for its attributed population, it should include residential providers serving as an alternative to premature nursing home placement (ALPs and ACFs), and providers capable of providing skilled home care services (certified home health agencies (CHHAs) and ADHC) and less skilled personal care services on a cost efficient basis (licensed home care services agencies (LHCSAs)). The current scoring construct does not account for this at all and ignores the need for community-based long term care providers in an integrated delivery system. These Medicaid LTPAC providers are designated safety net providers and play a specific role in the long term care continuum that is integral to the ability of the PPS to become an integrated service delivery system and reduce avoidable hospital use.

The "scale of implementation (3)" section should include individual lines for the expected numbers of ACFs, ALPs, LHCSAs, ADHCs, and CHHAs so as to encourage PPS leads to ensure these providers are in their network. The current scoring construct puts these providers together, along with any "other" provider type, into a single category. As drafted, it fails to recognize the unique role each of these providers plays and the need for each to be present in the continuum. The construct dis-incentivizes PPSs to have broad networks of each provider type, and perversely, creates an incentive to simply accumulate as many safety net providers as possible.

2a.iii Health Home At-Risk Intervention Program:

As above, we are concerned about the ability of LTPAC providers to achieve the HIT and HIE requirements by year 3, for the reasons noted above. Additionally, we see other home and community-based providers being critical to the success of this program, and yet the "scale of

implementation section" seems to focus solely on primary care providers. The scoring may result in a lack of focus on getting the necessary community based providers involved in the project.

2.a.iv Create a Medical Village Using Existing Hospital Infrastructure:

While not directly related to the application process, we want to identify an opportunity for DOH, the state, and communities. Hospitals will often have excess land adjacent to their property as a result of decertification. Land acquisition and cost is a major barrier to developing senior housing especially in the downstate market. Senior housing could be co-located next to the Medical Village so that residents could take advantage of the medical and support services. Such an effort could support project 2.a.v, but also provide an avenue to support much needed development of affordable senior housing.

2.a.v Create a Medical Village/Alternative Housing Using Existing Nursing Home Infrastructure:

We note that the project description on page 21 erroneously refers to "skilled nursing hospital capacity." The description goes on to say: "This project will convert outdated/unneeded hospital capacity into a stand-alone emergency department/urgent care center and/or spaces occupied by local service organizations and primary care/specialized/behavioral health clinics with extended hours and staffing." We want to clarify whether the Department is suggesting that unneeded nursing home capacity can be converted to these uses. Additionally, there is no mention of ADHC services as an option for this model; it should be explicitly included.

Under project requirements, there is a vague reference to any NORC within the PPS. It is unclear what the nexus should be between the medical village and a NORC; which we believe could be located on-site or off-site.

Project requirement #4 references consistency of any housing options with *Olmstead*. Given that all of these services would be on a campus with a nursing home and could even be in the same building or attached, we question whether this creates a compliance issue in light of the federal home and community based settings requirements. We recommend that the state provide clear guidance to those PPSs that select this project so that they develop a Medical Village that is viable when the state implements these federal requirements.

Project requirement #6 requires patient tracking using EHRs and other technical platforms. Could this requirement be a problem if housing is part of the campus? Housing operators generally do not collect such information. If the housing operator is put in the position of health care provider, they are likely going to need to meet the criteria for becoming licensed as an assisted living provider, per the Assisted Living Reform Act (Public Health Law Article 46-B).

Project requirement #8 would impose SHIN-NY requirements, including interoperability, on LTPAC providers which, as discussed above, have received no funding for HIT.

2.b.iv Care Transitions Intervention Model to Reduce 30-day Readmissions for Chronic Health Conditions:

The success of this project will rely heavily on the community-based partners such as home care and ADHC that provide post-acute services. We recommend that the scale of implementation should consider those providers, and not solely hospital providers. Again, investment in HIT and HIE for post-acute providers is needed.

2 b.v Care Transitions Intervention for Skilled Nursing Facility Residents:

As above, we are concerned about the ability of SNFs to achieve the HIT and HIE requirements by year 3, for the reasons noted above. Many SNFs have not deployed EMRs, and those that have will likely also have to invest in or modify systems to ensure the appropriate level of connectivity.

2.b.vi Transitional Supportive Housing Services:

We see how this project could be particularly useful in certain communities. We are concerned, however, about how this housing is regarded in light of the state Assisted Living Reform Act (Public Health Law Article 46-B). Ironically, this project appears to have a more medical focus than the services provided by traditional assisted living facilities, and would also appear to have to be licensed as assisted living if the project is executed as outlined. It may make sense to explicitly include assisted living as a "housing provider', but also to provide clarity regarding this licensure question to those interested in this project.

2b.viii Hospital-Home Care Collaborative Solutions:

Project requirement #1 references a Rapid Response Team which includes hospice, if appropriate. We recommend adding palliative care, as well.

Project requirement # 9 mentions utilizing telehealth, but there are some reimbursement issues that pose a barrier and ideally should be worked out before the project is implemented.

As above, this project also requires considerable HIT and HIE requirements, for which LTPAC providers have not received funding.

2.c.i Develop a Community Based Health Navigation Service to Assist Patients to Access Healthcare Services Efficiently:

We note that the application description and requirements fail to acknowledge the importance of culture as a factor in how someone accesses services. It may make sense to explicitly state this.

3.a.iii Implementation of Evidence-Based Medication Adherence Program in Community Based Sites for Behavioral Health Medication Compliance:

ADHC conducts effective medication management for many registrants, including those with behavioral health issues. In addition, home care providers can be effective in supporting medication adherence. It may make sense to explicitly name these providers in the scale of implementation section, as opposed to the "other".

3.b.i Cardiovascular Health - Evidence-Based Strategies for Disease Management in High Risk/Affected Populations (Adults Only):

ADHC programs do this kind of work with this population daily, and should be considered as a resource.

3.c.i Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only):

Numerous ADHC programs have diabetes management programs in place and the Adult Day Health Care Council conducted an evidence based practice collaborative for diabetes management involving

ADHC programs that showed statistical, positive value for registrants involved in these diabetes management programs.

3.c.ii Implementation of Evidence-Based Strategies in the Community to Address Chronic Disease—Primary and Secondary Prevention Projects (Adults Only):

ADHC programs would be effective partners in this project for the reasons stated under Project 3.c.i above.

3.d.i Development of Evidence Based Medication Adherence Programs (MAP) in Community Settings – Asthma Medication:

Again, ADHC programs would be effective partners in this project.

3.e.i Comprehensive Strategy to Decrease HIV/AIDS Transmission to Reduce Avoidable Hospitalizations—Development of Center of Excellence for Management of HIV/AIDS:

AIDS ADHC programs would be effective providers in this project.

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: Greg Allen
Mark Kissinger