December 6, 2013

Nirav R. Shah, MD, MPH
Commissioner of Health
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Draft New York State Healthcare Innovation Plan

Dear Commissioner Shah:

On behalf of LeadingAge New York, I am pleased to provide comments on the proposed State Healthcare Innovation Plan (SHIP). LeadingAge NY represents over 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout the state.

LeadingAge NY supports the underlying premise of the SHIP, namely to advance the Triple Aim and transform the healthcare system from being a reactive, volume-based one that is difficult to navigate to a proactive, prevention-focused, and value-oriented system that is both patient-centered and broadly accessible. This is a laudable, albeit very ambitious, vision that will require considerable efforts to advance across the various systems of care.

Similarly, we support the focus on ensuring access to services without disparity, promoting integrated care models, empowering consumers through data transparency, employing value-based payment arrangements and engaging in population health strategies. As the Plan makes clear, a well-trained workforce – appropriately distributed geographically and by discipline – as well as health information technology (HIT) and health information exchange (HIE) will be critical "enablers" to reaching the stated goals.

LeadingAge NY believes that LTPAC and senior services providers will need to play a pivotal role in advancing the goals identified in the SHIP. However, certain of the Plan's recommendations do not seem to fully acknowledge or reflect the importance of LTPAC and senior services in the overall innovation framework. Our more specific comments in this regard are as follows:

1. ***Integrated models:*** The SHIP relies almost entirely on the advanced primary care (APC) model to achieve its goals. It overlooks the role that LTPAC providers can play in advancing the Triple Aim.

   LTPAC providers serve many of the most medically-complex patients in the State --the "high-risk, high-cost populations" that comprise "10 percent of New York's population but 60 percent of overall healthcare expenditures." Aside from references to Health Homes and the Fully Integrated

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Duals Advantage (FIDA) demonstration; however, the Plan does not sufficiently address the needs of New Yorkers with complex medical conditions and/or functional limitations. A significant percentage of the frail elderly and disabled individuals served by LTPAC providers will not be eligible for FIDA because they do not reside in a FIDA county, do not qualify for Medicaid and/or need only post-acute care and not long-term care. Adding to this population will be any individuals who are eligible for FIDA, but elect to opt out of the program.

Any serious effort to reduce avoidable admissions and readmissions must engage with LTPAC providers, given the patient volume and dollars at issue. For example, in 2008, nearly 15 percent of all initial hospital admissions in New York resulted in a readmission within 30 days, generating nearly $3.7 billion in expenses. More than half of these readmissions involved patients age 65 or older.[1] Likewise, efforts to prevent and ameliorate chronic disease must actively involve the providers that care for patients after an acute episode or on a continuing basis.

Nursing homes, home care agencies and other LTPAC and senior services providers are already working closely with hospitals and physician practices to coordinate care and manage chronic disease and post-acute episodes. For example:

- These providers are participating in several post-acute bundled payment arrangements and readmission reduction interventions.
- Home care agencies are partnering with hospitals, patient-centered medical homes, managed long term care (MLTC) plans and accountable care organizations to support comprehensive assessments, develop care plans, provide patient/caregiver education and support care coordination and chronic disease management activities. They are deploying telehealth technologies to provide remote patient monitoring and medication management, reinforce self-management skills, facilitate physician access to time-sensitive patient data, improve clinical decisions and promote early detection of changes.
- Senior services providers offer a variety of social supports and health promotion activities, such as transportation to medical appointments, fall prevention programs including home safety assessments and home modifications, nutritious home-delivered and congregate meals, and exercise programs.
- By actively monitoring health status and engaging patients/caregivers in management of their conditions, these providers can help to avoid acute episodes that can lead to higher and more costly levels of care.

For these reasons, the SHIP should incorporate the LTPAC sector into its vision for transformation.

2. ***Levy on payers:*** The SHIP proposes "a time-bound levy on payers to fund practice transformation and care coordination." It does not specify the payers that would be subject to the levy. MLTC and FIDA plans should not be subject to the levy, unless they and the providers in their networks would directly benefit from practice transformation and care coordination investments.

[1] Chollet, Deborah, Barrett, Allison, and Lake, Timothy. "Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives, NYS Health Foundation., Sept. 2011. Available at http://nyshealthfoundation.org/uploads/resources/reducing-hospital-readmissions-payment-incentives-september-2011.pdf

3. ***HIT and information exchange:*** The effective and efficient deployment of HIT and HIE is fundamental to the success of almost every element of the Plan. In order to succeed, APCs must be connected, electronically and through collaborative models of care and payment, to LTPAC providers to ensure that the most medically-complex patients receive truly integrated care. In addition, effective participation in value-based payment models requires the adoption of robust HIT and financial management systems that enable providers to evaluate the risks and benefits of new payment arrangements and to measure both clinical and financial performance.

   LTPAC providers have been slower to adopt EHRs than hospitals, practitioners and clinics. This is attributable, in large part, to ineligibility for meaningful use incentives and limited access to other funding programs such as HEAL-NY. Without financial assistance, many LTPAC providers lack the resources to purchase and implement EHRs. For these reasons, additional State and federal resources should be dedicated to supporting adoption of EHRs in the LTPAC sector and connecting LTPACs to the SHIN-NY.

   Those LTPAC providers that have adopted EHRs have experienced substantial challenges in participating in HIE with other providers in the continuum. LTPAC EHR products are not truly interoperable with EHRs of other providers. In some cases, they do not have features essential to connect to RHIOs. EHR vendors have been less attentive to the needs of LTPAC providers and their ability to participate in HIE due to their focus on satisfying the meaningful use criteria for providers eligible for the incentives.

   Given the technology lag and the lack of financial support to date for LTPAC HIT adoption, a regulatory requirement that all licensed providers with EHRs connect to the SHIN-NY would be premature and onerous for this sector. It would have the inappropriate effect of penalizing early adopters of EHRs and might even discourage additional providers from purchasing systems out of fear that the system they choose might not have the necessary functionality, despite assurances to the contrary.

4. ***Population health:*** Multi-stakeholder and multi-disciplinary approaches, as described in the Plan, are the most effective means to advance the Department's Prevention Agenda and improve population health. Providers of LTPAC services – from senior services providers to assisted living programs and home care agencies to nursing homes – are actively engaged in a variety of activities to promote the Prevention Agenda. Their efforts include working with patients and caregivers to support chronic disease self-management, conducting evidence-based exercise and nutrition programs, and operating state-of-the-art fall prevention and behavioral health programs.

5. ***Workforce and care coordination:*** The SHIP speaks at length to the need for trained care coordinators and discusses the development of training programs to enhance this capacity. The Plan overlooks the fact that CHHAs and LTHHCPs have long-standing expertise in this area. CHHAs are leading Health Homes, they and LTHHCPs are assessing prospective and enrolled MLTC members, developing care plans, and overseeing their implementation. Some are partnering with hospitals and physician practices to supply transition coaches, care managers, and patient educators.

We welcome the State's commitment to strengthening the skills of health care workers engaged in these activities and to deploying additional data and planning capacity to strengthen the LTPAC workforce. In doing so, the State should take full advantage of the care coordination capacity that already exists in the LTPAC sector as previously noted.

Despite its focus on ensuring adequate primary care, the Plan does not address the growing shortage of geriatricians. The number of geriatricians is declining even as the aging population is growing, bringing with them multiple chronic conditions that their physicians might not be adequately trained to manage. As recommended by the Institute of Medicine, schools of medicine, nursing, and public health should be encouraged to immediately expand their geriatric training programs to avert a health care crisis as baby boomers begin to retire.

6. ***Access without disparity:*** The Plan's singular focus on APC as the vehicle for advancing the State's health system transformation raises the concern that available funds targeted for safety net providers will not be made available in sufficient amounts to LTPAC providers. Not-for-profit and public nursing homes, home care agencies, and assisted living programs serve a disproportionate percentage of low-income, vulnerable New Yorkers. Their efforts are important to reducing avoidable hospital and ED utilization and improving the health status of New Yorkers.

7. ***Governance model:*** We appreciate the inclusion of payers and providers in the SHIP governance model. However, given the significant role that LTPAC service delivery will play in achieving the SHIP vision, MLTC and FIDA plans should be specifically referenced and included in the Payer Group; and LTPAC providers and their associations included in the Provider Group.

Thank you for the opportunity to provide input. LeadingAge NY looks forward to working with the Department and its sister agencies on the New York State Health Innovation Plan. If you have any questions on our input, please do not hesitate to contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President

cc: Patrick Roohan
Jason Helgerson
Karen Westervelt