October 19, 2022

Ms. Judith Cash
Director
State Demonstrations Group
Center for Medicare and Medicaid Services
7500 Security Blvd, Mail Stop S2-25-26
Baltimore, MD 21244-1850

Submitted electronically

Re: New York State 1115 Waiver Health Equity Reform Amendment Public Comment

Dear Ms. Cash:

I am writing on behalf of the approximately 400 members of LeadingAge New York to offer comments on the State's 1115 waiver amendment request, "New York Health Equity Reform," seeking to reinvest $13.5 billion over five years in initiatives to improve health equity and strengthen our health care and social care systems (henceforth "the waiver"). LeadingAge New York represents not-for-profit and government-sponsored providers of long-term and post-acute care and aging services, including home care agencies, hospice programs, adult day health care programs, assisted living facilities, nursing homes, continuing care retirement communities, provider-sponsored managed long term care (MLTC) and PACE programs, senior housing, and non-medical social supports.[1]

LeadingAge New York commends the State's commitment to promoting health equity. Our members serve principally individuals who are adversely affected by health disparities based on advanced age and disability, which are compounded by race, ethnicity, socioeconomic status, limited English proficiency, gender identity, sexuality, and/or geography. We are concerned that the funding mechanisms outlined in the waiver are likely to bypass the population most adversely affected by the COVID-19 pandemic -- older adults. Working towards health equity includes combating ageism and ableism in our health care system and ensuring access and quality care to individuals with age- or disability-related challenges. With a rapidly aging population, and a long-term care system that has been decimated by the pandemic, New York State cannot afford to repeat the mistakes of the DSRIP waiver and neglect its long-term care and aging services systems as it embarks on this historic investment in population health.

While the waiver has many strengths, its fundamental flaw from the perspective of older adults and the long-term care providers that serve them is that it appears to be designed for a Medicaid-only population and not one that includes individuals dually-eligible for Medicare and Medicaid

[1] For purposes of these comments, the term "long-term care" includes both long-term care and post-acute care services and providers.

13 British American Blvd. Suite 2, Latham, New York 12110-1431
p 518.867.8383 | f 518.867.8384 | www.leadingageny.org

("dual eligibles"). Approximately three-quarters of the waiver funding is directed through managed care plans via "advanced value-based payment arrangements" that appear to involve two-sided risk for a comprehensive array of health benefits. As discussed more fully below, absent a flexible definition of qualifying VBP arrangements and directed payments, the waiver is unlikely to result in any meaningful investment in services for dual eligibles receiving long-term care services.

The vast majority of dual eligibles receiving community-based long-term care services are enrolled in *partially-capitated* MLTC plans that do not cover primary care, acute care, or other Medicare benefits. And, the vast majority of dual eligibles receiving long-term nursing home care are not enrolled in managed care plans at all. If waiver funds must flow through managed care organizations to providers via VBP arrangements that entail risk sharing for hospital and medical expenses, dual eligibles enrolled in partially-capitated plans, nursing home residents, and the providers that serve them will be excluded from those arrangements, and the LTC system will be ineligible for waiver funding.

Accordingly, the advanced VBP models that drive waiver funding and qualify for preferential treatment under the waiver must include models tailored for the needs of dual eligibles receiving long-term care services and the providers and plans that serve them. LeadingAge New York would like to work with the State and CMS to develop value-based arrangements that would both support waiver funding and strengthen the accessibility and quality of long-term care services in New York.

New York's long-term care system is struggling to survive as a result of skyrocketing costs, staffing shortages, and inadequate Medicaid reimbursement. The State's DSRIP waiver largely overlooked long-term care, which was considered "outside of the DSRIP program focus;" *less than 2 percent* of DSRIP funds were allocated to long-term care (LTC) providers.[2] We cannot make that mistake again. In order to rebuild and revitalize our long-term care system in the wake of this devastating pandemic, to expand our caregiving workforce, and to care for our growing population of older adults, New York State and the federal government must partner to prioritize long-term care in major Medicaid policy initiatives. We must make long-term care a focus of this waiver.

We recommend the following changes in the proposed waiver to address the needs of older adults and dually-eligible New Yorkers and strengthen our LTC system.

I. Ensure that VBP Models that Drive the Distribution of Waiver Dollars are Accessible to LTC and Aging Services Providers, MLTC Plans, and PACE Programs (Section 1.3)

Approximately $9.9 billion of the $13.5 billion requested under the waiver is to be distributed through "advanced VBP arrangements." This includes:

- $6.8 billion that is directly invested in "advanced VBP models."

[2] Weller, W. et al., DSRIP Summative Report, Aug. 2021, p. 31, accessed at: https://www.health.ny.gov/.../**dsrip**/.../2021-08-24_final_**summative**_rpt.pdf; LeadingAge NY analysis of DSRIP PPS Quarterly Report data.

- $1.6 billion for Transitional Housing Services which will be distributed through a pool consisting of the proceeds of VBP arrangements.
- $1.5 billion for the COVID-19 Unwind Quality Restoration Pool for Financially Distressed Hospitals and Nursing Homes which will flow through managed care plans to providers via VBP arrangements.

Although not explicitly defined in the waiver, the advanced VBP arrangements or models it describes appear to entail shared risk between managed care organizations and providers in order to support efficient operations, population health, and health equity. They include, according to the waiver, episodic and total cost of care models and all-payer, global prepayment structures.

We are concerned that, if the qualifying advanced VBP arrangements under the waiver are not properly designed with dual eligibles and long-term care in mind, this foundational element of the waiver, which drives the distribution of nearly three-quarters of its funds, will not support investment in the long-term care system or services for older adults. In order to understand how the funding mechanisms outlined in the waiver risk neglecting older adults and individuals with disabilities who use long-term care services, it is very important for CMS and other stakeholders to understand two foundational aspects of the State's financing of long-term care services for this population:

- The overwhelming majority of older adults receiving community-based long-term care services are enrolled in partially-capitated Medicaid managed long term care (MLTC) plans (251,000 of 2993,000 MLTC enrollees).[3] These plans do not cover services covered by Medicare, such as primary or acute care.
- Long-term nursing home services are not covered by partially-capitated MLTC plans, and the vast majority of long-term nursing home services delivered to Medicaid beneficiaries are reimbursed through the State's fee-for-service system.[4]

Assuming that qualifying advanced VBP arrangements under the waiver will resemble the higher level VBP arrangements in the existing VBP Roadmap and rely on shared risk between managed care plans and providers to drive reductions in excess utilization of hospital and other medical services, they are not likely to be viable for partially-capitated MLTC plans nor to generate savings that will be reinvested long-term care providers for the benefit of the beneficiaries they serve. Notably, none of the examples of VBP arrangements cited in the waiver involve the dual-eligibles or long-term care.

The reason for this omission is likely that partially-capitated MLTC plans cannot capture the savings that they and their network LTC providers generate in reduced hospital and medical

[3] Only 42,000 of 293,000 enrollees in MLTC plans are enrolled in integrated Medicare-Medicaid plans or PACE programs. NYS DOH, Managed Care Policy and Planning Meeting Presentation, Oct. 13, 2022, based on Sept. 2022 data.

[4] LeadingAge NY analysis of 2020 RHCF Medicaid Cost Report data. Partially-capitated MLTC plans cover only 3 months of long-term nursing home care. Long-term nursing home care is included in the benefit package of the integrated Medicaid Advantage Plus plans, PACE programs, and mainstream managed care for non-dually-eligible beneficiaries.

expenses. When a partially-capitated plan or LTC provider reduces the hospital utilization of dual eligibles through effective care management and high-quality home care or nursing home services, the savings accrues to Medicare, not Medicaid. Under DSRIP, the State was unable to secure CMS's approval to apply Medicare savings to support Medicaid VBP initiatives, and the State did not invest any new dollars in VBP initiatives for LTC.

Integrated Medicare and Medicaid managed care plans, by contrast, have greater opportunities to engage in advanced VBP arrangements. However, their enrolled population is far smaller than partially-capitated plans, making shared risk more challenging and less likely to generate significant savings for reinvestment in the delivery system. Moreover, even integrated plans' VBP models typically do not incorporate both Medicare and Medicaid benefits. For example, the current VBP Roadmap's "total care for the MLTC population" model for integrated plans includes only the Medicaid-covered benefits.[5] When integrated plan VBP models do include both Medicare and Medicaid benefits, LTC providers are not typically the lead entity and generally do not have an opportunity to participate in gainsharing.

Moreover, advanced VBP arrangements in which providers assume risk is made even more difficult for LTC providers by the federal home and community-based services (HCBS) conflict of interest rule, which prevents providers and their affiliates from conducting assessments of the individuals they serve or providing them with care management services. A provider cannot feasibly take on financial risk for a patient if it is barred from assessing them and developing their care plans.

The requirement that most waiver funds flow through MCOs via advanced VBP arrangements affects not only community-based LTC financed through MLTC plans, but also nursing home care. Although the proposed COVID-19 Unwind Quality Restoration Pool purports to fund financially distressed nursing homes, as well as hospitals, the pool's reliance on VBP arrangements with managed care plans to distribute the funding would likely result in the exclusion of nursing homes from funding. Because the nursing home benefit is largely carved out of MLTC, the overwhelming majority of nursing home services in New York are reimbursed through the fee-for-service system. If participation in advanced VBP arrangements with managed care plans is a condition of accessing the COVID-19 Unwind funds, nursing homes will likely be ineligible for them.

Our members are interested in working with the State and CMS to develop VBP arrangements tailored for long-term care that will allow waiver funds to strengthen the LTC delivery system, promote its integration with the continuum of care, support improved quality and access, and assist in the delivery of services in the least restrictive environment. In order to accomplish this, the state and CMS should do the following:

- Establish a mechanism to capture Medicare savings earned through Medicaid services delivered to dual eligibles. Medicaid long-term care services, such as effective care management, high-quality home care, adult day health care, and nursing home care, and 'social care needs' services reduce avoidable hospitalizations and other high-cost services

[5] NYS Dept. of Health, Value-Based Payment Update, May 2022, accessed at https://www.health.ny.gov/health_care/medicaid/redesign/vbp/roadmaps/docs/final_updated_roadmap.pdf , Oct. 17, 2022.

reimbursed by Medicare. If approval could be obtained to capture and share a portion of the savings generated for Medicare through this waiver, they could be reinvested through MLTC plans and shared with network providers.

- To the extent that integrated plans and PACE programs generate savings through reductions in spending on Medicare benefits, do not "claw back" the savings through reductions in Medicaid premiums.
- Make available Medicare data to MLTC plans and long-term care providers to support VBP arrangements.
- Develop, and dedicate funding to, long-term care VBP arrangements that do not necessarily entail global payment or total cost of care, but instead involve pay-for-performance on quality and shared savings. Models that support community transitions or innovative workforce development initiatives should be encouraged. We've shared several VBP concepts with the State.
- Load funding for MLTC plans and providers that engage in qualifying arrangements into MLTC premiums to support plan administration and direct payments to providers, like the VBP incentive funds proposed for primary care.[6]
- Waive the HCBS conflict of interest rule to enable providers or their affiliates to engage in assessments and care management for purposes of VBP arrangements in which HCBS providers take on risk.

II. Ensure that Social Determinant of Health Network (SDHN) Investments Build on Services for Older Adults and are Available to MLTC Plans on a Flexible Basis (Sections 1.2, 1.3, 1.4)

We commend the waiver's focus on the social determinants of health and social care services. Older adults in New York State who receive Medicaid-funded long-term care services already benefit from a variety of social care services, including many identified in the waiver, such as comprehensive assessments that cover social factors, care management, home-delivered meals, social adult day care, medical transportation, and environmental supports. However, there are gaps in services for some MLTC enrollees and for older adults who do not yet need long-term care services.

The waiver should invest in social care initiatives tailored to the needs of older adults that build on, but do not duplicate or disrupt, existing services and supports for older adults. The waiver should also ensure that MLTC plans and PACE programs that are not necessarily engaged in advanced VBP arrangements have access to SDHN services and are able to contract with SDHNs on flexible terms so that their beneficiaries are able to access their services -- particularly those non-covered services that are difficult to arrange. These contracts should be supported by waiver investments targeted for dually-eligible LTC beneficiaries, and should not rely on reinvestment of savings from MLTC plans to fund them. As noted above, savings generated from reducing avoidable hospitalizations and other excess health care utilization does not currently accrue to partially-capitated MLTC plans and their network providers that serve the vast majority of dual eligibles receiving LTC services.

[6] See NYEHR, at p. 27.

We also recommend that the waiver include targeted investments in social care services for older adults who are not yet receiving long-term care services, in order to prolong their independence and delay their need for higher levels of care. We were pleased to see the authority in the waiver for SDHNs to fund services related to identified gaps that are not covered by advanced VBP arrangements.[7] It will be important to dedicate funding to enable our growing population of older adults to maintain a high quality of life and optimize their health as they age in their communities. Those investments should include resident assistant services or service coordination in affordable senior housing, as described below, and Naturally-Occurring Retirement Communities.

III. Workforce Initiatives Should Strive to Rebuild and Expand the LTC Workforce (Sections 1.4, 3.2)

We applaud the waiver's recognition of the need to invest in the healthcare workforce and recommend a continued focus on long-term and post-acute care professionals and paraprofessionals. Severe workforce shortages are plaguing the long-term care system and constricting post-acute and long-term care capacity. This in turn is preventing discharges from hospitals, unnecessarily prolonging hospital lengths of stay, and reducing the available acute care capacity. Further, our aging population and recently enacted nursing home staffing mandates demand greater investment in the long-term and post-acute care workforce. The waiver should ensure that WIO resources remain focused on long-term/post-acute care and that funds are distributed to support recruitment and retention across long-term/post-acute care settings. Efforts to create career ladders and lattices should include opportunities within long-term/post-acute care and not just opportunities to transition to community health work or acute care.

IV. Support Housing Strategies Tailored for Older Adults to Enable Transitions and Prolong Independence in the Community (Strategy 2)

We commend the waiver's commitment to transitioning individuals to community-based settings and supporting stable housing for individuals experiencing homelessness. However, once again we fear that this program will not address the needs of older adults. The proposal appears to focus on transitional housing services targeted at high utilizers of Medicaid with high rates of hospital use or residency in an institutional setting for more than 90 days. Funds will flow through MCOs and contractors with advanced VBP arrangements to SDHNs which will provide various housing transition services.

In order to ensure that dual eligibles and nursing home residents are identified for these services and eligible for them, these parameters must be refined. The criteria for identification of "high utilizers" must include *numbers or rates* of hospital admissions or ED visits, rather than level of Medicaid expenditures, so that dual eligibles with high rates of hospital utilization, but not high levels of *Medicaid* spending, are able to access services. In order to ensure that dually-eligible nursing home residents are identified for services, managed care enrollment cannot be a condition of selection. The vast majority of dually-eligible nursing home residents are not enrolled in managed care plans; they are disenrolled from partially-capitated managed care plans three months after a long-term nursing home placement. Further, to ensure that SDHNs are

[7] NYHER, at p. 22.

properly reimbursed for services provided to dual eligibles, funds must be made available to the SDHNs for these services outside of VBP arrangements.

We note that the waiver focuses on time-limited transitional housing services and tenancy supports, rather than long-term housing-related services and supports. We are concerned that short-term transitional housing services for institutionalized individuals and those experiencing homelessness will not adequately address housing as a social determinant of health for New York's rapidly growing older adult population. The waiver proposal properly acknowledges medical complexity and physical disabilities as barriers to remaining stably housed in the community. These conditions are frequently evident among older adults, as well as cognitive decline and a lack of informal caregivers. We should not wait until an older adult is institutionalized or homeless before we provide them with the housing-related services they need to optimize their health and independence in the community.

We therefore recommend that the waiver support an expansion of service coordination in affordable independent senior housing. Older adults, whether experiencing homelessness, being discharged from a nursing home, or simply striving to live independently in the community, require consistent and ongoing supports to connect with needed services as they age and their condition changes. Service coordinators (or "resident assistants") work with the residents of affordable senior housing to promote their emotional well-being, stronger social supports, and better connections among residents, their property managers, and the programs and resources they need in the community.

Rigorous studies have shown that the service coordination in affordable senior housing reduces Medicare and Medicaid spending and contributes to long-term independence.[8] Unfortunately, federal funding for service coordination falls far short of need, and no similar program exists at the State level, leaving many subsidized senior housing properties without the resources to maintain this critical service and placing their low-income senior residents at greater risk of conditions that can ultimately lead to more complex and costly care needs. Expansion of this successful and cost-effective model – which has the potential to offer specialized support with both transition-related issues and ongoing challenges associated with aging – would increase the availability of supports in affordable and accessible housing appropriate for individuals who are able to live independently with light-touch supports, complementing the State's transition efforts.

Investments in housing-related services should also include the Medicaid Assisted Living Programs ("the ALP"). The ALP offers housing and supportive services for individuals who need 24/7 support, supervision and personal care in a homelike, community-based setting. We were pleased to see the waiver's reference to additional SSI state supplemental funding for high needs populations. The SSI room and board rate of $43.17 per day for ALP (and other adult care facility) residents is inadequate.

[8] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* October 2018. Li, G., Vartanian, K., Weller, M., & Wright, B. *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.

V. Ensure Equitable Access to the COVID-19 Unwind Quality Restoration Pool for Financially Distressed Nursing Homes (Section 3.1)

The proposed waiver would create a $1.5 billion pool for financially distressed safety net and critical access hospitals and nursing homes that have a high Medicaid payer mix to engage in advanced VBP arrangements and facilitate post-pandemic quality improvement, while contributing to health equity. The State would flow VBP funds through MCOs to support VBP models consistent with waiver priorities.

These funds should be allocated equitably among hospitals and nursing homes. Moreover, if nursing homes are intended to receive a portion of these funds, they should not be distributed exclusively through MCOs based on advanced VBP arrangements. Allocating funds based on engagement in advanced VBP arrangements through MCOs will largely exclude nursing homes. As described above, the long-term nursing home care benefit for dual eligibles is largely carved out of the State's partially-capitated MLTC benefit package, meaning that the vast majority of long-term nursing home care is excluded from managed care and advanced VBP arrangements.

Instead of relying exclusively on advanced VBP arrangements through MCOs to distribute these funds, the State should expressly include fee-for-service quality-related payments (i.e., the Nursing Home Quality Initiative, see approved NYS SPA #20-0007) in its definition of VBP engagement to ensure nursing homes will have equitable access to these funds.

The overarching goal of this initiative is to redesign and strengthen system capabilities to improve quality, advance health equity, and address workforce shortages. To this end, Restoration Pool funds should be made available to support financially-distressed nursing homes with high Medicaid utilization to:

- **Pay Competitive Wages and Enable Staff-Intensive Models**: Leading Age NY member nursing homes are taking extraordinary steps to recruit and retain staff. However, they are unable to compete with other employers, due to inadequate Medicaid rates. Many have closed beds and/or limited new admissions, in order to ensure appropriate levels of staff. This limits access to nursing home services and creates backlogs in hospitals that cannot discharge patients. An increase in support for staff wages is necessary to improve staffing levels in facilities that serve significant numbers of Medicaid beneficiaries. The waiver should also support staff-intensive care models, as described below.
- **Support Quality Improvement Initiatives and Training:** Funds are needed to strengthen quality-related initiatives and staff training in new models of dementia care and clinical pathways, as well as cultural and LGBTQ competence. In addition, funds should be made available not only for cross-coverage between inpatient and ambulatory settings, but also among long-term/post-acute care settings.
- **Recruit and Retain Medical Staff and Infection Preventionists:** With additional physician and mid-level professional services, nursing homes would be able offer higher levels of integrated care and optimize their COVID prevention efforts. Pool funds should be available to enhance medical services and specialized infection prevention expertise in nursing homes, thereby promoting reductions in hospital use and better outcomes for residents.
- **Support the Operating Costs of Innovative Nursing Home Models:** These models, such as Green House and small house nursing homes, person-centered dementia care, palliative

care, and restorative care models, have higher operating unit costs than conventional nursing homes due to their smaller size and specialty programming. Funding enhancements are needed to ensure that these models are available to Medicaid beneficiaries who need nursing home care. These models support the health equity goals of the waiver by optimizing the quality of life of the most vulnerable New Yorkers, contributing to infection prevention efforts, and reducing avoidable hospital use and other adverse outcomes.

VI. Statewide Digital Health and Telehealth Infrastructure Funding

LeadingAge NY welcomes the proposed investment of $300 million over five years in digital health and telehealth infrastructure. We agree that the expanded use of remote patient monitoring, access to specialty services and innovative care management technologies made possible during the pandemic has enhanced clinical effectiveness and, in many areas, improved the patient experience.

As noted in the waiver application, Medicaid reimbursement to safety net providers is insufficient to make needed investments in digital health and telehealth on their own. In this regard, we support the State's intention to ensure that Medicaid payments for telehealth services are the same as in-person services, and that dually-eligible individuals enrolled in an integrated plan can receive telehealth services aligned with Medicaid telehealth policies. We also note with interest and support the proposal to identify individuals who no longer have community supports in place (e.g., day programs are closed, loss of aides, lack of access to needed specialty care, etc.) and who need to be linked to other supports. However, it must also be recognized that many older adults in the community require in-person assistance with telehealth modalities, due to low vision, hearing impairment, cognitive issues, and lack of familiarity with digital devices and applications.

Even in the absence of a pandemic, telehealth is invaluable to enhance access to medical and behavioral health services and remote monitoring services. These services can avert avoidable emergency department and hospital use and expand access to specialty care. Long-term/post-acute care and aging services providers (which have historically received minimal public funding for electronic health record adoption and health information exchange) should be eligible for significant funding through the proposed Equitable Virtual Care Access Fund to support:

- Deployment of, and/or upgrades to, electronic health records systems;
- Software platforms that enable effective transitions in care and health information exchange among long term care providers and other care partners, such as hospitals, clinics and physician practices;
- Equipment such as telehealth carts, advanced cameras, and diagnostic and monitoring devices;
- Licenses for software and contracts with telehealth vendors;
- Upgrades to internet connectivity, including improvements in WIFI and broadband connections.
- Ongoing staff training on use of the equipment and software;

We also specifically support the following uses of pool funds as proposed in the waiver application:

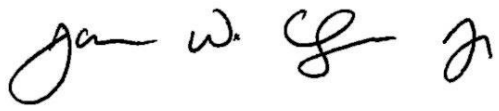
- Regional specialty e-consult programs so that nursing home residents can access specialty consult services (e.g., psychiatry, psychology, podiatry, etc.) from remote specialists, creating efficiencies and expanding access to specialty services;
- Virtual platforms that connect nursing homes and other long-term care facilities to health system partners for virtual visits, virtual consults and remote monitoring;
- Specialty virtual care models expressly designed to serve people who face accessibility barriers, such as people with long-term care needs;
- Remote or digital-only day habilitation or social day care services for individuals with long-term care needs. For example, LeadingAge NY member Selfhelp provides an evidence-based innovative model known as the Virtual Senior Center that meets this need.

While we support the proposed allocation of $9 million for telehealth services in nursing homes shown in the cost breakdown, we would note that virtually all of New York's approximately 600 nursing homes are certified for both Medicaid and Medicare.

Health equity demands that we make available the highest quality care for the most vulnerable New Yorkers, including those who are dually-eligible for Medicare and Medicaid and those who reside in nursing homes. We look forward to working with the State and CMS to ensure that older adults and individuals with disabilities have access to a high-quality, financially-viable continuum long-term care services that offers choices of setting and the opportunity to live vibrant, meaningful lives.

Thank you very much for your consideration of these issues.

Sincerely yours,



James W. Clyne, Jr.
President and CEO

Cc: Kristin Proud
Amir Bassiri
Adam Herbst
Michael Ogborn
Susan Montgomery
Angela Profeta