May 20, 2022

Amir Bassiri
Acting Medicaid Director
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza
Albany, NY 12210

Via E-Mail

Re: 1115 Waiver Public Comment

Dear Mr. Bassiri:

I am writing on behalf of the members of LeadingAge New York to offer comments on the State's draft 1115 waiver amendment request, seeking to reinvest $13.5 billion over 5 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 public 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, managed long term care and PACE programs, senior housing, and non-medical social supports.[1]

Let me begin by saying that LeadingAge New York commends the State's commitment to investing substantial resources in 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, gender identity, sexuality, and/or geography. Although the waiver is aimed at addressing health equity and the needs of vulnerable populations devastated by the pandemic, it overlooks the population most adversely affected by the pandemic -- older adults. As you know, 86 percent of the people who died of COVID-19 in New York State were over age 60.[2] 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 ignore its long-term care and aging services systems as it embarks on this historic investment in population health.

[1] For purposes of these comments, the term "long-term care" includes both long-term care and post-acute care services and providers.
[2] NYS Dept. of Health, COVID-19 Fatalities by Age Group, accessed May19, 2022, https://coronavirus.health.ny.gov/fatalities-0 .

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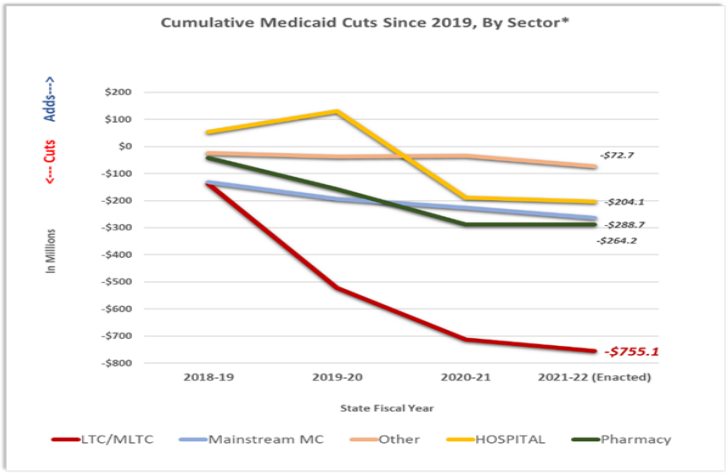
The draft waiver request falls short in several areas with respect to its treatment of the needs of older adults and long-term care (LTC) which are detailed below. However, its fundamental flaw is that it is designed for a Medicaid-only population and overlooks the bifurcation of health care coverage for older adults between Medicare and Medicaid. *Specifically, the waiver's reliance on advanced value-based payment arrangements to drive the vast majority of funding is likely to prevent any meaningful investment in services for older adults who are dually eligible for Medicare and Medicaid. The overwhelming majority of waiver dollars seem destined to bypass New York's battered long-term care and aging services sectors and deprive them of the resources needed to support recovery from the pandemic and continued viability as integral elements of our health care and social care systems*.

The omission of older adults and long-term care and aging services from the waiver, unfortunately, reflects a long-standing pattern in New York that continued through the DSRIP waiver and the COVID pandemic. *Less than 2 percent* of DSRIP funds were allocated to LTC providers. (Figure 2). Moreover, between 2018 and 2022, New York's LTC sector was subject to deeper Medicaid cuts than any other health care sector (Figure 1), while costs rose and administrative requirements grew exponentially. When the pandemic struck, and most other states increased Medicaid reimbursement to long-term care providers to cover the exorbitant costs associated with caring for a vulnerable population, New York cut rates by 1.5 percent.

This disinvestment from long-term care has destabilized the sector. Since 2014, 55 public and not-for-profit nursing homes have been sold to for-profit entities, and 23 not-for-profit and public nursing homes have consolidated or closed. Two more non-profit homes are close to completing their sales to for-profit entities. We fully expect to see many more close or sell to for-profit operators in the near future. Similarly, it is estimated that a majority of home care agencies are operating with negative margins and that their financial condition has worsened significantly since the onset of the pandemic. We are facing a dismal near future in which there are only a handful of non-profit and public LTC providers, and inadequate Medicaid rates mean that high-quality care is available only for wealthy New Yorkers who can pay out of pocket.



*Note: Figures are based on State-calculated impacts of new Medicaid budget actions since 2018-19, as well as enacted cuts reflected in the SFY 2021-22 Medicaid spending plan. More than $1.5 billion in retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due to the pandemic are not reflected, nor are savings actions that are not attributable to a specific health care sector.

Figure 1

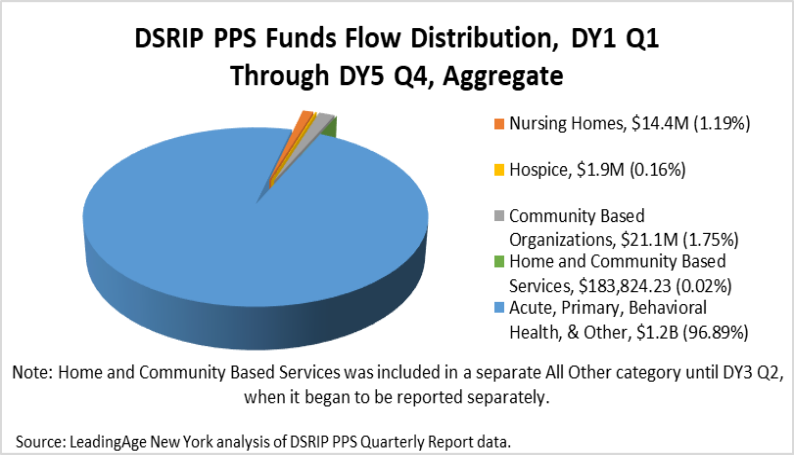


Figure 2

In order to rebuild and revitalize our long-term care system in the wake of this devastating pandemic, and to care for our growing population of older adults, we must prioritize long-term care in major Medicaid policy initiatives in New York State. The unique needs of older adults and the bifurcated (Medicare/Medicaid) financing and organization of the health care services they use must be considered from the outset and not squeezed into molds designed for other services and populations. Waiver programs should also be coordinated with the State's impending Master Plan on Aging and its Reimagining LTC Task Force.

We recommend the following changes in the draft waiver to address the needs of older adults and dual eligible New Yorkers. Our recommendations are organized by applicable section of the waiver request.

I. Investments in Regional Planning through HEROs

The draft waiver proposes the creation of regional planning entities, "HEROs," charged with evaluating health equity and identifying social care (non-medical social support) needs and developing advanced value-based payment (VBP) arrangements to address those needs. It also provides for the creation of regional social determinants of health networks (known as Social Determinant of Health Networks or SDHNs) that will contract with managed care plans and their "lead VBP contractors" (e.g., large health systems) to address social care needs via the advanced VBP arrangements. These entities – one per region – will drive nearly all of the initiatives under the waiver.

The waiver should ensure that HEROs include on their governing bodies MLTC plans and PACE programs, Area Agencies on Aging, and long-term care and aging services providers representing the continuum of LTC. It should require the HEROs to assess and address the needs of their regions' older adults and others who require LTC services and their caregivers. Similarly, SDHNs should be required to include long-term care and community-based organizations with a mission to address the unique needs of older adults.

The waiver proposes to draw the HERO planning regions based on managed care rate-setting regions. Instead, they should be drawn based on utilization and referral patterns for health care services and consultation with stakeholders. In 2012, the Department created regions, based on

public input and utilization patterns, for purposes of funding regional planning activities. While patterns may have changed in the interim, it may be worthwhile to consider the configuration of those regions, which are available here.

II. Investments in Advanced VBP Models that Fund the Coordination and Delivery of Social Care via an Equitable, Integrated Health and Social Care Delivery System

Nearly two-thirds of the waiver dollars ($8.7 billion) is allocated to "health equity-focused system redesign," and of that $8.7 billion, $7 billion is invested in "advanced VBP models." VBP arrangements also drive the allocation of social determinants of health funding, the Enhanced Supportive Housing Pool, and the COVID-19 Unwind Quality Restoration Pool. We are concerned that this foundational element of the waiver, which drives the allocation of nearly all of the funds requested, will not support investment in the long-term care system or services for older adults. As discussed below, the bifurcation of coverage between Medicare and Medicaid for older adults makes it very challenging to develop advanced VBP arrangements that include long-term care services.

Notably, nowhere does the VBP section of the waiver reference dual eligibles, older adults, or long-term care. This section emphasizes prepaid or global payment arrangements, and transfer of risk to VBP contractors, referencing episodic or bundled-payment arrangements involving Medication-Assisted Treatment, maternal health, alternative payment models with federally qualified health centers, and individuals experiencing significant episodic behavioral health needs. It identifies potential subpopulation arrangements as individuals experiencing chronic homelessness; children in foster care; individuals with I/DD who are in managed care; individuals who have previously been incarcerated; and persons living with HIV/AIDS or at high-risk of contracting HIV/AIDS. It also includes ongoing primary care investments. Older adults and long-term care are conspicuously absent.

The reason for this omission is likely that advanced VBP arrangements are premised on the assumption of risk by providers that can reduce overall spending principally through reductions in avoidable hospital use. However, when a managed long term care plan or LTC provider reduces the hospital use of dual eligibles, 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.

To date, the State has not been able to articulate or promote advanced VBP arrangements for the dually-eligible population receiving long-term care services. The overwhelming majority of the State's Medicaid beneficiaries receiving long-term care services are dual eligibles enrolled in partially-capitated MLTC plans. Partially-capitated MLTC plans are the single largest payer for long-term care services in New York. The partially-capitated MLTC plans enrolled 244,485 beneficiaries as of April 2022, in comparison with 32,650 beneficiaries enrolled in fully-integrated MAP plans, and 6,421 beneficiaries enrolled in PACE programs. Even though these partially-capitated plans bear so much responsibility for long-term care services and even though advanced VBP arrangements are the foundation for the waiver, the State's updated VBP Roadmap indicates that the State is abandoning VBP for partially-capitated MLTC plans. It will no longer calculate the VBP quality measures for those plans, except for the potentially

avoidable hospitalization measure. It makes VBP for partially-capitated plans optional, but does not present a vision for VBP among those plans.

While advanced arrangements might be conceptually feasible in the context of the MAP or PACE plan, the risk-based VBP arrangements undertaken by those plans typically involve Medicare-covered benefits and do not incorporate long-term care services. Nor does the DOH VBP Roadmap include specially-tailored arrangements for PACE and MAP plans that include long-term care services. Instead, the Roadmap applies the same requirements to MAP and PACE as mainstream managed care plans. Those arrangements do not include long-term care services. Further, we are unaware of any MAP or PACE programs plans that currently engage in total cost of care or advanced VBP arrangements that include *both* Medicare benefits and *Medicaid LTC* benefits (other than the PACE programs arrangements with the state and federal governments).

Even VBP arrangements under Medicare Advantage ISNPs cover only Medicare services, not long-term care. We are likewise unaware of Medicare Advantage or Medicare ACO VBP arrangements that include long-term care benefits. As a practical matter, individual long-term care providers (including those that operate continuing care systems) generally do not have the overall census, much less the volume of enrollment in a single MAP or PACE plan, to accept a total cost of care budget.

To reduce the barriers to VBP in long-term care, the waiver should attempt to 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 and nursing home care, and social care services reduce avoidable hospitalizations and other high-cost services reimbursed by Medicare. If approval could be obtained in this waiver, and a portion of the savings generated for Medicare could be captured and shared, they could be reinvested in MLTC, PACE, and MAP plans and shared with network providers. As an initial step, the Department should eliminate its "Medicare Savings Adjustment" (MSA) whereby it claws back PACE savings generated to Medicare above 3% of the premium.

In addition, the waiver should include dedicated funding for unique VBP arrangements tailored for MLTC, PACE and long-term care providers including:

- **Quality and Pay-for-Performance Arrangements:** The waiver should provide for an increase in funding for quality incentive and pay-for-performance arrangements for MLTC plans and their network providers. Since MLTC plans and the long-term care providers in their networks are not likely to be able to engage in advanced VBP arrangements involving total cost of care or combining Medicare and long-term care services, the waiver should also invest in alternative VBP arrangements that would benefit dually-eligible beneficiaries and the long-term providers that serve them.
- **Quality Funding for Nursing Homes:** The waiver should also allocate funds toward quality incentives for nursing homes that meet performance metrics. Nursing homes are largely carved out of the partially-capitated MLTC benefit package and are not likely to benefit from Medicaid managed care-driven VBP arrangements. Currently, the nursing home quality pool is self- funded through a withhold from rates. The State and federal

governments are increasingly focused on quality in nursing homes, but have not dedicated any new funding towards nursing home quality initiatives.

- **Workforce Funding to Test Innovative Models:** The waiver should include funding to enable long-term care providers to pay competitive wages and test innovative models of recruitment and retention. Due to inadequate Medicaid rates and very limited private payer penetration in long-term care, long-term care providers have been unable to compete with other employers for staff. As a result, home care agencies have been forced to delay or refuse new admissions, nursing homes have been forced to close units and suspend admissions, and hospitals have been unable to discharge patients who need post-acute care or long-term care. The waiver should fund not only training as currently proposed (see Capacity Building below), but also wage enhancements and innovative models that test the impacts of higher wages on recruitment and retention and on patient and resident outcomes. These models might also include career ladders, peer mentoring, flexible scheduling, apprenticeships, and partnerships with community colleges and high schools.
- **Transitions of Care and Discharge-to-Community VBP Arrangements:** One possible model for a long-term care focused VBP arrangement would be one that rewards MLTC plans and long-term care providers for successful transitions from nursing homes to the community and transitions of care along the acute/post-acute/long-term care continuums. These could be pay-for-performance initiatives or shared savings initiatives that enable plans and providers to share in projected savings generated from reduced nursing home lengths of stay. Potential participants in these models might be MLTC plans and PACE programs, nursing homes, assisted living facilities, home care agencies, and other community-based providers.

III. Investments in Social Determinant of Health Networks (SDHNs) Development and Performance

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. We are concerned that the waiver request may duplicate or disrupt existing services without addressing the unique, unmet needs of older adults. In particular, MLTC plans face challenges in connecting their members with certain non-covered services, such as age-appropriate behavioral health services and housing. In addition, dually-eligible older adults who do not yet need long-term care services and principally receive coverage of their health care through Medicare would benefit from expanded access to social care services to help them to maintain their independence and health in the community.

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. As noted above, many of the social care interventions identified in the waiver are already offered to Medicaid beneficiaries receiving long-term care services. The waiver should 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 them 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 utilization do not accrue to MLTC plans, and MLTC plan premiums are already at the bottom of the rate range.

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. Those investments should include resident assistant services or service coordination in affordable senior housing, as described below (see Developing Supportive Housing below) and Naturally-Occurring Retirement Communities. In addition, they should include care coordination, social engagement, respite services, and training and support for unpaid, informal caregivers.

We support the waiver's use of plan and provider assessments to identify social care needs. We agree that providers and care managers who are familiar with the beneficiary and accountable for addressing his/her needs are in a better position to conduct an accurate assessment than an independent assessor. We urge DOH to reconsider its commitment to independent assessment in MLTC, consumer directed personal assistance services and personal care services.

We further urge DOH to seek a waiver of HCBS conflict of interest rules that prevent providers from delivering integrated care and conducting the assessments and care planning that are essential for risk-based VBP arrangements. In prior comments and letters, we have provided the Department with more detailed analyses of the challenges these rules pose for integration of long-term care services and VBP. If long-term care providers are to engage in VBP arrangements that transfer risk, they must be permitted to conduct assessments and engage in care planning.

IV. Capacity Building and Training to Achieve Health Equity Goals

The waiver should invest in workforce initiatives that support rebuilding the long-term/post-acute care workforce. The workforce initiatives in the waiver application focus on investments in the Workforce Investment Organizations (WIOs) and expanding the role of the WIOs beyond long-term care to include acute and primary care services. However, the focus on long-term care should not be abandoned. 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 funds are distributed so that WIO training is offered for all long-term/post-acute care roles and across long-term/post-acute care delivery settings.

The waiver appropriately cites career ladders as an important component of workforce development. However, it seems to focus predominantly on *diverting* entry level long-term care staff (e.g., home health aides, dietary aides, and nurse aides) to *non-long-term care jobs* as

community health workers. With severe staffing shortage across the long-term/post-acute care continuum which are causing back-ups in hospitals and barriers to care, the waiver should focus resources on career ladders within long-term/post-acute care and support workers interested in progressing from entry level positions to LPN and RN positions and other advanced roles. Progression to advanced roles within paraprofessional certifications —such as peer mentor roles or medication aide roles should also be supported. Similarly, peer mentorship and fellowship programs are needed for home care and hospice nurses and social workers. These programs improve workforce retention and maximize staff contributions to care quality and outcomes.

The waiver speaks to "cross-training of staff to enable cross-coverage between inpatient and ambulatory care settings." However, it overlooks, cross-training of staff among long-term/post-acute care settings. Waiver funds should also support and promote the acquisition and retention of multiple aide certifications in long-term care – personal care aide, home health aide, certified nurse aide -- through universal worker training and stackable credentials. This would help to mitigate workforce shortages by facilitating effective deployment of certified aides across long-term care settings and enable career mobility and advancement.

WIOs should not be the only vehicle for building our long-term care workforce. In addition to training through WIOs, waiver funds should support:

- Provider partnerships with high schools, community colleges, and four-year degree programs to engage and train students in long-term care careers, while improving health equity through cultural competency and the multi-lingual services.
- Provider partnerships with nursing schools to prepare students for home health nursing careers and complex post-acute care, as nursing programs tend to be focused on acute and primary careers.
- Training programs to grow and develop recreation therapists, dieticians, and social workers for long-term care careers.
- Accessible employee wellness programs that include training for managers to help staff manage stress and personal needs and support groups for staff to enhance their emotional and physical wellbeing.

WIO activities should be reported and evaluated. Very little information is currently available about the activities and results of the WIOs. The Department should collect and publicly report data on WIOs' training and workforce outcomes, such as numbers trained by certification, new certifications awarded, recertifications, subject matter of the trainings, training format (virtual, in-person, didactic, lab), training satisfaction and completion rates, job preparedness, retention rates, and client outcomes.

V. Developing Supportive Housing and Alternatives to Institutions for the Long-Term Care Population

We commend the waiver's focus on housing and developing community-based services for individuals in need of long-term services and supports. However, we are concerned that the $1.57 billion Enhanced Supportive Housing Pool will not address the housing-related needs of older adults. Supportive housing is specific model, and other housing and congregate living models tailored to the needs of older adults and individuals who need skilled nursing and/or

personal care should also be supported with waiver dollars. Moreover, as discussed in more detail above, the use of VBP proceeds to fund the pool raises concerns that services for older adults who are dually-eligible and in need of housing supports and long-term care services will be bypassed.

Investments in housing-related services should include Affordable Senior Housing with Services and Medicaid Assisted Living Programs ("the ALP"). Affordable Senior Housing with Services is a proven model that saves both Medicaid and Medicare dollars. Service Coordinators (or "resident assistants") work with the residents to promote their emotional well-being, stronger social supports, and better connections between residents, their property managers, and the programs and resources they need in the community. This model generates Medicaid and Medicare savings by providing low-income seniors with "light-touch" services that help them to prolong their independence and improve their quality of life. It is exactly the type of social care investment that the waiver is designed to support.

Rigorous studies have shown that affordable senior housing with resident assistant services reduces Medicare and Medicaid spending.[3] A three-year research study focused on the health care savings and service utilization of Selfhelp Community Services residents living in Queens compared to older adults from the same zip codes. The study found that the odds of Selfhelp residents being hospitalized were approximately 68 percent lower than that of the comparison group, and the odds of visiting the emergency room were 53 percent lower.[4] Notably, with the resident assistance model in place, less than two percent of Selfhelp's residents are transferred to nursing homes in any given year.[5] While it cannot serve as an alternative to nursing home care, affordable senior housing with services does help to optimize the health and independence of older adults and can delay entry into long-term care services and nursing homes.

The Medicaid assisted living program (ALP) is another successful model that offers a more homelike, community-based setting than a nursing home for individuals who need 24/7 support and supervision, and personal care, but not skilled nursing care. We were pleased to see the waiver's reference to additional SSI state supplemental funding for high needs populations. The room and board rate of $43 per day for ALP (and other adult care facility) residents is wholly inadequate.

The waiver assumes that supportive housing is a viable strategy for transitioning nursing home residents to the community. Unfortunately, this is not a valid assumption. Long-term nursing home residents typically have complex medical conditions and require 24-hour skilled nursing care. Ninety-seven percent of nursing home residents in New York require assistance with toileting, and 40 percent require two people to assist with sitting up or turning in bed. We are

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[3] 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.

[4] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs*. Oct. 2018.

[5] Spotlight: A Conversation with Mohini Mishra, Selfhelp Realty Group. The Melamid Institute for Affordable Housing COVID-19 Resource Center. National Housing Conference (nhc.org), available at https://covid19.nhc.org/best-practice/a-conversation-with-mohini-mishra-selfhelp-realty-group/ .

unaware of any supportive housing program that offers assistance with toileting or sitting up in bed, much less skilled nursing care. Further, over half of all nursing home residents have diagnoses of Alzheimer's disease or other forms of dementia. Supportive housing programs are likewise ill-equipped to care for individuals with dementia.

Thus, in addition to supportive housing, the waiver must provide support for nursing homes. We agree that everyone should be able to access services in the most integrated setting. Sadly, many older adults have complex medical needs, requiring 24/7 skilled nursing care, coupled with cognitive impairments that interfere with their ability to self-direct their care. Too many lack close family or informal supports who could assist with directing their care and filling in the gaps in services. *Health equity demands that we make available the highest quality care for the most vulnerable New Yorkers.* We cannot abandon those who need nursing home care because we wish they could be served in an independent living setting, when in fact they cannot.

Instead, we should ensure that these most vulnerable individuals have access to homelike residential settings, where their autonomy is honored and where they can lead vibrant social lives, rich with relationships and meaning. The Medicaid waiver should provide operating support for smaller, more homelike nursing home settings that have a strong track record of infection prevention.[6] Early research suggests that Green House or small house facilities are more successful at preventing COVID infection than others. The waiver should also fund enhanced medical care and palliative care in nursing homes to enable nursing homes to avoid hospitalization and accept discharged hospital patients earlier in their recovery. And, it should support staff-intensive models, like Comfort First, for nursing home residents with dementia who present high supervision and social engagement needs and high risks for transmission of COVID. While the recently-enacted state budget includes capital support for these models, it does not provide any operating support. Inadequate Medicaid rates will make development of these models infeasible for facilities that serve predominantly Medicaid beneficiaries. Operating support is needed to make these models available to the most vulnerable Medicaid beneficiaries.

Finally, the funds flow of the waiver must make allocated funds reasonably available to housing and congregate living programs that serve older adults. Under the proposed waiver, the Enhanced Supportive Housing Pool will be funded by MCOs and VBP arrangements with matching 1115 waiver dollars. Again, advanced VBP arrangements are unlikely to benefit older adults. Targeted waiver dollars must be invested in residential options for older adults.

VI. COVID-19 Unwind Quality Restoration Pool for Financially Distressed Hospitals and Nursing Homes

The waiver proposes to create a $1.5 billion VBP pool that would be available to financially distressed safety net and critical access hospitals and nursing homes that have a high Medicaid payor mix to engage in VBP arrangements and facilitate post-pandemic quality improvement and contribute to health equity. Facilities would engage with MCOs, HEROs, and SDHNs to coordinate these efforts with regional plans and strategies.

[6] Waters, R. The Big Idea Behind a New Model of Small Nursing Homes. *Health Affairs.* Mar. 2021.

These funds should be distributed equitably among hospitals and nursing homes and should not be distributed exclusively based on VBP arrangements. Allocating funds based on VBP engagement will disadvantage nursing homes, unless the Department includes fee-for-service quality-related payments in its definition of VBP engagement. As noted above, the VBP arrangements described in the waiver application and the Department's VBP Roadmap are unlikely to serve dual eligibles, as savings generated will accrue to Medicare. Moreover, since long-term nursing home care for dual eligibles is largely carved out of the partially-capitated MLTC benefit package, the vast majority of long-term nursing home services will be excluded from these arrangements.

Restoration Pool funds should be made available to promote health equity by supporting nursing homes with a high percentage of Medicaid bed days to:

- **Pay Competitive Wages for Staff**: Our nursing home members are doing everything within their power to recruit and retain staff to deliver high-quality care and meet new minimum staffing requirements. However, they are unable to compete with other employers, due to inadequate Medicaid rates. According to the most recent publicly-available PBJ data from CMS (third quarter 2021), *over 80% of New York State's nursing homes fell short of at least one of the three targets and would be deemed non-compliant with the statute.* An increase in support for staff wages is necessary to improve staffing levels in facilities that serve significant numbers of Medicaid beneficiaries.
- **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. Enhancing the medical services and specialized infection prevention expertise of nursing homes will promote reductions in hospital use and improved outcomes for residents.
- **Support the Operating Costs of Innovative Nursing Home Models:** These models, such as Green House and small house, person-centered dementia care, palliative care, and restorative care models, have higher operating costs than conventional nursing homes. Rate adjustments are needed to ensure that they are developed and available to Medicaid beneficiaries who need nursing home care. As discussed in more detail above under Developing Supportive Housing, although these models are more expensive to operate, they support the health equity goals of the waiver by optimizing the quality of life of our most vulnerable New Yorkers and reducing avoidable hospital use.

VII. Statewide Digital Health and Telehealth Infrastructure Funding

We welcome the investment in digital health and telehealth, but were puzzled by the $9 million allocated to:

> equip approximately 600 Skilled Nursing Facilities (SNF) who are not dually enrolled in Medicare with telehealth equipment for their residents, which includes an estimated $370,000 estimated for claim costs, based on 50 percent of the 200,000 Medicaid enrollees in SNF and a $37 per visit cost.

There seem to be some mistaken assumptions underlying this proposal. Specifically, all nursing homes in New York State that participate in Medicaid are also required to be Medicare-certified.

A total of approximately 600 nursing homes are licensed statewide, and nearly all are dually-certified. There are approximately 90,000 total nursing home residents in New York State, of which about 80 percent are Medicaid beneficiaries. With the exception of some pediatric and young adult residents and some immigrants, virtually all nursing home residents on Medicaid also have Medicare coverage.

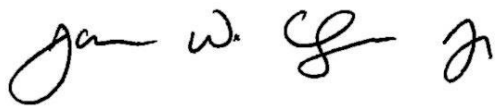
Nevertheless, the COVID pandemic has heightened demand for telehealth in nursing homes. Even in the absence of a pandemic, telehealth is valuable to enhance medical and behavioral health services in nursing homes, to avert avoidable emergency department and hospital use, and to provide access to specialty care. Accordingly, waiver funds should be deployed to support:

- Software platforms that enable effective transitions in care and health information exchange;
- Equipment such as telehealth carts, advanced cameras, and diagnostic and monitoring devices;
- Staff training to use the equipment and software;
- Licenses for software and contracts with telehealth vendors;
- Upgrades to internet connectivity, including improvements in WiFi and broadband connections.

In addition to telehealth services, investments are needed to support upgrades in electronic health records and health information exchange between nursing homes and other care partners, such as hospitals, physician practices, and home care agencies.

Thank you very much for your consideration of these issues. We would welcome an opportunity to meet with you at your convenience to discuss our recommendations.

Sincerely yours,



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