# Statement on New York State's Implementation of Medicaid Section 1115 Waiver

***Introduction***

LeadingAge New York represents nearly 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout New York State. We are pleased to provide comments on New York's implementation of its Medicaid Section 1115 waiver authority, which seeks to utilize a managed care system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, extend coverage to certain individuals who would otherwise be without health insurance, and restructure the health care delivery system through the Delivery System Reform Incentive Payment (DSRIP) program.

For decades, the State has focused on curbing Medicaid long-term care (LTC) spending by reducing provider reimbursement and more recently by shifting to a managed care system for service delivery and coordination. Investments or regulatory changes that would support the development of new capacity or lower-cost models of LTC have not been a priority, nor has investment in programs that would help seniors to avoid or delay enrollment in Medicaid.

On the contrary, as the State has pursued an ambitious effort to provide care management for all and reduce avoidable hospital use, only a minuscule fraction of the billions of dollars invested in the health care delivery system through DSRIP and other infrastructure programs has been invested in the LTPAC sector. Instead, funds have been targeted at primary care and behavioral health care and essentially compensating hospitals for lost volume. As currently structured, the State's DSRIP program and value-based payment (VBP) initiatives are not only unlikely to drive new investment in LTPAC and senior services; they are likely to have the opposite effect unless the approach changes.

Rather than investing new funds in the LTPAC sector, the State has indicated that it will continue to fund its managed long-term care (MLTC) quality pool and its nursing home quality initiative through withholds of payments and that these withholds will grow exponentially in conjunction with VBP initiatives. Furthermore, the State has indicated that it intends to rely on savings generated through VBP arrangements as the source of new investments in health care delivery, community-based organizations, and affordable housing. However, because the overwhelming majority of savings derived from the LTPAC sector will accrue to Medicare (rather than Medicaid), there will be little, if any, savings to be invested in that sector. As a result, if the State pursues this strategy, the LTPAC sector will experience only reductions in revenue and no new investment, despite a rising population of older New Yorkers.

Although they have not been given a central role in the State's health care reform efforts, LTPAC providers and MLTC plans are well-positioned to contribute to New York State's initiatives to transform care and reduce avoidable hospital use. They serve medically-complex and frail elderly and disabled individuals, who experience high rates of hospitalization and frequent transitions between health care


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settings. With longstanding experience and clinical expertise in the care of seniors and people with complex conditions and functional limitations, LTPAC providers have been at the forefront of innovative models of coordinated and person-centered care.

Our remaining comments focus on two areas central to the future of LTPAC providers and MLTC plans and their ability to advance the goals of the State's 1115 waiver authority.

***Strategic Investments in Health Information Technology***

Success in today's LTPAC operating environment depends heavily on a robust health information technology (IT) infrastructure. The ability to collect, share, and analyze clinical and financial information electronically is integral to all of the new models of care and payment embraced by the State and federal governments under health care reform and as part of the State's 1115 waiver authority. Providers need the capacity to collect and share information electronically with care partners securely and efficiently, in order to coordinate care, avoid unnecessary utilization and optimize outcomes. Data and analytics capacity is also critical to quality measurement and improvement efforts and to population health management initiatives. As the State and federal governments move from fee-for-service payments to VBP arrangements, effective health IT solutions that link clinical, cost and expenditure data across settings are needed to assess and manage the risks associated with these new payment arrangements.

Despite the clear need for sophisticated health IT in today's health care environment, public investment in the health IT infrastructure needed by LTPAC providers to succeed under MLTC and VBP has been negligible. Given their heavy reliance on Medicaid and Medicare revenues and their shrinking margins, many LTPAC providers have not been able to self-fund the substantial investments in robust electronic health record (EHR) systems, health information exchange (HIE) and data and analytics tools necessary for these new initiatives.

While general hospitals and physician practices have benefited from concerted federal and State efforts to fund investment in EHRs and HIE, the LTPAC sector has been largely overlooked. DSRIP payments through performing provider systems (PPSs) are unlikely to fill this major gap in health IT investment. Based on our analysis of the PPS first quarterly reports, only 4.2 percent of DSRIP incentive payments are projected to flow to nursing homes over the next five years, only 3.6 percent to community-based organizations, and only 1.1 percent to hospice programs. More recently, State infrastructure grant initiatives (e.g., Essential Healthcare Provider Support Programs, etc.) have excluded LTPAC providers.

The heavy reliance on public payers in the LTPAC sector, together with progressively shrinking margins, has prevented necessary development of IT infrastructure. This gap will inhibit the adoption of new models of care and payment by LTPAC providers and the ability of the State and federal governments to advance the Triple Aim and the objectives of the 1115 waiver.

Like hospitals and physician practices, LTPAC providers require a substantial public investment in IT infrastructure. The adoption of EHRs and broad participation in health information exchange among LTPAC providers will be critical to their success in VBP arrangements and the State's DSRIP efforts. LTPAC providers will also need public funding for technology to support the management of financial

risk, quality measurement, and performance improvement efforts under VBP. LeadingAge NY is recommending that $100 million be made available for EHR adoption and HIE in the LTPAC sector. A significant portion of these funds should be dedicated to expenses that cannot be capitalized, such as software leases and licenses, and associated training costs.

In addition to investing in EHRs, HIE and systems to support data and analytics, the State should make funding available to expand access to telehealth and remote patient monitoring tools. These technologies can improve access to care, while reducing transportation expenses, home health nurse visits and avoidable hospitalizations. These modalities are especially useful in rural areas, where telehealth and remote patient monitoring can allow for more efficient use of a limited workforce.

***Medicare-Medicaid Alignment***

The centerpiece of New York's efforts to rein in LTC costs while producing better outcomes has been mandatory enrollment in MLTC plans. The decision to institute mandatory enrollment in MLTC was based on the assumption that MLTC could reduce spending and improve outcomes by rationalizing provider payments and providing care management and utilization controls that would produce more coordinated care and reduce unnecessary services. Managed care quality reports indicate that MLTC plans are, indeed, making available high-quality care through care management and contracted networks of providers. The plans' care coordination activities with physicians and hospitals are believed to be effective in reducing avoidable hospitalizations and improving outcomes.

However, MLTC plans' ability to reduce LTC utilization is limited by the intensive needs of the beneficiaries they serve and various State policies. Unlike mainstream Medicaid managed care plans which serve a mix of beneficiaries in good health and poor health, and can generate savings by reducing duplicative services and avoidable hospitalizations, MLTC plans, by definition, serve beneficiaries with complex conditions and functional limitations, the vast majority of whom would otherwise qualify for nursing home placement. MLTC plans' only options for producing savings within their benefit package are to substitute lower cost services for higher cost ones or to limit LTC service utilization. Even these options are severely limited by the State's continuity of care and fair hearing policies. Likewise, the plans' ability to generate savings by reducing the prices they pay for services is limited by State wage and provider rate requirements.

Although MLTC plans and their network providers have limited ability to generate savings on Medicaid-covered LTC services, there are opportunities for those plans and providers to generate reductions in Medicare spending on acute and post-acute care. LTPAC and senior services providers have the clinical resources and expertise to meet the needs of complex patients and residents with multiple co-morbidities and functional limitations in multiple settings. LTPAC and senior services providers generally also have far more intimate and ongoing knowledge of their patients and residents, their living environments, their caregivers, and their support needs than a typical physician practice or hospital.

However, the separation of LTPAC funding streams and associated policies between Medicare and Medicaid represents a significant impediment to real reform. Because MLTC plans are not paid by Medicare, there is no common pool of expenses from which Medicare and MLTC plans can share savings. In fact, if LTC providers and MLTC plans succeed in reducing inpatient and post-acute

utilization by dual eligible beneficiaries, they will only drive up Medicaid LTC utilization and associated spending. Every day that a dually-eligible beneficiary is in the hospital or receiving post-acute care services represents a day covered by Medicare, rather than Medicaid. If those Medicare-funded acute and post-acute days are reduced, Medicaid will have to fill in the gap. Thus, the Medicare-Medicaid divide at best creates perverse incentives, and at worst it can lead to cost shifting and lack of accountability for delivering care in the most appropriate setting.

New York is seeking federal approval of a VBP Medicare alignment proposal to enable the State to "virtually pool" Medicare and Medicaid payments so that providers and plans can share in the risk of overall health and LTC spending, regardless of the payer source. This concept will be key to the successful engagement of LTC plans and providers in VBP initiatives. However, we understand that the federal government has not yet shown interest in moving forward with this virtual pooling concept.

Without such a construct, LTPAC providers and MLTCs may be deprived of the opportunity to generate meaningful VBP shared savings. This could lead to continued stagnation in the level of Medicaid payments, which would further threaten access to high quality LTPAC services throughout the State and undermine the goals and expectations of the 1115 waiver.

***Conclusion***

LeadingAge New York is appreciative of the opportunity to provide input on New York's 1115 waiver authority. We look forward to working with the State and federal governments on these critically important issues. Please do not hesitate to contact us at (518) 867-8383 with any questions on our input.

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