LeadingAge New York

September 9, 2021

Howard A. Zucker, M.D., J.D.
Commissioner of Health
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: 1115 Demonstration Waiver Concept Paper

Dear Commissioner Zucker:

I am writing on behalf of the members of LeadingAge New York to offer comments on the State's recently released concept paper proposing a $17 billion Medicaid waiver. We were disappointed and baffled to see that this proposal, like the MRT and DSRIP waivers implemented by the prior administration, once again overlooks the needs of vulnerable older adults and people with disabilities who require long-term care (LTC) services. The proposals contained in the concept paper purport to focus on those who were disproportionately impacted by the COVID-19 pandemic. As you know, 87 percent of the people who died of COVID-19 in New York State were over age 60.[1] However, the paper barely acknowledges the devastating impact of the pandemic on older adults. While the concept paper calls for a coordinated effort across the sectors of the health delivery and social services systems and an equitable recovery for all, it offers little to assist New York's battered LTC sector to recover from the pandemic.

As the primary payer for LTC services in New York and nationwide, Medicaid bears significant responsibility for the financial viability of the sector, its ability to provide access to high-quality care, and its capacity to compensate staff appropriately for the difficult and essential services they deliver. The prior administration largely abdicated that responsibility. For too many years, New York's principal focus for LTC has been to reduce Medicaid spending on these services. Year after year, New York's LTC sector has borne deeper Medicaid cuts than any other health care sector (Figure 1), while costs have risen and administrative requirements have grown exponentially. Although New York's LTC providers have taken more than their fair share of cuts, they have not gotten their fair share of capital investments or funding from the MRT waiver's DSRIP program. Only about 2 percent of DSRIP funds and 10 percent of Statewide Health Care Facility Transformation Program funds have been allocated to LTC providers. (Figures 2 and 3)

[1] NYS Dept. of Health, COVID-19 Fatalities by Age Group, accessed 8/26/2021, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n

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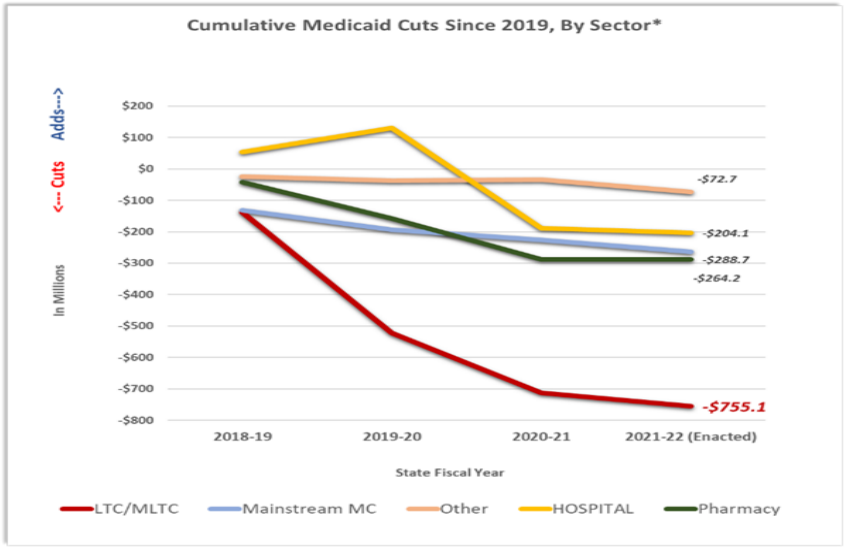


Note: Figures are based on State-calculated impacts of new Medicaid budget actions since 2018-19, as well as enacted cuts reflected in the SFY 2021-22 Medicaid spending plan. More than $1.5 billion in retroactive cuts to Medicaid managed care and MLTC rates ascribed to lower utilization due to the pandemic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

Figure 1

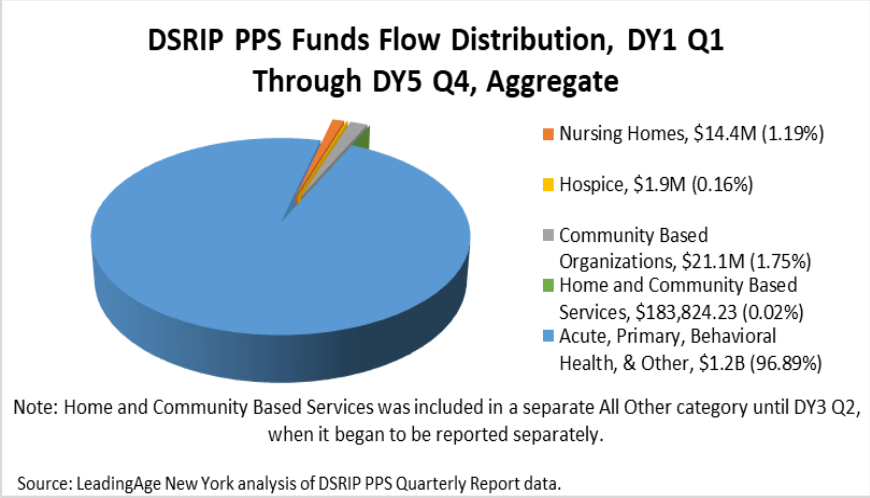


Figure 2

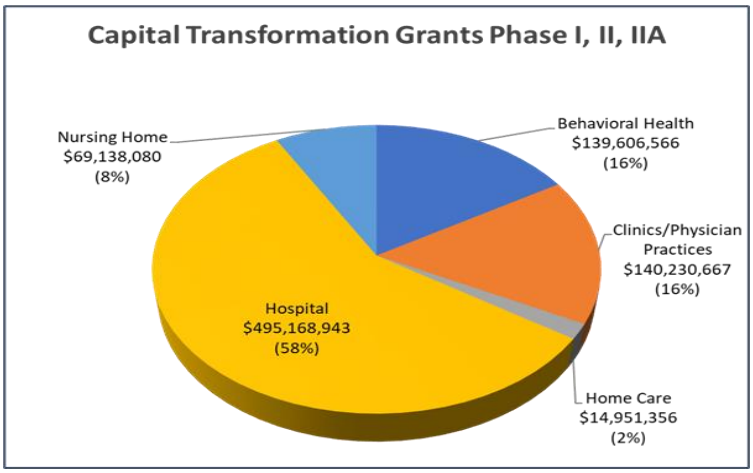


Figure 3

The prior administration's policy of depleting the LTC system continued even when the pandemic struck and public health experts projected that older adults and those living in congregate care facilities would be at gravest risk for severe disease and death. At the height of the pandemic, when most states poured resources into their LTC systems, offering Medicaid rate increases, staffing support, and other funding, New York State cut Medicaid reimbursement by 1.5 percent (a $168 million cut on nursing homes alone). By contrast, according to the Kaiser Family Foundation, during the pandemic, more than two-thirds of states increased Medicaid payments for home and community-based services (HCBS) providers, and more than half increased Medicaid payments to nursing homes.[1]

The extraordinary unbudgeted costs of the pandemic and dire workforce shortages, coupled with years of under-funding, are decimating our LTC sector. In 2019, two of every three not-for-profit nursing homes were operating at a loss, while 90 percent of public homes were losing money, including three of the five veterans' homes operated by the Department of Health. Based on data gathered from members, the number of homes losing money on operations skyrocketed in 2020, and margins have deteriorated further due to the financial impact of the pandemic and across-the-board Medicaid cuts. Since 2014, 50 public and not-for-profit nursing homes have been sold to for-profit entities, and 20 nursing homes have consolidated or closed. 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. Our nursing home members are already closing units and suspending admissions for lack of adequate staff. Our home care members are turning away new patients because they don't have nurses to conduct admission assessments, and they are unable to fill needed home care hours. This lack of capacity will create growing challenges for hospitals, which will face increasing difficulty discharging patients who need post-acute care. Hospital beds will remain occupied by patients who no longer need hospital care, but have nowhere else to go. Those beds will not be available to other patients who require acute care.

We had hoped that through the successor to the MRT waiver, the State would begin to rectify the historic inequity in the allocation of waiver funds between the long-term/post-acute care sector and other health care sectors. We had hoped that it would include an innovative and concerted approach to strengthening our LTC system, promoting high quality and access to all levels of LTC. Sadly, the State's $17 billion waiver proposal neither dedicates funding for LTC nor offers any vision for the future of LTC in New York. If even a fraction of those funds were dedicated to revitalizing the long-term/post-acute care delivery system and supporting recruitment and retention of staff in nursing homes and other providers that were ineligible for the enhanced HCBS federal matching dollars, we could make progress in assuring that the state will have adequate capacity to serve its aging population.

There are several ways in which the concept paper misses the mark with respect to meeting the needs of older adults and the LTC system:

- It speaks to expanding on the value-based payment (VBP) initiatives under DSRIP. However, these DSRIP initiatives did not result in any meaningful new resources for LTC providers. They were largely premised on reinvesting savings derived from reducing avoidable hospitalizations. As you know, the LTC population is primarily composed of dually eligible beneficiaries, and any savings from avoiding hospitalizations accrues to Medicare. Under DSRIP, the State was unable to secure CMS's approval to apply Medicare hospital savings to support Medicaid waiver VBP initiatives and did not invest any new dollars in VBP initiatives for LTC. The concept paper once again appears to focus VBP on the non-dually eligible population, specifically mentioning initiatives involving individuals with serious mental illness or substance use disorders and primary care. It does not appear to include any new resources or opportunities for VBP in LTC.

- The concept paper emphasizes efforts to address the social determinants of health through new planning entities known as HEROs, but fails to reference the social factors that specifically affect older adults or to recognize the long-standing activities of LTC and senior services providers to address these factors, including through home-delivered meals, affordable senior housing with services, assisted living programs, senior centers, MLTC and adult day health care case management, and more. While we support the focus on social determinants of health, we know that prior planning efforts (e.g., DSRIP PPSs) and networks have required sizeable investments of resources in administrative infrastructure and have largely ignored the needs of older adults and the networks of providers that serve them. This proposal threatens to do the same, at great detriment to aging New Yorkers and their loved ones.

- The only substantive reference to nursing homes in the concept paper is in the context of creating alternatives to institutionalization and incarceration by expanding supportive housing. LeadingAge New York wholeheartedly supports efforts to expand HCBS and ensure that individuals with LTC needs are served in the most integrated setting appropriate to their needs. Unfortunately, the vast majority of nursing home residents cannot be appropriately cared for in supportive housing, nor will the new "medical respite programs" provide long-term, skilled nursing care for older adults. 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 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.

  For older adults with LTC needs who do not require nursing home care, but do require housing or a lower level of 24/7 care, we support investments in affordable housing with

services and Medicaid assisted living programs. Although the MRT supportive housing dollars were supposed to provide support for affordable senior housing with services, those dollars were overwhelming awarded to traditional supportive housing models for individuals with serious mental illness and not to programs that serve frail elderly individuals.

Our Affordable Independent Senior Housing Assistance Program proposal to expand funding for affordable senior housing with services – a proven model that saves both Medicaid and Medicare dollars – would align well with this aspect of the concept paper. While affordable senior housing cannot serve as an alternative to nursing home care, it does help to optimize the health and independence of older adults and can delay entry into nursing homes. However, the Department chose not to advance a model that successfully addresses the needs of older adults, nor did it choose to invest in expanding or otherwise enhancing the Medicaid assisted living program, an effective program that can properly serve older adults with cognitive or physical disabilities in the community.

- The concept paper's proposal to redesign and strengthen the health and behavioral health systems to respond to future pandemics and disasters overlooks the critical roles played by the long-term/post-acute care system and the devastating effects of the pandemic and other disasters on the vulnerable people they serve. The concept paper refers to utilizing "the larger, stable, high quality systems throughout NYS in a manner that supports more vulnerable patients and their community healthcare systems during a pandemic response." How will these larger systems support long-term/post-acute care systems? It is our understanding that many of our members supported the hospital systems during the pandemic by dedicating space in their facilities to acute care and by creating COVID-only post-acute care facilities.

- The concept paper also offers support for physical and IT infrastructure planning for hospitals to update their oxygen, electrical, and IT systems and convert space. Why not provide resources to nursing homes and assisted living programs to update HVAC systems and convert double rooms to single rooms to support infection prevention? Similarly, the concept paper proposes inventory planning activities for safety net hospitals to determine their needs for consumable supplies and how to fund them. Given the dire shortages of personal protective equipment and the lack of attention to the needs of LTC providers and their patients during the early months of the pandemic, why is this initiative limited to safety net hospitals?

We appreciate the concept paper's mention of investment in workforce recruitment and retention in LTC settings, including nursing homes. However, it lacks detail and does not specify the amount of funds that would be dedicated to LTC. As you know, nursing homes are largely ineligible for the federal funds made available through the HCBS enhanced FMAP. Yet, as mentioned above, they are experiencing more severe workforce shortages than ever before and need a sizeable investment in order to continue to attract qualified personnel and deliver high-quality care.

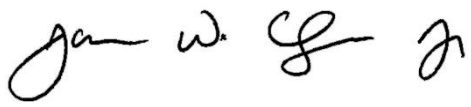
Further, to carry out its recruitment and retention initiatives, the concept paper appears to rely on the WIOs created under the prior waiver. We are interested in learning more about the outcomes of the WIO program and how this iteration would learn from and improve upon the prior version.

We are also optimistic about the references in the concept paper to investments in the State Supplement to SSI. We are hoping that these references are to the Congregate Care Level 3 rate that pays for room, board, and an array of supportive services in adult care facilities. The current rate of just over $41 per day is wholly inadequate. We look forward to learning more about this proposal.

The State's new 1115 waiver demonstration presents a unique opportunity to make transformative and critically needed investments in LTC. It could help ensure that New York's elderly have access to quality care in the future. New York's older adults and people with disabilities who need LTC should have access to a range of services to meet varying levels of acuity and lifestyle preferences. Our Medicaid program should enable those services to be appropriately staffed by qualified personnel. It should support integration of our long-term and post-acute care services with other services along the health care continuum to ensure that transitions from one level of care to another are seamless and that whole people are treated – not just diseases. We have previously submitted an array of proposals for your consideration and would be happy to expand upon them. With a burgeoning population of older adults and a shrinking population of working age individuals, the State cannot afford to overlook this opportunity yet again.

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

Sincerely yours,



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