January 30, 2020

Mr. Mark Kissinger
Special Advisor to the Commissioner of Health
Office of Primary Care and Health Systems Management
NYS Department of Health
Empire State Plaza, Corning Tower 14th Floor
Albany, NY 12237

Re: Comments on CON Reform for Certified Home Health Agencies

Dear Mark,

LeadingAge New York offers the following comments regarding NYS Department of Health's (DOH) position paper on reform of the Certificate of Need (CON) process relating to Certified Home Health Agencies (CHHAs). As you know, LeadingAge New York represents over 400 not-for-profit and public providers of aging services, senior housing, long term and post-acute care, home care, as well as provider-sponsored Managed Long Term Care (MLTC) plans. Our members often provide the continuum of long term care providing New Yorkers with ease of access to services while continuing to age in the most appropriate and independent setting as possible. Our member CHHAs are both freestanding or part of long term care networks. We appreciate the opportunity to comment on your proposal.

In considering reform of the Certificate of Need process, LeadingAge NY believes it is critical that DOH consider the many challenges affecting the field of home health today. Ensuring a financially stable population of certified home health care agencies throughout the state that are well staffed, and providing quality care to all who need it is of utmost importance. We appreciate the opportunity to comment on the Department's position paper and express our concerns regarding the many pressures CHHAs face in the field today.

Combine Options 1 and 2

Of the options presented in the DOH position paper, LeadingAge NY believes that a combination of Options 1 and 2 would be most reasonable for CON reform.

To preface, LeadingAge NY believes that a presumption of no need if there are at least 5 CHHAs per county is an arbitrary method for evaluating need in a service area. Such a threshold per county bears no indication that need is being met. This measure does not take into account the size nor capacity of agencies, the availability of nurses or aides in those agencies, or whether there are gaps of unmet need in a county due to workforce, geography or cultural competence. Treating rural and urban counties the same makes little sense considering the population differences.

13 British American Blvd. | Suite 2 | Latham, NY 12110
P 518.867.8383 | F 518.867.8384 | LeadingAgeNewYork.org

With that said, LeadingAge NY believes that a conservative approach to issuing CHHA CONs is in order. While we oppose the numbered cap on CHHAs, a requirement for agencies to demonstrate need based on patient choice, cultural competency and geographic and travel challenged areas would be appropriate.

We also support elements of Option 2 that would create a specific population-based formula utilizing the number of Medicare enrollees and the existing caseload of each CHHA in the planning area. We would urge you to base this on Medicare and Medicaid ***eligible*** enrollees, not just Medicare enrollees, compared to the existing caseload of each CHHA and other projected population data. And we urge you to add Medicare Advantage, MLTC and Medicaid waiver eligible enrollees to that population as well. We remain concerned, however, that CHHA patient caseload data might not demonstrate the true case capacity or interest of CHHAs in taking on cases due to staffing challenges.

Option 3

LeadingAge does not support a wholesale RFP process that would allow all agencies, both current and new, to compete for planning areas. We urge the Department to consider facilitating a combination of Options 1 and 2 and consider our recommendations below for more efficient and flexible planning area reconfiguration.

Flexibility Regarding Planning Areas

LeadingAge New York believes that providing flexibility in planning areas will help ensure better delivery of CHHA services. As in our comments regarding the proposed LHCSA need methodology, LeadingAge NY urges the Department to consider granting flexibility along county borders for CHHAs. Strict adherence to county lines can sometimes leave areas immediately adjacent to a border unserved or underserved, especially if CHHAs in the planning are located near more populated areas on the opposite side of the county. Currently, there are pockets of unmet need caused by these arbitrary barriers. We believe the overarching goal of the need methodology should be to adequately serve the population, and flexibility should be granted for applicants that demonstrate such need patterns. This flexibility would be particularly helpful upstate.

Further, CHHA patterns of service often mirror one or more hospitals' referral and discharge patterns. When considering planning areas for CHHAs, we ask the Department to consider these patterns. A map of existing general hospital referral regions overlaid by existing CHHA services might allow agencies to demonstrate their ability to deliver services in areas not currently allowed on their agency's CON. Such an exercise would allow CHHAS to reconfigure their services, minus county barrier restrictions, to serve more logical areas in their region, including those harder to reach areas. It would also allow other CHHAs the opportunity to drop down and confirm that they will not serve certain distant areas.

We recommend pursuing this flexibility before moving forward with authorizing additional agencies. The Dartmouth Atlas for Health Care has organized regions based upon patterns of hospital admissions and discharges and might be helpful when considering this option.

Workforce Pressures

Much the state's unmet need is due to lack of workforce, not a lack of agencies. Establishing a need process that authorizes new agencies will not necessarily deliver more care, but may likely exacerbate

workforce limitations by diluting even further the State's limited number of nurses and aides. In addition, adding more agencies will unnecessarily create more layers of management and administration staff. This will likely add to the cost of care and further stretch financial resources away from efforts to develop and retain a viable workforce. In essence, adding agencies could hinder our effort to solve our workforce challenges.

Workforce is the first and foremost concern of our members. The issue is not just a rural one, but affects agencies statewide. CHHAs are facing a significant shortage of RNs and LPNs. They also lack personal care and home health aides, but skilled nurses are by far the greatest need. Nurses are the key to their business plan – performing assessments, care and supervision for all cases. A shortage of RNs translates to delays in opening cases, reductions in hours of care and the turning away of cases altogether.

In addition to the significant shortage of workforce, agencies are also losing RNs to hospitals, MLTCs, other managed care companies, and their contractors where they deliver care management services. This competition only adds to the difficulty of finding, hiring, onboarding and retaining skilled nurses.

As we stated in our comments on the LHCSA Need Methodology regulations, we similarly support the idea that applicants for new CHHA licenses should propose and carry out a workforce development and retention plan. The Department should also encourage CHHA partnerships and affiliations with other providers, health systems, and educational institutions to develop plans to bring new people into the field of home care.

LeadingAge NY ask the Department and the State to engage in long term care workforce development on a statewide scale. No single agency with a workforce plan, nor additional newly established agencies will be able to move the needle on this issue without a firm commitment and investment from the State. The data on the current and future lack of long term care workers and the projected growth of the 65+ and 85+ populations is well established and fast upon us.

Lack of Reimbursement

With the viability of this provider type in mind and our goal to ensure CHHA ability to serve New Yorkers in both quality and capacity, we also draw attention to the lack of reimbursement for this provider type. As the Department well knows, reimbursement rates have lagged for home care providers for years. New York has failed to provide cost of living adjustments and trend factors in Medicaid reimbursement rates in over a decade, despite significant increases in cost of care. Providers have been dealing with negative operating margins for years and regulatory requirements increase every year on both the state and federal levels.

Medicare Advantage (MA), in particular, has gained substantive ground, with some counties enrolling 60% of their Medicare population in MA. While this payor was a small portion of agencies' business plans when it was first introduced, it has grown substantially and negotiated reimbursement rates in MA are well below the cost of care. CHHAs, both large and small, do not have the negotiating power to take on national and regional MA plans. While New York has limited ability to affect these rates, it behooves the State to be aware of all of these pressures. Coupled with new Fee-for-Service federal payment models, the financial sustainability of many CHHAs is fragile. Our members tell us most freestanding CHHAs will not be operating in the near future if something isn't done to address inadequate reimbursement rates.

Unlevel playing fields are also at play. Unlike CHHAs, private physical therapy service companies have no Conditions of Participation to contend with when delivering therapy services under Medicare. Furthermore, patients lose out when therapy companies under part B do not inform patients that they are entitled to CHHA services without copays. Assisted Living is where we are seeing this dynamic play out the most.

In considering the Department's *Additional Ideas for Consideration*:

Eliminate Public Review Entirely

LeadingAge NY is opposed to eliminating the CON review process for CHHAs. We have seen the proliferation of LHCSAs with a lack of a review process. We do not want to repeat this with CHHAs. It would only exacerbate many of the problems we have previously mentioned.

Elimination of Special Needs Category of CHHA

Like the Department, LeadingAge NY recognizes the problems that surfaced with the special needs designation during the 2012 RFP process. While some agencies adhered to their missions, many did not. We believe the Department should track and ensure special needs care is available and that its workforce is developed accordingly. Special needs populations require specialized care and general purpose CHHAs are often not prepared to serve their needs as these patients often require a very different staffing and care configuration.

Simplification of Review for Character and Competence

We do not have specific recommendations on this aspect of CHHA CON at this time.

We ask the Department to consider the many forces affecting CHHA service delivery when planning CON reform. Adding more agencies alone will not necessarily improve and increase delivery of home health care to New Yorkers.

Thank you for the opportunity to comment.

Sincerely,

Meg Carr Everett
Home and Community Based Services Policy Analyst
LeadingAge New York