April 29, 2014

Jason Helgerson
Medicaid Director
NYS Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: 1115 Waiver Amendment Special Terms and Conditions-DSRIP

Dear Mr. Helgerson:

On behalf of LeadingAge New York, I am pleased to provide comments on New York's 1115 Waiver Amendment Special Terms and Conditions (STCs) regarding the Delivery System Reform Incentive Program (DSRIP). LeadingAge NY represents over 500 not-for-profit and public providers of long-term and post-acute care (LTPAC) and senior services throughout the state.

LeadingAge New York has been supportive of the concept of the waiver and the opportunity to strategically reinvest savings derived from Medicaid redesign into the health care system. Investments are needed to further support rebalancing of the delivery system and more efficient use of ever-dwindling resources. While we see promise in the DSRIP, the plan has evolved significantly from the original proposal and appears to be more limiting in terms of available avenues for participation.

The objectives of DSRIP are decidedly ambitious, and the mechanisms by which they are to be accomplished are complex in a variety of ways. Even greater risk has been built into this final iteration, both for the State and for providers. Although a principal goal of the waiver amendment is to reduce avoidable hospital use among Medicaid beneficiaries, the STCs and other aspects of the waiver amendment largely overlook the population of frail elderly Medicaid beneficiaries receiving LTPAC services and the providers that serve them.

Given the fundamental realignment that this plan seeks to accomplish in the service delivery system for all Medicaid services (and by implication, other payers), we are concerned that there has not been enough time allotted in the application process to thoroughly understand the complex plan as well as for providers to engage with potential collaborators. Furthermore, there has not been enough outreach – particularly to LTPAC Medicaid service providers – to ensure that these organizations understand the plan and the potential implications of participating versus not participating in a DSRIP project.

Below are specific comments and questions on the DSRIP STCs:

1. ***A more prominent role for LTPAC services is needed:*** Any serious effort to reduce avoidable admissions and readmissions must engage with LTPAC providers, given the significant Medicaid

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beneficiary volume and dollars at issue. Successful management of elderly and disabled individuals in the community requires the involvement of LTPAC providers. In spite of this reality, however:

a. These providers are not considered in the DSRIP Project Plan Application Score valuation;
b. The DSRIP Data Workbook Series does not include any LTPAC service utilization; and
c. The attribution framework excludes LTPAC services, even though LTPAC can have a major bearing on the outcomes of many Medicaid beneficiaries given the scope, frequency and duration of services delivered and the care coordination provided.

The final STCs and other aspects of the amendment should address this reality.

2. ***Revisiting the "safety net" definition:*** We appreciate the recognition that the safety net of services is comprised of providers that serve a significant proportion of Medicaid beneficiaries within their overall utilization, and that providers that do not meet the safety net definition may participate in Performing Provider Systems (PPSs). Having said that, there are certain aspects of the definition that seem particularly limiting to various service types:

   a. The hospital safety net definition includes not only measures of patient volume but also proportions of individuals served in the county/community. The latter standard should also be applied to non-hospital based providers in addition to the patient volume criterion;
   b. There are other types of safety net providers that serve large proportions of vulnerable Medicaid-eligible individuals, but inexplicably they are not reflected in the eligible safety net provider listings. These include assisted living programs (ALPs) and adult day health care (ADHC) programs. Both serve dual-eligible frail elderly and chronically ill individuals, and play an active role in reducing hospitalizations. These important providers should be specifically identified and reflected in eligible provider listings;
   c. The Vital Access Provider Exception refers to "any hospital" that is uniquely qualified to serve based on various criteria. This reason should be expanded to include any non-hospital based provider meeting these criteria; and
   d. The low percentage (i.e., 27%) of certified home health agencies (CHHAs) that qualify as safety net providers is confusing to us, since cost report data suggests that 60-70 percent of overall CHHA volume is comprised of Medicaid and dual eligible recipients.

3. ***HIT and information exchange in LTPAC settings:*** The effective and efficient deployment of health information technology (HIT) and health information exchange (HIE) is fundamental to the success of the underlying goal of reducing avoidable hospital use and achieving the Triple Aim. As noted in the STCs, DSRIP coalitions will need to have a data agreement in place to share and manage data on system-wide performance, and to invest in technology to strengthen PPS ability to serve target populations and pursue project goals.

   LTPAC providers have lagged hospitals, practitioners and clinics in HIT adoption due, in large part, to ineligibility for federal meaningful use incentives and limited access to other funding

programs such as HEAL-NY. Without financial assistance, many LTPAC providers lack the resources to purchase and implement HIT systems. For these reasons, additional resources should be dedicated to supporting adoption of HIT in the LTPAC sector and HIE between LTPAC providers and hospitals, practitioners and other providers. In this regard, we are also seeking clarity as to whether the incentive payment itself can be used for such investments in HIT and HIE, particularly since LTPAC providers were excluded from receiving federal meaningful use payments.

Given how critical these investments are to support LTPAC service delivery and integration, this in itself, may be a worthwhile DSRIP project. Providers could receive a DSRIP incentive payment for meeting certain criteria related to HIE, essentially creating New York State "meaningful use" criteria.

4. ***Providing advance funding:*** We appreciate that the revised plan provides access to funding to enable providers that are financially distressed or have limited planning resources to participate in DSRIP projects. However, while the STCs do not appear to limit the types of providers eligible for the Interim Access Assurance Fund (IAAF), the presentation delivered during the public hearings included the following bullet point: *"Total IAAF allocation is $500 million ($250 million for public hospitals, $250 million for non-public hospitals)."* If this is the intent, it must be reconsidered as it could significantly limit access to DSRIP by non-hospital providers that are essential to the success of the initiative. We support the inclusion of planning grants; this funding is critical to ensuring that providers can file well-thought out applications that can be successful.

5. ***Providing greater assurances of payment and continuation:*** Risk has been an element of the DSRIP from the very beginning. There is risk at the provider level simply in being engaged in a DSRIP initiative or not; it forces providers to collaborate with their competitors and take significant leaps of faith. PPSs clearly take on risk in that they do not receive incentive payments if they do not achieve benchmarks. This version of the STCs infuses more risk, however. Now the State and all PPSs must take on even greater risk in that if one PPS fails, all will see a reduction in funds. Lastly, the Centers for Medicare and Medicaid Services (CMS) authorizes this plan and funding only until the end of 2014, with contingencies on renewal.

   In several areas of the State, both the health care system and the local economy are quite fragile. There are also longstanding high quality providers scrambling to reorganize in the face of relentless waves of change. Many of our mission-driven not-for-profit LTPAC members cannot afford to invest significant resources without having confidence of a return. It is unfair to place Performing Provider Systems (PPSs) in the position of being harmed by the substandard performance of one or more other PPSs; this aspect of the demonstration design should be revisited. It is not entirely clear whether statewide performance on the metrics will be measured based on the cumulative performance of all PPSs in the State or overall statewide performance inclusive of non-DSRIP activity. If it is the latter, we see this as less fair and controllable for the PPSs. In addition, while we understand that the State must meet the expectations of CMS to proceed with this plan, CMS should give some assurance to providers

that the plan will move forward, and any changes will not be so significant that they require a fundamental change in course.

6. ***Reconsidering the timing of payment reform:*** While changes in managed care contracting to support and encourage the DSRIP objectives will certainly support the effectiveness of the PPSs, mandatory enrollment is still being implemented across the community-based LTPAC population and has not even begun for the nursing home population. Providers and managed care plans are still working to adjust to a radically different environment, and not all providers are even able to contract with managed care plans. These fundamental changes are requiring significant investments in time and money, and have added a significant layer of risk for both providers and plans.

   The envisioned scope for managed care reform – namely the requirement for a goal of 90 percent of managed care payments to providers using value-based payment methodologies – and the timeframe for having a plan in place by 2015-16 seems overly aggressive given the current state of flux among providers and managed care plans. We urge reconsideration of the scope and timeframe for this requirement, as well as development of a carefully thought out definition of "value-based payment methodologies." For instance, we would argue that a service unit reimbursement that includes a quality pool payment advancing the Triple Aim should be considered as a type of value-based methodology.

7. ***Rationalizing care coordination:*** LeadingAge NY is a strong proponent of care coordination; a clear theme in all Medicaid Redesign reforms and the DSRIP initiative. The State is advancing several different initiatives at once, however, creating the potential for duplication of efforts, and for the development of care coordination strategies that may not be viable in the future. As the State weaves in "conflict free" requirements, and involves health homes, care coordination requirements of specific providers and managed care plans, and care coordination-specific DSRIP projects, it is critical to determine which entity is responsible for each aspect of care coordination to avoid duplication, potential conflict and waste of limited financial and other resources.

8. ***The role of learning collaboratives:*** Learning collaborative activities should include an expectation that the knowledge, best practices and other information gleaned from the demonstration be made available to all providers and practitioners, including those that are not part of any PPS.

9. **Sustainability**: More thought needs to be given to sustainability, particularly since not all providers are likely to be included in PPSs. This could create two different kinds of systems, which could erode ongoing viability. Without an incentive payment, providers may not be able to afford to continue the interventions that achieved the milestones. Furthermore, a fundamental reshaping of the service delivery system will have major implications for non-Medicaid payers, which will need to be considered and addressed to ensure sustainability.

10. ***Adjusting for random factors***: As noted above, providers that engage in DSRIP initiatives are taking on risk and committing to efforts to achieve the ambitious objectives identified by the

State and CMS. We urge CMS to include criteria in the STCs authorizing any needed adjustments to the metrics based on random factors that could influence the rates of hospital use such as pandemics and natural disasters.

11. ***Ensuring transparency and meaningful input:*** We appreciate the theme of transparency built into the STCs and waiver amendment process. Unfortunately, the complexity of this plan and the short timeframes for finalization hinder stakeholders' ability to truly engage in the process and provide meaningful input. The public hearings began before stakeholders had an opportunity to review the revised plan. To address this issue, we urge DOH to remain actively engaged in educating the provider community and other stakeholders as this initiative moves forward.

12. ***Addressing other areas:*** In reviewing the STCs, we have identified additional questions:

    a. Can PPPs evolve over time? This is a dynamic time in health care, and one can foresee a scenario in which PPS coalition participants change over the duration of the project. Can new entities join a PPS after the initial application is approved? Would a merger or change in sponsorship affect an entity's ability to remain engaged in or withdraw from a PPS?
    b. Will DSRIP in any way limit consumer choice? How will DSRIP attribution square with managed care enrollment for Medicaid, Medicare and/or other payers? Will attribution somehow place pressure on a consumer to select one provider over another?
    c. What bearing, if any, would the DSRIP and other elements of the waiver have on the State's Medicaid global spending cap?
    d. Will any additional requirements (i.e., performance, reporting, etc.) be imposed on the underlying providers/services funded through Designated State Health Programs (DSHPs) in connection with the demonstration? Would any DSHP penalties negatively affect providers and recipients of DSHP services outside of the DSRIP context? Will there be maintenance of effort requirements on the State for expenditures made through DSHP programs?
    e. Will there be opportunities for public input on other elements of the waiver amendment for which more limited information is currently available (i.e., Health Home development and investments in long term care, workforce and enhanced behavioral health services)?

Thank you for the opportunity to provide input on the STCs. LeadingAge New York is intrigued by the creative approaches the State is envisioning to realign the service delivery system, and we look forward to commenting on other aspects of DSRIP and otherwise working with DOH on implementation of the demonstration. If you have any questions on our input, please do not hesitate to contact us at (518) 867-8383.

Sincerely,

Daniel J. Heim
Executive Vice President