August 26, 2019

Mr. Paul Francis
Deputy Secretary for Health and Human Services
Executive Chamber
New York State Capitol Building
Albany, NY 12224

Dear Mr. Francis:

We submit this letter on behalf of our statewide health associations which have each signed on below. It outlines key principles and proposals that New York State should include in its 1115 federal "Partnership" waiver amendments, including in any continuation of DSRIP and related programs.

Our organizations, and the providers and services represented – primary, pre-acute, post-acute, in-home, behavioral health and long-term care – constitute the vast majority of the continuum of care for New Yorkers.[1] We are core to the healthcare system's (and waiver's) functionality, performance and goals.

Our associations and their members support the State and federal waiver goals that align with the population's needs and the Triple Aim of improving health outcomes, enhancing patient experience and providing value. We look forward to continued, mutual work toward the waiver's success.

Fundamental to the waiver goals is the system's shift to community-based care, reduction in avoidable hospitalizations and corresponding reinvestment necessary to support this restructuring. Accordingly, we request that amendment of the waiver and allocation of funding be aligned to optimize these goals and the participation of the primary, pre-acute, post-acute, in-home, behavioral health and long-term care providers that are key to the system's reform, restructuring and improved overall performance.

We ask that the waiver's design, policies and practices, and those of any future DSRIP and related programs, embody the following principles and recommendations:

- Allocation of waiver funding for primary, pre-acute, post-acute, in-home, behavioral health and LTC
- Alignment of waiver and DSRIP with community resources and expertise
- Collaboration for complex, interdisciplinary care and priority public health solutions
- Workforce support and "Lean" regulation
- Broad Data access
- HIT and clinical technology support
- Medicare optimization
- Innovative payment arrangements
- Expanded/flexible coverage of primary, in-home, long-term/post-acute and behavioral health services (Smarter Medicaid)

[1] These providers include federally-qualified health centers, primary care physician practices, home care agencies, hospice programs, nursing homes, adult day health care programs, assisted living programs, and community-based programs licensed by OMH, OASAS, and/or OPWDD.

I. Allocation of Waiver Funding for primary, pre-acute, post-acute, in-home, behavioral health and LTC

A continuation of the waiver and corollary programs should ensure that funds are apportioned consistent with the waiver's goals to shift the locus of care to primary, pre-acute, post-acute, in-home, behavioral and long term care services. This must include a commensurate shift in both service funding and in infrastructure support policies for these providers.

Under the present waiver and DSRIP experience, only a fraction of the $8 billion funding has made its way to primary, pre-acute, post-acute, in-home, behavioral health and other long term care providers; nearly all has been allocated to and directed by institutional PPS lead entities. Moreover, substantial new "health transformation" funding appropriated in the state budget has also followed this same allocation pattern – a majority of the funds were dedicated to hospital-based infrastructure. We fully support critical investment in our hospitals; however, renewed waiver and/or DSRIP allocations must be changed. These allocations must be realistically commensurate with the needs of the primary, pre-acute, post-acute, in-home, behavioral health and long term care providers, patients and services, and the waiver's restructuring, vision and goals.

Along with this realignment of funding, the waiver treatment of primary, pre-acute, long-term, post-acute and behavioral health care providers must also change, starting with addressing the initial waiver's diminutive and subordinate positioning of these service providers. Primary, pre-acute, long-term/post-acute and behavioral health care providers are constantly framed under the waiver as "downstreams" of other, ostensibly controlling entities, rather than as the primary, preventive and ***priority first layers*** of the system that comprise the substantial pre-acute, post-acute, in-home, behavioral and long term care majority of the continuum (providing the unique and core services ranging from those that prevent medical problems to those that address high intensity conditions of patients with complex health and social needs). The current waiver posture placing primary, pre-acute, post-acute, in-home, behavioral health and long term care providers at the fiscal, programmatic and proverbial "bottom" is upside down to the waiver's own stated reform goals. The waiver's execution and practice need to be righted.

II. Alignment of Waiver and DSRIP with Community Resources and Expertise

Some Performing Provider System (PPS) initiatives have shown the way in partnering with primary, pre-acute, post-acute, in-home, behavioral health and long term care providers to address the waiver goals of preventing hospitalizations, emergency room avoidance, improved outcomes and reduced costs.

Yet, substantially, the incentives under the waiver and DSRIP have too often led to existing community resources, expertise and licensure being bypassed, and funds and authority usurped to "reinvent" rather than leverage these services. This has been an uninformed and wasteful practice of attempting to "rebuild" rather than harness the community services already successfully established for these roles. Its result is duplication, overlap, conflict/confusion and scofflaw risk. The waiver's community health focus should not be a sanction for some to forge their own imitative strategy and bypass the existing primary, pre-acute, post-acute, in-home, behavioral health and long term care system, standards, credentials, practitioners and jurisdiction in the continuum. A cohesive body of standards relative to scope and setting of service, along with specific training and expertise, are necessary in all areas of health care, including services in the community, and especially services at home.

Waiver and DSRIP amendments should build on primary, pre-acute, post-acute, in-home, behavioral health and long term care collaborations along the continuum throughout the PPS projects and align with the existing, ready and eager non-hospital expertise. The policy should go further to prioritize, as a waiver standard, the use of these providers' services, and the prevention of waiver resource use that duplicates, excludes or marginalizes community and long term care services.

III. Collaboration Models for Interdisciplinary, Complex Care and Public Health Solutions

Synergizing providers' joint expertise and interdisciplinary jurisdictions is a core theme of the waiver. We fully support, and all the more recommend, collaborative solutions. This can especially benefit complex, comorbid care and care transitions, and sets a strong foundation for new payment innovation.

Provider collaboratives should be further specifically leveraged by the waiver to address critical and costly public health problems, such as asthma, cardiovascular and respiratory disease, complex maternal and perinatal care, behavioral conditions and co-morbidities, sepsis prevention, health disparity, end of life care, and many other significant issues. Collaboration models that join interdisciplinary community and institutional providers create a powerful, "continuum approach" to public health intervention that exceeds what a single-sector can do in isolation. Further, the waiver application offers an opportunity for the state to support IPAs, BHCCs and other provider collectives to support the goals of access, quality and sustainability.

The most significant factors affecting health and health expenditures are those in an individual's personal life, home and community. Those who serve these individuals on a frequent and regular (sometimes daily) basis, who know their formal and informal caregivers, and who are expert in the core competencies for individuals with disabilities or age-related functional limitations are the non-hospital providers. Accordingly, the Department should amend the waiver's current top-down (hospital) dominated structure for collaboration that is incented throughout the waiver/DSRIP provisions. This should be replaced with bilateral/multilateral leadership opportunity, incentives and engagement for collaboration across sectors and partners. Bringing the institutional, health plan and community-based sectors together into bilateral/multilateral collaboration is imperative for better care and efficient outcomes. At the state level, the Offices of Mental Health, OASAS, OPWDD, and Aging should be engaged in facilitating these waiver goals and given the stature to achieve them.

Moreover, the payment structure for dually eligible (Medicare/Medicaid) beneficiaries is not maximized in the current waiver and DSRIP process and Medicare savings generated by Medicaid providers are not reinvested. Appropriate use of the Medicare benefit and Medicare reinvestment is possible when the appropriate Medicare-certified providers and plans are collaborative partners under waiver and DSRIP programing. (See item VII on page 4 for further discussion of Medicare.)

IV. Workforce Support and Lean Regulation

The most significant and growing areas of workforce need are in the primary, long-term, pre-acute, post-acute, in-home and behavioral health care sectors. While the waiver and DSRIP have targeted workforce development among its project areas, to date these have failed to offer either urgent relief or structural, long term solutions.

Further, as the waiver continues to move deeper into value based payment designs and milestones, there are no explicit provisions within VBP or other finance or rate mechanisms (for either plans or providers) for workforce investment needs and goals.

Meanwhile, the primary, post-acute, in-home behavioral health and long term care sectors continue to struggle with market disadvantage in recruitment, retention and occupational draw. The problem worsens when new funds, such as the multibillion State Health Care Transformation Program, are disproportionately invested into certain segments of the system, without commensurate allocations made for primary, pre-acute, post-acute, in-home, behavioral health and long term care sectors.

The ongoing and unaddressed workforce need in the primary, pre-acute, post-acute, in-home, behavioral health and long term care sectors has been of longstanding and reverberating concern, with huge consequences on access, cost, outcomes, and avoidable use of higher cost systems.

We urge that amendments to the waiver, along with any new or continued waiver funding, prioritize workforce needs, shortages and substantive solutions in primary, pre-acute, post-acute, in-home, behavioral and long term care. This must include goals of adequate compensation and promotion of new worker entrants into these settings, from pipeline, community colleges, professional schools, and other sources. Additionally important are waiver amendments that could provide relief from excessive documentation, administration and procedures which are diverting practitioner time from direct patient care, and adversely impacting productivity, satisfaction, sustainability/turnover and cost. The waiver should support and help achieve "Lean" concepts throughout the system as a progressive way to eliminate these workforce overburdens and operational costs.

V. Broad Data Access

The goals of the waiver, and indeed of all of the state's health care reforms, are predicated on access to data. Data sets that are key to performance under the waiver (e.g., UAS-NY and Medicare claims data) continue to remain unavailable to providers, researchers, and many waiver partners. This has been the subject of continuing concern and request for remedy by providers and our associations.

Data, such as SPARCS data for value based payment measures, which bases performance on retroactive data, is limited in its utility to providers and plans (for lack of real-time applicability) and fairness. Medicare claims data is needed to target and refine interventions to improve the outcomes of dual eligibles and to enable integrated value-based arrangements.

Additional data sets that are germane to the waiver goals are also limited in availability or in their linkage with other key data that could permit providers and partners to piece together the profiles and analyses needed for population health management and better performance measurement and improvement.

As overall data to support providers' efforts is especially lacking, we urge state action to optimize data access for community providers. We further urge the formation of a workgroup to inventory data needs, and help develop and recommend solutions to the Department for appropriate data access for community providers and waiver partners.

VI. HIT and Clinical Technology Support

While support for health information technology, connectivity and exchange have been DSRIP goals, little has extended to the primary, pre-acute, post-acute, in-home, behavioral health and long term care sectors. HIT and HIE are prerequisites for the operational and clinical integration sought by the waiver and related programs; yet the primary, pre-acute, post-acute in-home, behavioral health and long term care providers have had the least funding for these essential purposes. There is a similar void in support for the primary, pre-acute, post-acute, in-home, behavioral health and long term care provider acquisition of clinical technology tools for new, innovative and cost-effective approaches to patient care. These are proving their value in evidenced-based usage under outside grants or limited philanthropy, but have no sustainable funding. The state's current methodologies for managed care premium and for community based provider Medicaid rate setting lack components to support these technology essentials.

Accordingly, we recommend that the waiver and corresponding state policies be amended to include the ability to reflect HIT and technology supports in state managed care plan premiums, provider reimbursement methodologies and grants.

VII. Medicare Optimization

We support state efforts to continue seeking federal approval for Medicare shared savings to NY providers and plans whose interventions achieve offsets in Medicare spending with equal or better patient outcomes.

As a parallel step, the waiver design should seek to optimize Medicare coverage of services for dual eligibles wherever appropriate. This should include optimal use of Medicare reimbursed agencies and services, including Medicare reimbursed certified home health agencies (and LHCSA contractors), Long Term Home Health Care Program (LTHHCP) providers, hospices, community behavioral health and other Medicare eligible providers. (See comments in item III on page 3 regarding collaborative use of Medicare-certified providers in waiver/DSRIP programing.) The state should amend waiver terms and policies consistent with this goal and could convene an industry and consumer advisory workgroup to assist in these policy revisions. As part of this process, the state must examine and consider action to address Medicare's inadequate reimbursement and coverage levels including significant underpayments to providers that are undermining Medicare covered services and benefits. These include Medicare's lack of participation in compensation for minimum wage, the consequences of Medicare prospective changes to the nursing home and home health reimbursement methodologies, excessive co-pays for ambulatory behavioral health services, and new Medicare opportunities coming available for Advantage Plans to offer supplemental benefits in conjunction with home health providers for in-home care supports, with adult day health care programs, and with assisted living programs.

The following helps further illustrate. In the *Jimmo v. Sebelius 2013 settlement*, and further enforced in *Jimmo v. Burwell 2016,* CMS is required to make clear the entitlement to "maintenance" coverage under Medicare home care. This settlement seeks to ensure that CMS not impose arbitrary durational limits on Medicare coverage of home health, and clarifies opportunities for Medicare recipients to receive covered home health services over a long term basis. The policy of Medicare certified home health agencies and LTHHCPs delivering these Medicare-covered services could be examined for benefit to the recipients as well as to the Medicaid Program.

VIII. Innovative payment arrangements

The waiver promotes innovative payment arrangements, but favors certain facilities and health plans as the basis for creating and leading innovative models or pilots. We recommend that waiver amendments provide new, direct opportunities for the primary, pre-acute, post-acute, in-home, behavioral health and long term care providers to be the sponsors and leaders of proposals for such innovative projects, whether within or across community sectors, or vertically with other providers. This may require the development of innovative models to attribute populations and share risk across the health care system.

IX. Expanded/Flexible Coverage of Community Services (Smarter Medicaid)

We support the waiver's continued opportunities for flexible and creative service coverage under Medicaid. These are currently primarily extended to managed care payments. The waiver goals can be further advanced however by amendments that would also allow expanded patient-centered, cost-effective services on a provider basis. Allowing this flexibility for providers under the 1115 waiver, analogous to expansions provided under 1915(c) waivers, will enable providers' (and the waiver's) capability for more customized and efficient service planning and delivery. It will also allow opportunity for smarter use of government funds where less dollars can actually purchase a better and more sensible result for the patient and the Medicaid program. Such flexibility should be piloted in the primary, pre-acute, post-acute, in-home, behavioral health and long term care services.

Another example would be the establishment of a hospice concurrent care pilot for Medicaid beneficiaries over age 21. Currently, beneficiaries under age 21 can continue to receive cure focused care as well as hospice care. The hospice staff's medical and spiritual and psychosocial services will help the patient and family more fully understand the impact of the treatment decisions. They will have experienced the supports and good pain and symptom management available to them. At the appropriate time, they can then more readily decide to discontinue futile treatment options. The binary choice to stop all curative treatment in order to be on hospice, which is a difficult and painful choice for patients and families to make, now goes away. In the end, it's better care for patients and their families. In addition, there will be cost savings. NY state already recognizes the

benefits of hospice care by providing for a 1-year prognosis rather than 6 months. Unfortunately, it is not utilized because of the need to forgo treatment for hospice care.

We appreciate this opportunity to offer comment on these broad and important areas, and look forward to the opportunity to meet or speak to address any questions or provide further information to explain these issues and recommendations. Primary, pre-acute, post-acute, in-home, behavioral and long term care providers look forward to helping shape and deliver services in this health care transformation. We urge state waiver amendments that incorporate the policy, program, participatory and finance recommendations provided in this letter.

Thank you.

Sincerely,

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