December 27, 2022

Mr. Amir Bassiri
Medicaid Director
NYS Department of Health
Albany, NY

sent via email

Re: Conflict Free Care Management, MLTC and the ALP

Dear Amir:

As we work with the Department of Health to bring Assisted Living Programs (ALPs) into compliance with the Conflict Free Care Management provision of the CMS Home & Community Based Settings (HCBS) rule, ESAAL and LeadingAge NY have been exploring various options including carving the ALP in as a Managed Long Term Care (MLTC) benefit. With this letter, we describe the serious and likely insurmountable challenges with the MLTC option.

Serving just over 14,000 nursing home eligible New Yorkers, the ALP provides comprehensive and integrated services, including personal care, home health aide services, and coordination of skilled services, in a homelike environment, at a fraction of the cost of nursing home care. It is the only alternative to nursing home care for many Medicaid beneficiaries who require 24/7 personal care or supervision. Obtaining and maintaining consistent 24/7 home care, especially in the context of today's workforce shortages, is often impossible, especially for individuals who lack close family who can coordinate care and fill in service gaps. The individual must reside in a safe and accessible home, which may not allow access to the broader community and socialization opportunities. Moreover, 24/7 home care, when it is available, actually exceeds the cost of the ALP.

Challenges Created if the Assisted Living Program (ALP) is carved in as a MLTC Covered Benefit

Complications of the ALP services, reimbursement, and benefit structures: ALP services are already capitated and managed. Carving the ALP into the MLTC benefit package would add another layer of administration – authorizations, utilization review, and billing -- which would add to the cost of the ALP without adding any value for residents or the state.

Under the current program, there are systems in place to ensure that residents are eligible for the program, that their needs are addressed, and that their services are coordinated. In order to qualify for the ALP, prospective residents are assessed via the UAS assessment tool, which is also used to determine the resident's RUG category and their care plan. The ALP is required to provide or arrange for an array of long-term services and supports that are included in the ALP's rate.

The ALP provides care management and care coordination services, the coordination of certain skilled services, arranging for ancillary services and generally assuring that the resident's health and social needs are met. As per the Partial Capitation Model Contract, many MLTC-covered services are duplicative of those included in the ALP rate (e.g., personal care, home health aide services, nursing,

therapies, adult day health care, and *some* durable medical equipment). As a result, in order to avoid duplicative payments, certain services would have to be either carved out of the ALP or out of the MLTC benefit for ALP residents. This would either fragment a successful program or create additional complexity for residents, families, and MLTC plans.

As the experience of carving in the nursing home benefit into the MLTC package shows, higher-cost, lower-incidence services are difficult to accurately reflect in capitation. The nursing home benefit required the state to calculate a separate "nursing home transition (NHT)" rate which then needed to be blended with the community rate. Even with benchmark rate protections in place, the delays inherent in the State's issuance of nursing home rates along with the prevalence of retroactive adjustments, resulted in a cumbersome, administratively intensive process for plans and providers. This dynamic would be even more problematic for ALPs as they tend to be smaller, are more vulnerable to financial disruption, and are unlikely to be able to engage in managed care contracting without adding staff.

These challenges would, at a minimum, result in limited authorization of the ALP benefit by MLTC plans, denying Medicaid beneficiaries a homelike alternative to nursing home care. At worst, it will impair the viability of existing ALPs, which are already struggling with negative margins due to rising costs and rates that are based on 1992 nursing home costs and have not been adjusted for inflation for 15 years.. It will also discourage expansion of a valuable community-based service at a time when our population is aging and access to LTC services is shrinking.

Long-Stay Nursing Home Benefit Limit is Instructive and May Disincentivize ALP Services: Beginning in 2015, the state required Medicaid-eligible, long-stay nursing home residents to enroll into MLTC. Three years later, the 2018 State Budget carved the long-stay nursing home benefit out of the MLTC package (with the exception of the first 3 months of the stay) because it learned that MLTC offered little value to long-stay residents. Given that nursing homes provide a package of services to the resident, there was little need for care management, and little opportunity for savings, for long-term residents. The ALP population is analogous. Why would the state take on this administratively complex endeavor only to discover what we already know?

In addition, the existence of the nursing home benefit limit may create an incentive to authorize nursing home care, instead of the ALP, for high-acuity MLTC members who cannot be served in a private home. Some plans may prefer nursing home services for high-acuity members, knowing that they will be disenrolled after 3 months. This will lead to avoidable and costly admissions to nursing homes. It is also inconsistent with the Olmstead Act and the most integrated setting standard.

Network Adequacy: To maintain the viability of the program and ensure minimal resident disruption and continuity of care/services, ALPs would need to be deemed "providers" and MLTC plans would need to be required to contract with ALPs and meet the established network adequacy requirements. Network adequacy standards require that MLTC plans maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. Currently, 14 counties in New York State have no ALPs and another 18 counties have only one ALP. Therefore, if a network adequacy standard of two providers per county was to be applied, there would be 32 counties in which an MLTC could not meet that standard. Moreover, in many of these counties, it is unlikely that the NYS-mandated geographic accessibility standard will be met.

Further, there is currently no ability for entities to apply to establish a new ALP because the enacted FY 23 budget delayed a new legislatively approved Certificate of Need application process for ALPs from 2023 to 2025. Even then, based on history, once approved in 2025 or thereafter, it could take at least one year from application submission to receive all final DOH approvals for each applicant to operate.

When considering this challenge, it is important to recognize that the ALP is not merely a Personal Care Services Program (PCSP) and that network adequacy cannot be met based solely on the availability of Licensed Home Care Services Agencies (LHCSAs) in a county. Under the regulatory definition at 18 NYCRR 494.2, an ALP includes the residential setting in which personal care services are delivered:

> (a) Assisted living program means an entity which is approved to operate pursuant to section 485.6(n) of this Title and which is established and operated for purpose of providing long-term **residential** care, **room, board, housekeeping**, personal care, supervision, and providing or arranging for home health services to five or more eligible adults unrelated to the operator."

Therefore, the ALP is not solely a PCSP and consequently, for the purpose of determining network adequacy, it would not be appropriate to count other freestanding, community PCSP's in the county within the same category as the ALP.

The existing ALP rate structure would present a challenge for MLTCs: ALP rates are based on the RUGS II category/score for each resident and the respective Wage Equalization Factor (WEF) region. There are 16 RUGS II categories into which an ALP resident could score and 16 WEF regions in NYS. Those two factors yield 256 individual ALP rates. When ALP as an MLTC benefit was first explored, MLTCs found the rate structure to be too complex and were resistant to having to operationalize the use of 256 rates. Imposing such a structure on the MLTCs will result in their underutilization of the ALP program.

We are happy to talk with you further about our concerns and are working together to articulate a possible approach to address the federal rule. We will share that with you shortly.

Sincerely,

Lisa Newcomb
Executive Director

Diane Darbyshire, LCSW
Vice President of Advocacy and Public Policy

cc. Adam Herbst
Val Deetz
Angela Profetta