June 4, 2021

Donna Frescatore
Medicaid Director
Brett Friedman
Director, Strategic Initiatives & Special Medicaid Counsel
New York State Department of Health
One Commerce Plaza
Albany, New York 12210

Via E-Mail

Re: HCBS eFMAP Spending Recommendations

Dear Ms. Frescatore and Mr. Friedman:

On behalf of LeadingAge New York's non-profit and public long-term/post-acute care provider and managed long term care members, we offer our recommendations for New York's enhanced Federal Medical Assistance Percentage (eFMAP) for Home and Community-Based Services (HCBS) as provided in the American Rescue Plan. LeadingAge New York's HCBS members include certified and licensed home care services agencies, social and medical model adult day programs, Assisted Living Programs, NHTD/TBI waiver services providers, PACE programs and managed long term care plans. The eFMAP offers a once-in-a-generation opportunity to make transformative investments in the community-based long-term care system at a time when our population of older adults is growing rapidly and the working age cohort is shrinking.

The pandemic has exposed and exacerbated longstanding under-funding of long-term care services and staffing shortages in New York and nationwide. Even before the pandemic, providers were struggling with rising costs and flat or reduced reimbursement, growing demand and a shrinking workforce, and reduced competitiveness in the labor market. The pandemic generated new, unreimbursed costs for PPE, testing, overtime, hazard pay, worker supports, telehealth technologies, and more. At the same time, COVID triggered quarantines and furloughs of staff, while making recruitment and retention even more difficult.

The long-term care system and the people it serves have been battered by the pandemic. Too many older adults have been isolated from their families, friends, medical professionals, and caregivers for nearly a year or more. They lost the ability to maintain routines and relationships established with adult day health care programs, social day programs, and PACE Centers. Many also reduced or discontinued their home care services. They are now suffering from the results of that isolation, with untreated and

worsening health conditions, diminished cognition, and deepening depression and anxiety. Some have survived COVID, but are now experiencing the symptoms of long-COVID. The dedicated caregivers who work in long-term care are facing the challenge of helping their patients to regain what they have lost.

At the same time, providers are struggling mightily to provide services in the midst of staffing shortages at all levels. Our home care members report challenges opening cases due to a shortage of nurses and a lack of aides to staff all of the home care hours needed. It is particularly challenging to staff cases in areas without access to public transportation and cases that are authorized for just a few hours a week.

We anticipate that demand for community-based care will rise not just as a result of natural demographic changes, but also as a result of changes in consumer preferences attributable to the pandemic. Our members report that demand for nursing home care has dropped dramatically since the pandemic. We believe this is due in part to consumer concerns about infection control and limits on social interaction and visitation in facilities. We expect to see a proportionate increase in demand for home and community-based care. For individuals with medically-complex conditions, cognitive deficits, lack of social supports, and/or inadequate housing, a variety of services will be needed, including home care, adult day health care, PACE, and assisted living. We need to invest in capacity, workforce, and effective models of care across the long-term care continuum to address the growing need.

Accordingly, LeadingAge New York recommends focusing eFMAP funds on expanding and enhancing the workforce needed by the many provider types offering Medicaid HCBS services, including home care, adult day health care (ADHC), waiver services, Assisted Living Programs, and PACE programs. In addition, we recommend that funds be invested in COVID-related supplemental payments to support infection prevention measures and unreimbursed COVID expenses in each of the settings; technology and telehealth to enable communication and coordination amongst providers, consumers and caregivers; data tools and models that support integrated approaches to Medicare- and Medicaid-covered services for dual eligibles; and collaborative quality initiatives. This letter sets forth our recommendations in eight parts: Parts I-III apply across all HCBS provider types, Parts IV-VI provide specific recommendations for adult day health care, assisted living, and PACE and MLTC, Part VII discusses some considerations related to the use of MLTC as a vehicle for distributing eFMAP and state funds equivalent dollars, and Part VIII includes recommendations to support a new resident assistance program in affordable senior housing.

I. EXPANDING AND STRENGTHENING THE HCBS WORKFORCE

For all HCBS providers, workforce continues to be the most daunting challenge, with aide and nurse shortages causing significant waiting lists, and thus access to care barriers. Training programs are

either not in operation or yielding very few graduates due to a preference for less demanding jobs. Our members are always trying to develop new ways to incentivize and attract staff, but these efforts often yield limited results. We recommend that the eFMAP and state funds equivalent be invested in workforce as follows:

1. **Compensation for Direct Care Workers**

We recommend that funds be targeted to enhance compensation paid to direct care workers, while giving agencies and providers the discretion and flexibility to tailor the nature of the compensation enhancement to address the staffing challenges they are facing and regional labor market dynamics. Needs may vary depending on agency size, service area needs and characteristics, training availability, and unique characteristics of the local workforce or caseload. Funds should be targeted not only at aide compensation, but also at compensation of RNs, LPNs, and therapists. Some suggested spending options include:

- Payments to recruit new workers and retain existing direct care workers. This could take the form of enhanced pay, signing bonuses, retention bonuses, and other provider-specific approaches that meet their particular challenges and circumstances;
- Payments to recognize workers who are active during the public health emergency through hazard pay bonuses or other incentives or supports;
- Differentials for hard-to-serve geographies, challenging shifts, etc.;
- Development of salaried aide staffing models;
- Work-related supports such as child care and transportation.

2. **Workforce Training**

The state needs to recruit and train new entrants in the long-term care field, as well as develop enhanced training and career ladders for those who have already entered the field. It is important to note that in several areas of the state, there are no PCA/HHA aide training programs. Our training recommendations include:

- Loan forgiveness, tuition repayment, and stipends for nursing students who seek to work in the long-term care field, including aides who are seeking nursing degrees;
- Stipends for students seeking PCA or HHA certification;
- Support for training-related expenses (e.g., transportation, books, materials);
- Development, expansion, and operation of traditional and hybrid remote aide training programs;
- Programs to build career ladders and advanced skills, e.g., in dementia care, or infection control;
- Mentoring and apprenticeship programs; and

- Funding for training slots in non-agency programs.

The Department has suggested funding for workforce initiatives could potentially flow through MLTC plans and WIOs. We are interested in the outcomes of the WIOs, and in particular whether they operated HHA and PCA certification training programs, and their completion rates.

II. COVID SUPPORT FOR HCBS PROVIDERS

As noted above, HCBS providers have incurred, and continue to absorb, substantial unreimbursed costs as a result of COVID. These costs include personal protective equipment (PPE), hand sanitizer, disinfectants, COVID-19 testing, hazard pay, overtime, paid sick and medical leave, and unemployment insurance increases. In addition, PACE programs, ADHC programs, and ACFs have had to invest in facility-based modifications and compliance with new infection prevention requirements outlined below. eFMAP and state funds equivalent dollars should be used to support the continued response to COVID and the viability of HCBS providers across the continuum.

III. INVESTMENTS IN TELEHEALTH AND TECHNOLOGY

The pandemic accelerated the use of telehealth modalities by HCBS providers and highlighted the need for electronic exchange of data among providers. We recommend the following for investments of eFMAP and state funds equivalent dollars:

- Digital devices (e.g., tablets) for use by aides in the home that improve care, identify changes in condition, and reduce costly interventions;
- Investment in telehealth equipment and reimbursement parity for telehealth services
- Investment in health information technology and integration with QEs/RHIOS.

IV. ASSISTED LIVING PROGRAM

It is critical that New York include the assisted living program (ALP) in its spending plan for eFMAP and state funds equivalent dollars. New York's ALP is predicated on the personal care Medicaid state plan benefit, which is specifically named as an HCBS for which this enhanced FMAP is intended. ALPs are a proven alternative to nursing home care that utilize home and community-based services to deliver needed care for nursing-home-eligible residents at a fraction of the cost. The ALP is the only Medicaid-funded assisted living option in the state. It provides consumers who have significant functional limitations, but do not require ongoing skilled nursing care, with the services and supports they need in a more home-like environment than a nursing home. As such, it is a valuable asset in the care continuum

that should be bolstered to ensure choices for low-income seniors. Notably, the ALP is not an MLTC covered benefit and would therefore require a different vehicle for distribution of funds.

Due to inadequate reimbursement, recent Medicaid cuts, and significant workforce challenges, ALPs were struggling financially prior to the pandemic. The impact of COVID on the ALP has been staggering. There was no room in the rates to absorb the enormous unbudgeted costs over the past 14 months; including PPE (which initially was impossible to obtain and overpriced), increased staffing to provide necessary care during furloughs; new equipment to facilitate virtual visitation and safe in-person visitation; cleaning supplies; staffing to manage and ensure compliance with infection control, visitation, communication and reporting requirements; and over a year of weekly testing of staff and others that may enter the ALP. At the same time, revenues were reduced significantly due to reduced census. To date, the state has provided no financial support to these providers and the costs continue to accumulate with no sense of how they will be addressed. This eFMAP opportunity provides a critical lifeline to an essential home and community-based service.

In talking with ALP providers, it is clear that while the need is great, a one-size-fits-all approach would not be optimal for use of these funds. In addition to the support described in Parts I through III above, we ask that you consider the following more specific uses of funds for ALPs and allow them the discretion to adapt the funding to their specific needs and circumstances:

- Workforce: Most of the recommendations in Part I for HCBS workforce compensation and training would be welcome and appropriate for the ALP. Additionally, the eFMAP or state funds equivalent dollars must be available to support not only the home health aide, LPN and other direct caregiver staff in the ALP, but also the food service, maintenance and housekeeping workers that are critical to the organization.
- Technology: Many ALPs need to invest in the ability for a whole building to have access to wifi to support ALP residents' social interactions, as well telehealth, monitoring, communication, streamlined response to resident needs, and record keeping. Funds are also needed to implement electronic health records and information exchange with other providers.
- Medicare-Medicaid Care Coordination: The vast majority of residents in the ALP are dually eligible for both Medicaid and Medicare. The ALP manages and coordinates the care of this population and those services covered under both benefits. Funding through this opportunity could support ALPs in providing enhanced case management services, and additional case managers to reflect the growing acuity of this population and the complexity of their needs, and maximize the opportunities to save dollars and improve outcomes.
- Conversion of Nursing Home Beds to ALP: Given the rising demand for affordable assisted living options and declining demand for nursing homes, we recommend allowing funds to be

used to develop ALP services and further rebalance the system. Capital investment will be required to ensure a homelike environment.

V. REOPEN AND REBUILD ADULT DAY HEALTH CARE

We encourage the State to direct enhanced FMAP funds to reimagine and improve medical-model adult day health care (ADHC) programs. ADHC is a cost-effective, community-based alternative to nursing home placement and other higher levels of care. ADHCs offer all-inclusive and skilled services in a congregate setting with opportunities to socialize, allowing older adults with complex medical conditions and functional limitations to continue to live in their homes, especially in communities where there is a shortage of private duty nurses or home health aides.

ADHC was the only community-based long term care program that was mandated to close during the pandemic and was just authorized to reopen in April 2021. For over a year, ADHC programs incurred costs, but were unable to provide in-person services to their patients (known as 'registrants'). Reopening has been slow, due to restrictions on capacity and costly requirements. The eFMAP creates an opportunity for the state to update, strengthen and maximize the value of this important program.

The state should use eFMAP funds for ADHC in a variety of ways, including, but not limited to:

- Workforce Support: The options set forth in Part I above would be appropriate for ADHC.
- Specialized Payments:
  - Provide specialized payments to medical model adult day health care programs to make physical changes to program space to support infection prevention and compliance with the HCBS Settings rule, including relocating the entrance of ADHC program to separate it from the nursing home, and remodeling or relocating ADHC program to an off-site location.
  - Use specialized payments to purchase new vans or ambulettes or maintain existing ones to transport registrants to and from program and medical appointments. These payments could also be used for safety features on vehicles, such as plastic barriers, as well as driver training for specialized populations.
  - Use eFMAP funds to make retainer payments to ADHC providers. ADHC providers never received retainer payments or any other relief from the state throughout the 13-month long interruption in service delivery. During the COVID-19 pandemic, ADHC programs received little to no reimbursement, but continued to pay rent, heat and maintain the building or program space. Retainer payments for ADHC are long overdue.
- Purchase Personal Protective Equipment (PPE) and Testing Supplies: Payments for supplies and equipment to be used to cover the costs of staff and registrant testing, PPE, plastic barriers in program and on vehicles, signage, larger tables and other equipment to ensure safety of registrants.

- New and/or Additional HCBS:
    - Add telehealth as a new Medicaid ADHC service. Continue the authority of ADHC programs to provide telehealth, along with in-person services, after the expiration of the PHE executive order.
    - Enhanced Care Coordination ADHC model. Develop an enhanced case management program utilizing ADHC services and staff for individuals transitioning from institutional settings back to the community.
    - Add transportation aides to non-emergency Medicaid transportation. Transportation aides are necessary to assist some participants with intellectual or physical disabilities and those with memory impairments to and from ADHC.
    - Add meal delivery to the ADHC benefit package. ADHC programs routinely provide specialized diets to participants in program and should be reimbursed to offer this service in the home. Most meal delivery services are unable to meet this need.
- Develop Cross-System Partnerships: Create incentives for partnerships among managed care plans, ADHC programs, behavioral health organizations, independent living centers and housing agencies to improve care coordination and health outcomes.
- Expanding Provider Capacity. Provide nursing facilities with funding to convert existing nursing home space to adult day health care or purchase/lease space in community.

VI. MANAGED LONG TERM CARE AND PACE INVESTMENTS

Since a significant portion of the state's HCBS is coordinated and paid for by managed long-term care plans, strengthening the capacity of plans to promote high-quality care and to integrate Medicare and Medicaid services would be an effective and system-based use of the eFMAP and state funds equivalent. While this section addresses the potential uses of funds by MLTC plans, Part VII on eFMAP funding mechanisms addresses the issues that should be considered in using the MLTC plans as a vehicle for distributing the eFMAP and state funds equivalent.

We recommend providing eFMAP and state funds equivalent resources to MLTC plans, both partially-capitated and integrated Medicare-Medicaid plans, to support the following:

- Data tools and health information exchange;
- Devices to support communication among staff, members, and formal and informal caregivers;
- Collaborative quality initiatives with providers and funding of the MLTC quality pool;
- Outreach and coordination of services to promote access to the COVID vaccine;
- Enhanced care coordination to support safe and sustainable transitions from nursing homes to community-based settings; and
- For partially-capitated products, care coordination models to support integration with Medicare providers.

In addition to these investments in all MLTC products, we recommend that funds be targeted to support the state's goal of expanding integrated Medicare-Medicaid managed care for dually-eligible individuals, as follows:

PACE programs: PACE programs have incurred (and continue to incur) significant unreimbursed expenses as a result of the pandemic. The state should provide flexible COVID relief supplemental payments to PACE programs to support activities such as the following:

- Cover expenses associated with bringing medical, social, and supportive services ordinarily provided at the PACE centers to PACE members' homes, while PACE centers are closed or operating at reduced capacity;
- Provide additional compensation and support for direct care staff occasioned by COVID such as hazard pay, other incentive pay, additional overtime, etc.
- Help PACE centers to reopen safely and institute effective infection control measures, including:
  - The purchase of PPE, disinfectant, and COVID testing for staff;
  - PACE center renovations and improvements, such as partitions for infection prevention, HVAC, and/or air filtration improvements;
  - The purchase of symptom screening devices and kiosks; and
  - Infection prevention strategies in PACE transportation.

In addition, the state should eliminate the PACE Medicare Savings Adjustment—i.e., the clawback of Medicare margin if the program succeeds in managing care to reduce Medicare-covered expenditures. The recoupment of Medicare savings generated through the PACE model risks non-compliance with eFMAP maintenance of effort requirements. Moreover, PACE programs that succeed in reducing hospitalizations and other avoidable costs through effective care management, primary care, and high-quality long-term care services should not be penalized.

Medicaid Advantage Plus (MAP) and PACE: In addition to the more general managed long term care investments enumerated above, the state should provide funding for both MAP and PACE to encourage enrollment in these products and to promote enrollment growth in these plans. This could include funds for outreach and education. It could also include funding for optional benefits to encourage enrollment.

VII. FMAP FUNDING MECHANISMS

LeadingAge NY appreciates and shares the states interest in maximizing federal funding to invest in HCBS services, and the accompanying need to make these investments as expeditiously as possible. However, we urge the state to view this as an opportunity to also make some transformational investments in long-term care services and supports to help build capacity and sustain the system going forward.

Understanding the programmatic imperatives that favor distributing funds through MLTC plan rates, we recommend that this be done in the most straightforward and transparent way possible while minimizing the administrative burdens for both plans and providers. Past experience indicates that pass-through funding characterized by ambiguous timing and uncertain funding amounts only serve to undermine the type of trusting and cooperative relationships required for productive plan-provider partnerships. Whenever possible, specific allocation amounts should be targeted to individual providers and predictable distribution schedules should be provided to plans. DOH should distribute the same funding schedules and instructions to providers. Plans must be reimbursed for administrative costs associated with the initiative.

At the same time, the use of plans as an efficient distribution mechanism should not restrict the state from using some of the funding for innovative investments, even if those require fee-for-service rate adjustments or grants. For example, a different funding mechanism would be needed for services outside of the plan benefit package, such as the Assisted Living Program, and for a Resident Assistance Program in affordable senior housing.

VIII. RESIDENT ASSISTANCE PROGRAM IN AFFORDABLE SENIOR HOUSING

We recommend allocating a portion of the state funds equivalent to support the development of a "resident assistant" model within affordable senior housing. Research has shown that resident assistance programs in senior housing promote emotional well-being and stronger social supports, higher resident awareness of services, and better linkages between residents and needed services. Resident assistants provide so-called "light-touch" services that address social determinants of health and mitigate health disparities. These services may include:

- Establishing and maintaining networking relationships with community-based services and organizations;
- Providing residents with information and referral lists for community services and assisting them with follow-ups;
- Arranging for educational and socialization programs for residents;
- Helping residents arrange for housekeeping, shopping, transportation, Meals on Wheels, cooking, and laundry services;
- Establishing resident safety programs; and
- Advocating for residents.

This model generates Medicaid and Medicare savings by prolonging seniors' ability to live independently at home and helping them avoid both high-cost emergency medical care and costlier

levels of care like nursing homes. Rigorous studies have shown the reduced Medicare and Medicaid spending that can result from a resident assistant model.[1] We propose that grants of approximately $45,000 per property be made available to congregate senior housing operators to work with seniors and that those assistants specifically focus on linking residents to the services they need to remain healthy in their communities.

LeadingAge New York appreciates the opportunities for input the Department of Health has offered to providers and associations on this issue. We look forward to working with you to develop and carry out a plan that will strengthen HCBS providers and create a sustainable system to ensure access to quality home and community-based care for all who need it.

Sincerely,

Karen Lipson
Executive Vice President for Innovation Strategies

Cc: Susan Montgomery
Valerie Deetz
Adam Herbst

[1] Gusmano, MK. Medicare Beneficiaries Living in Housing With Supportive Services Experienced Lower Hospital Use Than Others. *Health Affairs.* October 2018. Li, G., Vartanian, K., Weller, M., & Wright, B. *Health in Housing: Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016. *Exploring the Intersection between Housing and Health Care*. Portland, OR: Center for Outcomes, Research & Education. 2016.