Transcript: ***Overview & Discussion on CMS Guidance for Additional Support for Medicaid Home and Community Based Services (HCBS) – Consumer Advocates***
May 27, 2021

Hi everyone, this is Brett Friedman. I still see people trickling in as attendees. Let's wait about two minutes and then we'll get going thanks.

Okay, let's get started. Looks like the attendee count has leveled off, which is great. Good afternoon, happy Thursday everyone this is Brett Friedman, the Director of Strategic Initiatives for the Medicaid program. And we're here today mainly as a listening session, but to discuss the recent opportunity as a result of the American Relief Plan Act (ARPA) that's providing 10% enhanced federal medical assistance percentage or FMAP for an enumerated list of home and community-based services. And we wanted today to do three things. This is the only slide just to orient our discussion, but we'll do three things.

One we'll give an overview of the CMS guidance governing the calculation of the enhanced FMAP and how that enhanced FMAP could be spent in connection with that overview of the CMS guidance, which was released on May 13th as part of the State Medicaid Director Letter number 21-003, we'll provide you with the process by which we're calculating the fiscal estimates. We'll discuss the ability of CMS to permit reinvestment of that enhanced FMAP, the so called maintenance of effort requirements that go along with claiming the enhanced FMAP to ensure that the funding supplements and does not supplant, consistent statutory language, existing home and community based services programs, and then some of the permitted uses that CMS has enumerated in its guidance.

Then, we'll give an overview of five or six ways that the department with our agency partners are viewing how the money should be spent. We are getting unsurprisingly a number of proposals, even before the CMS guidance was released. We had a list of over 90, and many more have come across the transom over the transom since the guidance has been released, but how we're viewing and prioritizing consideration of proposals for inclusion of our submission to CMS. And then we want to hear from you. What are your comments, questions about the guidance, about how we will consider proposals for inclusion. And then if you want to make suggestions on this call, we will happily record them.

At the outset consistent with other WebEx that we've used over the course of the pandemic, there are a few ways you can make comments. The first and preferable would be to raise your hand, and that is a little button in the bottom right corner of your WebEx screen. It looks like a hand. So, if you click that, that will notify us that you want to be unmuted so you can make a comment or ask a question. Or if you are phone shy, you can type your comment into the comments field on the bottom right you'll see a chat little bubble, or in the Q & A. Either or all three will be acceptable means of communication; we will record these questions. We are taking notes and we will include those in our consideration process as we prepare the plan.

We have about 45 minutes reserved today, happy to go a little bit longer, if we have comments, but I just wanted to give that lay of the land.

So, with that, let me jump into the guidance. The first thing that the CMS guidance did was it identified categories of HCBS services aligning to something called the CMS-64 process, so that's the submission we make to CMS that tells us what our match is going to be on the services and so, very helpfully, in a technical way gives us a clear indication of what waiver services or State Plan services or managed care services we'll be eligible to claim the enhanced FMAP on. We are currently working through the calculation process by waiver and by program for determining the amount of enhanced FMAP to determine the universe of new federal money we are getting through this statutory authorization. At this point, it's looking like it will be around 2 billion dollars and that is a reflection of our anticipated HCBS spend on those categories over the period April 1st, 2021 to March 31st, 2022, consistent again with ARPA.

Importantly, assuming that two million dollars is accurate or close to accurate, that money will be generated over the course of the year. It's actually aligns nicely to our state fiscal year 2022. And we can use that money to reinvest it in a number of qualifying HCBS expenditures. Those expenditures can occur over a three-year period, so starting today until March 31st, 2024, while we're generating the money in this first year, we can spend it over the next three years, which is a really helpful clarification because we were worried we'd have to spend it as fast as we were getting it. This gives us a little bit of time to make ongoing enhancements such that we can help preserve and sustain the HCBS deal, but the timing of those reinvestments as well as which reinvestments we choose to make, will impact the total amount of money we have to spend. To clarify, so we can reinvest the money twice. So, let's say that we're spending a dollar today. We are getting ten cents on that dollar, and we can take that ten cents and then reinvest it as the state share portion in a Medicaid covered service. So, we turn that ten cents into 20 cents at our normal 50% match. But if we spend the money quicker, when we reinvest that money- that ten cents - into calendar year '21, that ten cents gets matched, not at 50%, but at the 60% that CMS is providing on those HCBS expenditures and then plus another 6.2% because we're assuming that the enhanced match from the Family's First Coronavirus Response Act (FFCRA), the 6.2%, also applies. So, there's a strategy here in that the sooner we spend the money and the sooner we reinvest it in qualifying services, we can exponentially grow the money through these expiring federal matches. So, we'll generate more federal match in calendar year 2021. We'll generate a little bit less between January and March of next year and then after March of next year, assuming there isn't any other enhanced FMAP, it'll be matched only at 50%. So, the strategy around reinvestment and the potential for that reinvestment is important as we think through the guidance.

The third component of the guidance is this maintenance of effort requirement. So, CMS in interpreting the supplement not supplant language in the statute, said that we need to do certain things and make assurances that we are not going to make changes to our HCBS program, so that we're not taking the money and, you know, trying to use it on

things we would have otherwise spent it on, and so there are three maintenance of effort requirements: one - we can't impose stricter eligibility requirements on HCBS as existed on April 1st of 2021. That maintenance of effort prohibition calls into question how soon we can implement the 30-month asset look back test from MRT II, that is a new HCBS eligibility requirement. And so, we need to work with CMS to consider whether we can give them the assurance as they request, or demand, in connection with claiming this money. If we will lose the money by virtue of implementing the 30-month lookback, for example, we will delay that implementation to capture this money.

The second requirement is that we have to maintain the amount, duration, and scope of HCBS that has existed as of April 1st, 2021. So, we cannot reduce the amount we're currently providing to members under the categories enumerated in the guidance. We've received questions and we've asked those questions to CMS, whether that prohibition implicates things we're doing on the long-term care side, because personal care and CDPAS are qualifying HCBS services under the guidance. As to whether we can proceed with the change in the needs criteria, the ADL requirements, as well as aspects of the independent assessor process that we've been working to implement. We think given that they've been approved as of April 1st, 2021 that these are things we can proceed on because they're grandfathered under the guidance. But given that this is a lot of the federal money that we don't want to jeopardize. We've asked CMS that question.

And then the third component of the maintenance of effort requirement is that we have to preserve the rates. We can't cut HCBS services rates. So, if there is an ATB, we can't apply the ATB across the board to HCBS services or else we will lose the enhanced FMAP.

So those are critical requirements that we have to navigate as we claim and spend this money. The maintenance of effort requirements will last through fully expending the money or the end of the period March 21st, 2024. So, you know that's a critical component.

And then the last element is that CMS defines not in a fully inclusive way, but an illustrative one, the ways we can spend the money. Thinking through it - and it feeds into the the guiding principles - we can spend it on services that are matchable, whether under a waiver or a State Plan. Or we can spend on things that aren't matchable like technology, admin, social determinants, things that aren't part of our existing Medicaid benefit package or Medicaid State Plan. To the extent they enhance and support and they're new and supplemental to HCBS, CMS, consistent with an approval process, is allowing us to seek expenditure on those uses. So that's very important as well.

The process for seeking approval for the permitted uses is that we need to submit a narrative plan and our fiscal calculation, as previously mentioned, to CMS. It was initially within 30 days of the guidance letter, so June 12th of 2021, which I was reading as June 14th, because June 12th is a Saturday. But has indicated that a state can request up to a 30-day extension of that period, so through July 11, 2021. We are, with our agency

partners and these stakeholder sessions, working to put together that plan and put it out per submission. There will be a single plan submitted. It will be through DOH which is the single Medicaid State Agency, but we are collecting guidance and feedback from our agency partners - OASAS, OPWDD, OMH, OCFS - to ensure that the submission we make is comprehensive of the agencies responsible for overseeing those services and programs.

So, with that overview of the CMS guidance now to very quickly provide you with an overview of the guiding principles through which we will assess inclusion of potential reinvestment and investment opportunities for the permitted uses. Unsurprisingly, the first criteria is we are going to give preference to uses that are matchable. As CMS has permitted in this guidance, they are allowing us to use the enhanced FMAP to generate additional federal match if we reinvest that money in matchable Medicaid services and Medicaid covered benefits, whether through waiver or State Plan. And so, to the extent we can have more money to spend on things that appropriately enhance HCBS, we will do so. That is smart system management. We're not saying we're only going to do that if there are important investments to make that we just through no channel can match them, we will consider those. I'm not saying we won't. But there won't be a clear preference given to things that are. And we'll utilize authorities and channels that will help achieve Medicaid match. So, as opposed to granting money directly to providers or to training organizations, or to workers, we will prefer to send them through the managed care plans, for example, because doing so by including it in managed care plan premium and directing those plans to pay for certain specified uses we can achieve match on those dollars where we otherwise wouldn't.

The second principle governing our consideration of proposals is that there will be a general allocation of expenditures by the programs that generated the enhanced FMAP. So, a very broad-based example, OPWDD HCBS waiver services are generating a substantial portion of the enhanced FMAP. They are the largest single discrete component of our HCBS delivery system. The idea, and this is subject to ongoing discussion, but that OPWDD will be able to invest the enhanced FMAP it generates on OPWDD services. So, we'll try and keep the expenditures within the HCBS programs that generate them from the purposes of allocation. We believe that's fair and equitable and it avoids the fungibility problem, or the fungibility strategy around trying to apply enhancements over a different program. To us that's an important component because it fairly directs investment to the size of the HCBS programs that have generated them.

The next principle that is critical for our consideration is sustainability. This is required by CMS as a consideration which is the investments, while they're for a limited period of time, need to be a sustainable change to the delivery landscape and so one-time or temporary rate adjustments may have a slight impact, but we'll look to do things that create real and meaningful, sustainable change like building workforce capacity, for example. That I think will go a long way to ensuring that the workforce exists to really promote the delivery system.

The fourth principle is that the proposal should recognize that this is - it's a little bit counter to sustainability - but that these are limited duration investments. So, we will utilize strategies that by their definition sunset or unwind automatically by March 31st, 2024, as opposed to a rate increase that will ultimately have to unwind through a subsequent State Plan Amendment or a waiver change.

The fifth principle is we're going to address known risks and challenges within HCBS delivery landscapes. We know where we have capacity and access challenges. We know where there have been challenges. So, to the extent there is a known risk, and that is something that our programmatic staff are grappling with on a day to day basis, those will dictate and help dictate where we choose to spend this money.

The sixth principle is that we want to be sure whatever we do is aligned with MRT II and enacted State Budget reforms. We've been working hard to implement MRT II with your input and advice, and we want to keep that path going because the MRT II recommendations were important to achieving Medicaid fiscal sustainability and longevity.

And then finally the last principle is it should reflect the COVID experience. This is reflected in CMS's guidance as well but to the extent something is a specific response to challenges that arose during the COVID-19 pandemic, the COVID tie-in to us will resonate with an anticipated use. So, PPE elements, workforce challenges, hazard pay, retention pay, training in terms of emergency response and preparedness, those are things that will have resonance with us as we consider proposals as well.

So that's an overview of the guidance, as we read it. We provided these principals or considerations that, you know, DOH and the other agency partners will give as we assess feedback and proposals we're receiving from advocates and consumers and others. With that I'd like to open up the line and hear from you as to where you think this money is best invested or reinvested, understanding that from our standpoint what we've heard, and we're having a number of these listening sessions with different stakeholders, is that workforce, workforce, workforce has been what we've heard. It was a capacity issue before, it's become a more acute capacity issue going forward, but it extends across all HCBS waiver services and programs. To the extent you have existing proposals, guidance, thoughts, we'd really like to hear them. I'm happy to use the next 20 - 25 minutes, if not longer to hear what you have to say on it. Last statement before I ask you to raise your hands or present comments, is that you'll see an email address down here at HCBSrecommendations@health.ny.gov. Please, that's our BML, that's our mailbox for purposes of questions or further comments. So if you don't want to speak today, but you have something to say you can either, if you have my email address send it to me and your general points of contact roads will flow back to us or send it to this email address, which we monitor, and it'll certainly get considered as part of the inclusion process. So, with that, please don't be shy.

Okay, Allison Cook you're unmuted, please. You may be double muted.

We still can't hear you unfortunately. Are you muted locally on your phone?

Let's see. Is that better? Can you hear me now?

Now, we can hear you. Hello Allison.

Hi, this is Allison Cook from PHI. I have a couple of thoughts that I'll share briefly and then I'll send a little bit more detail over email. So, PHI, of course, we're very focused on direct care workforce, so we're happy to hear that others share our opinion that this money could really benefit the workforce. We have three specific ideas, two of which really align with some of those guiding principles you outlined. One is establishing the homecare jobs innovation fund. And so, there is a proposed bill in the Senate, which I'll share, and I'll also share some information about what the guiding belief behind the innovation fund is. But it would really be to create a pool of funding for pilot projects that test innovative approaches to better recruit and retain homecare workers. And the idea is that those successful strategies could be scaled up at a regional or statewide level. And then another one is really thinking about investing in training. So, the workforce investment program ended as of March 2021, and we don't have a concrete plan for what comes next. So, either some of this funding could be used as stop gap funding until we figure out what that next program is. Or we could really create a Workforce Investment Program 2.0. PHI has some thoughts about what that would look like. So, I'm happy to share that. Then, even though this is a little bit outside of some of your guiding principles, I do think it's really worthwhile thinking about increasing worker pay. Some of this money could be used as a down payment for that. There's been recent studies, including one by CUNY, on all the return on investment you get for increasing homecare worker pay. I'll stop there. I'm happy to answer any questions you have, and as I said, I'll be sending additional details.

Thank you, Allison. Those are really helpful comments and we'll look forward to the additional detail. I think all of these things, whether it's, you know, additional money for recruitment and retention, training investments, including innovative training, investments and worker pay are all things - and worker pay, being, not just sort of holistic wage increase across the board - but ways to increase worker pay, including benefits, including things like shift bonuses or retention bonuses for longevity. Those are all proposals we've heard and we are strongly considering. One element here, and I think it could apply to each of these programs is, what we can do again through MLTCs or mainstream managed care plans, not to help them necessarily drive the parameters of the program, but to the extent that we can utilize the existing managed care program as a means of enhancing the match on those services, so that we can increase the pool of dollars available to innovation, to training, to workforce pay, and evaluate and reward plans, LHCSAs, FIs, and other entities in the homecare space for ensuring the money gets into the pockets of workers and does the things that we need them to do. That's one of the ways that we're looking to align some of the guiding principles together, right. Ways that we will - can achieve these initiatives, including promoting and having a robust workforce in the homecare industry going forward while at the same time, not leaving federal money on the table. So if there are strategies or program parameters

within that managed care construct that are either entirely objectionable to you or exciting, with appropriate evaluation criteria and metrics, we'd love to hear those as well, because again, like, we want to make sure this money goes to the most needed areas of the delivery system. But, again to do so we're really maximizing the federal investment that's been authorized here by Congress.

So, with that, we can go to Susan Platkin.

Oh, can you hear me. I think so.

We can hear you now.

Great, I'm a part of the New York Self-Determination Coalition, which is a volunteer group of parents and affiliates who mentor other families and advocate for self-directed services within OPWDD. My thought was to have some of the money go towards a program modeled on Money Follows the Person. However, not taking people out of traditional large institutions, like ICFs and nursing homes - but to move people who wish to, out of group homes in the OPWDD system into non-certified setting using self-directed services. I think it really meets a lot of your criteria. It reflects the COVID experience because we've seen what the death rate for people living in congregate settings are. It certainly addresses a challenge in HCBS because housing is an ongoing challenge. It's a limited duration investment because it really would just be for that transition. And it will be sustainable because people who move into non-certified settings using self-direction will then have waiver funding to continue their self-directed services. So, it seems to really meet a lot of your criteria. I think that that would, you know, in addition to settings like Olmstead. You know, we could go on and on, but I think that that would be a really valuable way to use the money.

No, I appreciate that guidance. Just so we ensure, have you been communicating these ideas too on the OPWDD side just so we're aligned, and we can cross pollinate ideas to the extent possible? I just want to understand what they know as well.

Incessantly.

Okay, I expected so. But that's helpful here as well. Thank you, Susan! Anyone else in the attendee lists that we'd love to hear from?

Oh, there we go. Okay. Meghan Parker.

Hi Brett. Thanks for doing this. I just want to add my voice to the chorus you've been hearing of the great need to increase wages for home care workers. You know, the acute crisis is only going to worsen upstate after July 1st, when people will be making minimum 15 dollars an hour in fast food, which is a much easier job than it is to be a homecare worker where, at most, earn a few bucks less an hour doing that and so anything this state can do to leverage these funds to offset that I think is absolutely critical to keeping people out of nursing homes. We run a couple of statewide

programs, and just I keep hearing that you know, we can't get people - we find it's very hard to find affordable, accessible housing. We even do that and then we can't get them homecare. And we have them all set at home, and then they lose their homecare workers and they can't recruit new ones. And so, it's an absolute crisis and whether it be increasing wages across the board, which is absolutely what needs to happen, but if it's not that, then yeah, absolutely boosting recruitment and retention efforts with one-time payments, both for maybe people who were working over the past year through the crisis as well as giving people who sign up to be homecare workers bonuses and maybe later in the year closer to the holidays, bonuses – different ways to incentivize to bring people on and keep them on I think is just a crucial from our perspective, which is not the provider perspective as much as just people with disabilities who want and need to live in the community.

Thank you, Megan. One thing we've asked CMS, and it came up on one of the all-state calls, was that, you know, whether we could spend the money for retroactive costs. And so, if you were a homecare agency or even a worker themselves who went out of pocket to buy PPE, when PPE wasn't adequately funded or readily available early in the pandemic. And we've heard no, that we can help you know spend it on future things that may have addressed past things, but we can't sort of say, show us the receipts and we'll reimburse you for the receipts that you incurred. And so that's a critical distinction I just wanted to highlight because it has come up in conversations with CMS as to how they're designing this program. And it does, I think limit the utility of, like you know, paying for past PPE expenses in particular, given we know the challenges faced earlier in the pandemic around that specific issue. But we can use it to say, you know, build up stores of new PPE so that, you know, in the event, there's another pandemic there's an adequate pool and resource to draw from. But that's one of the challenges that we're facing as we try and interpret CMS guidance. So, your comment raised that point too just about sort of past access issues, but, you know, certainly hear you on recruitment and retention crisis, pay bonuses, training bonuses, et cetera.

Gail Meyers, please, if we can unmute your line. We're happy to hear your comment or question.

So, I agree with the previous speakers and thank you also for this briefing, this is - speaking on behalf of the New York Statewide Senior Action Council. I'm very much concerned about recruitment and retention of the workforce, but would like you to add into the mix something that I haven't heard raised and that is the state needs to do a PSA on why this is a valuable career, and that there's lots of work that's been done on trying to figure out messaging, but certainly don't want to spend most of the money on a PSA. You want to put the money into the workforce and into the wallets of those that are continuing to work. And another idea is within those recruitment and retention strategies, a bonus for workers who also bring in other workers into the field. So, thanks for letting me share.

Okay, yeah, so I think I would say like a referral bonus for recruitment and retention got it. Okay. Noted.

We have one question another for Alison. Does that mean that retroactive hazard pay is off the table? Based on what we've heard so far from CMS, it appears so, right in terms of, like – hazard pay is an interesting one, right? Which is you're incurring the cost now for expenses that have yet to occur, but effort that was put in. We think hazard pay could be a possibility, right? Because you're saying we are bonusing workers and we're saying we're bonusing them because of what they went through during the pandemic. We think that line of argument would potentially be possible under the permitted uses. But, you know, we and other states have definitively asked that question to CMS, which is, it is a new expenditure because the bonus obligation would be new, even if the bonus obligation dates back to hazard type work that was performed during the pandemic. So, we are keeping that option on the table. But some of what CMS has appeared to say, would make paying for past work more challenging, so I can't say yes or no definitively, but it's a concept that's on our radar and one that we will try and pursue.

I don't see any other hands raised, but I want to give more opportunity and there are several folks on the line that we haven't heard from yet. So, again, if you don't feel comfortable speaking on this line, or sharing your comments across the board, or if what you'd say you believe is already said, you know, feel free to email, send on to the email box below.

Oh, okay, Fred, thank you. If we could unmute Fred. That would be wonderful.

Hi, Brett, thank you. This is Fred Ricardi from the Medicare Rights Center. I agree with the earlier statements in particular with what Allison and Meghan had shared. I'm thinking something that's related - directly part of HCBS services, but also related to Medicaid eligibility so it falls into the bucket that you previously mentioned around technology. I think this may be a good opportunity to make some investments into the New York State of Health by moving eligibility determinations for disabled, aged, blind Medicaid and home and community-based services into the New York State of Health. Ideally, I think this would mean that individuals who are eligible for Medicaid while moving from the New York State of Health could then be screened and enrolled without having to go to the Local District, so it would require moving all of the disabled, aged, blind budgeting, including related programs like the Medicare Savings program, long-term care into the New York State of Health, and so I think it would allow for seamless transition for people who are receiving Medicaid when they become Medicare eligible, or have a disability. Then also it would allow for new enrollments directly through the New York State of Health while continuing to have a Local District presence for people who need in person service.

We appreciate that, I think moving away from WMS has been a long-term objective of all of us and then to enter into the NYSOH system. Your points are especially germane because some of our marketplace integration staff and Lisa Sbrana's team have been very concerned about what it's going to look like when a lot of the COVID related flexibilities that have applied on the eligibility side will be unwound we're thinking at the

end of the year. There can't be enough time to sort of try and undo that backlog that is necessarily going to occur given that so many of those eligibility processes have been suspended during the pandemic, so we really appreciate that comment. It's very prescient. Thank you.

Lynn Decker, please, we can unmute your line.

Find out where to do that.

Okay, Lynn, you're up. We can hear you. We did it. We did it on our end. Yep.

All right, thank you. Unlike where Fred is suggesting that you migrate a function to State of Health, similarly to the antique state of technology with WMS, the folks over at OPWDD have legacy systems that are not up to the current demands being placed on them, and although I do not think it would be match eligible, you spoke about a sort of a second tier of expense that would be permitted, but not matched. I want to bring your attention to technology investments that should be made possibly also in Office of Mental Health, although I don't follow that sector closely, but definitely at OPWDD in its central office.

Sorry, are you referring to the Tab system most directly?

Tabs and Choices, in particular, are very clunky, and there are a lot of opportunities for data analysis across pooled data of many, many system participants that are simply not possible in part because the richest datasets on individuals are held by their contract partners - the care coordination organizations. And there's a very elaborate data pooling strategy that Ms. Black of OPWDD has presented in public meetings of that agency over the last year and a half. And I imagine they've made progress on it during the pandemic. I hope they have. But simply they're trying to build a boat with popsicle sticks there and I think that they need some money to actually do something that's going to be always on, and reliable, and robust, and I don't think what they are going to be building with what resources they have is going to meet those standards.

Understood yeah, I have spoken with folks at OPWDD about Tabs in particular as being one area where - this is very much on their radar. For lots of the reasons you mentioned, right, which is the limited ability to generate meaningful data reports, right, anything under the quote unquote round numbers and there it may very well, and this is beyond my Medicaid match expertise, but there are ways to get Medicaid match on Medicaid Systems investments and so that's one thing being explored, especially on the OPWWD side, given the antiquated nature of their processes. So I will convey that to them as well, as I'm sure you have, just to say that, you know, I think we support anything that will improve the systems and data infrastructure of our ability to make good and actionable decisions, whether it be around eligibility or service delivery

Cool and to answer the question that you posed to Susan Platkin - yes, I've been telling them that too and hearing it from them, so that's not new information to them at all.

And we certainly support OPWDD's efforts in that regard as well.

Thank you.

Now, we're coming up towards the end of the appointed time, but again, I'm happy to hear from others if comments have not been made yet. I do want to thank everyone for chiming in where they have. The more we hear from you the better in terms of ensuring that it's a lot of money and this is a wonderful opportunity coming out of the pandemic, but it's also finite and time limited so we do want to make good choices.

Seeing more workforce comments that's definitely the theme and we do appreciate that. I think it's been very much highlighted by this. So seeing no one else jumping in to speak and with a reminder to please use the mailbox for any additional comments and questions to the extent they have not been conveyed, I'm happy to let folks go on this very beautiful Thursday afternoon here in the city, at least. So, with that, thank you and we look forward to a collaborative process, and getting these proposals out the door in the next two to four weeks. Thanks so much.