Transcript: ***Overview & Discussion on CMS Guidance for Additional Support for Medicaid Home and Community Based Services (HCBS) – Health Plan Associations***
May 28, 2021

Good afternoon everyone it is about 2:02 on May 28th in the afternoon. I'm going to give everyone a few more minutes to file in and then we can get going. Thank you.

All right let's get going I think the attendee account has slowed down so it's evening off. I hope most people joined at this point. Good afternoon. This is Brett Friedman. I'm the Director of Strategic Initiatives for the Medicaid program. And we are helping coordinate the State's response to the enhancement to the HCBS federal match percentage (FMAP) and the potential uses for that enhanced federal money under the American Relief Plan Act (ARPA). And so, the purpose of today's call is threefold. The first, is to provide an overview of the CMS guidance that was released with regard to the claiming and spending of this enhanced federal match on Home and Community Based Services (HCBS) and programs. We will go through seven guiding principles that we are using informally within the Department and other agencies to help inform the proposals that best meet the requirements of the CMS guidance and State need. And then we will spend the vast majority of time hearing from you, I hope, on any comments and questions you have with regard to this federal opportunity and ways the Department can help support the needs of the programs and services that are to be funded under this initiative.
So we've been given a very short time window by CMS to develop a plan for approval with regards to spending this money and so this call is one of several we've had this week with different HCBS stakeholders to solicit your input as quickly as possible. Looking at the attendee list, several of you have probably been on many of these calls already and so I'll hopefully be as consistent as I can with the other calls we've had this week.

So, with that, let me dive into the CMS guidance. As I mentioned, in mid-March Congress enacted the American Relief Plan Act enacted of 2021. It was the latest stimulus bill as a result of the COVID-19 pandemic. In that, one provision of the bill provided 10% enhanced FMAP, above and beyond other enhanced FMAP that's already been provided through the pandemic, to fund certain home and community-based programs and services that exist within Medicaid program. The statutory authorization for this money was fairly broad. It basically said the money needs to be used to enhance, sustain, and support existing HCBS programs and services and to fund new and/or supplemental uses around those programs, and that the money should supplement and not supplant state expenditures on those services. And so, when the federal legislation was first enacted, the task fell on CMS to implement it. And CMS, just recently on May 13th, 2021 issued State Medicaid Director Letter 21-003, which provided a lot of helpful feedback, a lot of guidance, on the questions we had as a State. It raised a number of other questions that we've been working through with CMS since release of the guidance, but most critically the guidance requires the State to submit a comprehensive narrative and submission to CMS initially by June 12th, 2021, 30 days from the issue of the guidance, but because June 12th is a Saturday we thought we had June 14th. But CMS may entertain up to a 30-day extension for submission of the plan, and in that plan we'll tell CMS what our calculations are with regard to the amount of federal money we expect to claim above and beyond what we would have claimed already for HCBS and how we intend to spend the money. And so again, the purpose of this call is to hear from you about ways that we could spend the money to enhance, sustain, and support the HCBS programs that generate it.

The first thing that the CMS guidance did was, it's helping us reach a fiscal estimate on the amount of money we will generate through this enhanced FMAP. The time period we get to claim the 10% match from April 1st, 2021 through March 31st, 2022, and the guidance delineates specific lines on how we claim money to CMS on the so called CMS-64, and how those align with our State Plan and waiver programs that qualify for the match. So, we've been taking that guidance back and working to generate a fiscal calculation that will provide how much money we will generate in this - it's really State Fiscal Year '22.

Right now, we are still completing the analysis, but we expect the number to be around two billion dollars, give or take. That's a reflection of the fact that New York has one of the largest existing HCBS programs in the state, between our 1915(c) waivers, between what's funded under our 1115 waiver, as well as State Plan services, mainly personal care services and CDPAP, which I would say hasn't historically qualified under HCBS, but does so under the statutory authorization and the CMS guidance. So, that should give a sense of the universe of the claiming that we'll have as a result of this opportunity. CMS says that once we generate this two billion dollars and enhanced federal match under the proposal, we can use that money as our State share to fund matchable Medicaid services. And this was a really important point, which is that we're not just spending the two billion dollars we can spend the money towards other matchable services so that that two billion dollars could double under our existing 50% match rate and even more than double, depending on whether those services are already subject to further enhanced match percentage. So, for example, through the end of the calendar year, assuming the federal public health emergency continues under the calendar year, those that match will also include the 6.2% enhancement through FFCRA, the Families First Coronavirus Response Act, and then if we match the money through March 31st, 2022, it will continue to get doubly matched for the 10% enhanced FMAP another time. So, there's certainly an opportunity to invest this money strategically to maximize federal reimbursement beyond just the initial match we get through the enhancement. So there is, to go on the agenda, strong reinvestment potential.

The third agenda item here is maintenance of effort requirements (MOE), and this is the only slide for those of you who are following along at home. CMS imposed stringent maintenance of effort requirements to ensure that our changes supplement and do not supplant existing HCBS programs and expenditures. Maintenance of effort requirements often come with enhancements in FMAP. FFCRA had one, for example, there were investments back to the ACA and the like, and this maintenance of requirement is quite stringent. And it has three specific components to it.

The first is we cannot apply more strict procedures for determining eligibility, nor stricter eligibility requirements for HCBS programs and services. And so, this implicates several MRT II recommendations, namely, the 30-month lookback with regard to the asset transfer test for home and community-based services. And so, we're working with CMS to determine whether that MRT II proposal, which is subject to a pending 1115 waiver submission, could be processed for the duration of the maintenance of effort requirements period. Similarly, raises questions under the ADL requirements that we apply the PCS and HCBS eligibility, although we believe those are grandfathered because we received State Plan approval on April 1st, so, prior to the application of the maintenance of effort period, but we're confirming that with CMS. And it also raises issues with the HCBS CORE transition, as it applies to certain behavioral services in the HARP benefit package. So, we are working with CMS to determine the application of those MOE requirements to long standing MRT II derivative initiatives being implemented in the Medicaid space, and trying to balance out how that process would work.

And then the last thing the guidance did, was it defined a very broad universe of permitted uses. So, the ways that we can reinvest the money. And the critical piece here is that the permitted uses include both matchable Medicaid services and non-matchable Medicaid services. So, things like rate enhancements which would be a matchable Medicaid service, whether under waiver or State Plan, or things that aren't matchable, like, technology developments or SDH interventions, social determinants of health interventions, or grant programs, those things we could spend HCBS money on with appropriate CMS approval but we wouldn't get the benefit of the additional match on those dollars.

CMS is going to have, if it's a matchable expenditure, CMS will have a two-part approval process for the extension of any funds. The first, is they will approve it as part of our initial plan submission and quarterly reporting, which is required under the guidance and two, if we have to do something pursuant to a State Plan or a waiver amendment, which would be typical under 1915(c) waivers or even our 1115 waiver, we will have to go through a normal approval process on those, hopefully streamlined and expedited. But the idea is that we'd have to go to the necessary public comment, transparency requirements, and submission requirements.

Two things on 1115 waivers while many things could be matchable through a new 1115 waiver amendment, CMS has told us on All-State calls that we should not look to 1115 waiver amendments as the primary source of match because, one, it takes a long time. Any 1115 waiver amendment requires at least six months of transparency and CMS review and approval. So that's not an expedited way to spend this enhanced money, and two, it will impact our budget neutrality calculations so it could hurt other waiver redesign efforts if we try and invest too much money to the 1115. Alternatively, CMS recommends using State Plan amendments, 1915(c) waivers, and cost reporting templates under those waivers, and directed payment templates as a means of pushing the money down to providers in a matchable way.

So that's permitted uses and then to go to the second agenda item, guiding principles for those permitted uses. So, as we assess proposals - and we've received lots of proposals already, we've been receiving them since enactment of the federal legislation and we hope to receive all of your best thinking on ways to spend this money most effectively to enhance, support, and sustain HCBS - we thought it would be helpful informally to lay out the considerations, or the principals that we are viewing as we assess proposals for inclusion in our State submission. And these should not be surprising, but just to lay them out on the table.

The first is, we think, and these are ongoing discussions with the Governor's Office and Division of Budget, but that the allocation of funding will be by the HCBS program that generated the match. So, if you're thinking about - we have an enormous HCBS delivery system, some of it's regulated by OPWDD, by OMH, by OASAS, by DOH, different waivers within DOH - to the extent possible, and it was reflected in this year's appropriations language and the enacted State budget, that the HCBS programs that generate the enhanced FMAP will get to reinvest those dollars as a broad based allocation. So, if its personal care services driven, those will go back to personal care services, the OPWDD system and the like, within those systems there may be some flexibility but, you know, just sort of broad-based allocations. We think that's an equitable principle for the uses.

The second principle is maximization of federal match. It is not in the State's history and experience to leave federal money on the table. And so, if we're looking at permitted uses and one permitted use is a matchable expenditure and the other is a non-matchable expenditure, the matchable expenditure will have preference, because the money will go further. It's not to say that we're only going to spend money on matchable uses, or we're going to do something

simplistic like Georgia has proposed where they're going to do a 10% across the board rate increase for HCBS, but we will prioritize ideas or strategies that work to maximize federal match. So, if we do things funded through the managed care plans through a directed payment template, that would have more benefit then, say, a direct grant award to the providers, because, again, it would allow us to receive the match on those funds.

The third principle is sustainability. This is in the CMS guidance. We're looking to make investments that create systems sustainability. So upfront investments in workforce capacity, systems capacity, that can sustain themselves even after the period of time in which we can spend these funds has expired, which will run through March 31st of 2024. Those will receive preference. Additionally, we will give preference to proposals that are of limited duration. Right? This money is only being generated for a year, while we can reinvest it over a three-year period, at some point this money is going away. It's not a permanent federal match. The money is finite, so we will look at proposals that are more one-time in nature, rather than a built-in rate increase that we would have to then unwind at a later time.

The fifth principle is to address known risks and challenges. So we are aware, but, you know, it's always helpful to hear where there are access challenges, there are provider recruitment challenges, there are ongoing legal risks in terms of our ability to develop and sustain a program, risk mitigation, service delivery, access challenges are our focus.

The sixth principle is MRT II and State Fiscal Year 2022 enacted budget alignment, right? We've recently gone through MRT II and this year's State Budget and an enormous Medicaid redesign process, and we want to ensure that what we do is consistent with that policy thinking.

And then finally, you know, we will prioritize proposals that speak to the COVID-19 experience. So, challenges that were exacerbated by COVID-19 will have a preference in our consideration of opportunities and options, because it's reflected by the CMS guidance and it's the basis by which the statutory enactment was made. So, to the extent some things related to PPE or specific workforce challenges coming out of the pandemic, we think those initiatives, those proposals should garner a measure of a prioritization through our consideration of proposals.

So, with the description of those principles on our consideration of permitted uses, we want to cede the floor to you and spend the next 25 to 30 minutes hearing from you o0n anything that you would like to tell us questions you have about use of the funds, about how you think we should use the funds, whether there are concerns about utilizing the existing managed care infrastructure to help push money down to providers with appropriate plan support. That's what we want to hear today. And so, there are a few ways to make a comment or to ask a question. The first, is and those of you who are now very familiar with our WebEx platform, there's a little hand on the bottom right hand side of the screen that, it's a really kind of poor logo, but if you scroll over it says "raise hand". So raise your hand, that will sort of show you in the attendee list and we'll unmute you and you can make a comment or ask a question. You can also type it into the Q&A box or into the comments field then we'll record those, I can even go through those and sort of call out the questions if your phone shy, but that's also a way. And then finally, the last way, if you don't want to do it today or you want to give further thoughts to your comment or question, we built a centralized DOH mailbox called HCBSRecommendations@health.ny.gov, projected here on the screen and you can email your comments and questions. That mailbox is centrally monitored and will be part of the proposal consideration process.

So, with that, I will be quiet and turn the floor over to those of you on the phone in hopes that you are vociferous and punchy on a Friday afternoon before a long weekend.

Okay, I'm actually going to call on Kathy first before Karen - only Karen, because we've spoken already on these as part of a different call. So, we'll start with Kathy. We'll go to Karen then Megan.

Okay, hi. Can you hear me?

I can hear you Kathy, hi.

Okay, okay so you mentioned Brett, CMS has said don't look to the 1115 waiver as the best place to get a match does that mean that you don't want to focus on things that are going to be part of the next waiver application like, social determinants of health and telehealth infrastructure?

No, it's my way of saying that if we have to submit an 1115 waiver amendment on a proposal to get the match on that proposal, that's less preferable to other matchable means of applying the proposal from a policy direction standpoint. I know we've had several conversations on where we want the waiver design to head, to the extent that we want to make a down payment on certain of those things, I'm all for it. I actually think that's aligned from a policy perspective, but I just want to say that, you know, well, it's like, "well, this is a good proposal, you can get match on it through an 1115," it's like, that's a really hard channel to get a match on. And so, you know, again, we would prefer from an authority's perspective, State Plan amendments, 1915(c) waiver amendments, directed payment templates. In fact, one of the proposals we're probably most considering here, as it applies to the managed care and MLTC side of the house is to do a fairly comprehensive directed payment type program around personal care services and CDPAP development and support. And so, to run that as a directed payment program with the plans, and LHCSAs and FIs to utilize those existing channels to help with workforce development, which we know is a huge access challenge coming out of the pandemic. And so, to the extent that we can partner with plans to find a mechanism to pay the money to plans and have the money, you know, sort of get paid to the providers in your network that meet the requirements of the program. That would be, to me, an ideal mechanism where we could support some of the workforce training and development needs but do it in a way that utilizes a matchable means in the plan infrastructure.

Okay, okay.

Great. So, thank you, Kathy. Should we go to Karen? Karen you're muted. Hi. Oh, you're, you're unmuted on WebEx I don't know if you're unmuted locally. We still can't hear you if you're trying to comment.

Here I am, can you hear me now?

Now we can, hi Karen.

You would think I could be able to do this after 14 months, but all right.

I told you that every day is a challenge. Yeah.

So, we've been sort of trying to digest the federal guidance, and the ways that funds can be matched, and I just want to shout out to Manatt for their excellent brief on this which helped me a lot. It seems to me that this is a once in a generation opportunity to invest in our long-term

care system, which has been starved for resources for so many years. And I completely understand the need to maximize federal match and to get the money out quickly, but I would also argue for thinking about some more creative strategies that would help to revitalize our system. You know, I'm not sure that pushing out the money in the ways we always have, the easiest and fastest, will be the highest and best use of all of these funds. So, I would urge you to think about that and we'll put some of these ideas down on paper. And when you said that the Appendix D services, or options, are not matchable. Did you mean not matchable at all or just not matchable at the enhanced rate? Because I think they're matchable but possibly not at the at the enhanced rate.

So Appendix D?

So those are the sort of the menu of more creative items like social determinants of health.

Oh, yeah, so I think some of them may be matchable. Some of them may not. They certainly, because they're not traditional HCBS or, I mean, new or additional HCBS, which is the first category, would be matchable at the enhanced rate. Because you're spending more money on HCBS, your generating more money on the enhanced FMAP. The other ones, - Cross system partnerships, training and respite, eligibility - Some of those, maybe matchable, some of those may not be matchable, even baseline matchable right? So, SDH interventions right, limited ability to get match on SDH, you know, unless we do it say through an in lieu of service, I don't know how to generate match on a lot of the SDH interventions. They're not State Plan services, They're not part of the standard MCO benefit package, right? So, some of those just may not be matchable at all. Unless we want to do say, an in lieu of services template on it. But it's my way of saying, as you bring proposals for our consideration, in terms of where you think the money is best spent to the extent that there is a strategy that goes with it that helps us understand the best way to obtain federal match on it if possible, those will be worthy of greater consideration because I can go back to my principals and say, I'm not leaving federal dollars on the table. And it's not to say that we're only going to spend money on federal matchable uses. I mean, you know, there could be a strong enough case, which is like, listen, we need to fund technology, and we can't find a way to fund that technology in a meaningful way through an existing match channel, so we'll do a grant program, and we'll do technology matching – or sorry, we'll do a grant program, and we'll fund the providers directly for that technology. Right? But that's part of this difficult and very truncated decision-making process is, you know, we don't want to do just like what Georgia did, a 10% across the board increase. Right, that's not creative. That doesn't address the ills, but we do want to understand a strategy, which is, especially in discussing it with the plans, that to the extent we can do things through existing claim match channels that achieve these long term purposes. That would be a preference for us.

Okay. Just one other consideration I understand the reasons why you would want to push money through the plan, but also, please keep in mind the conflicts and tensions that have arisen over that strategy in other contexts of reconciliations and transparency and contract negotiations, et cetera and, you know, sometimes it doesn't seem like that's the most efficient way to get money out. So, if we can think about those issues, as we're developing this proposal.

Okay, thank you.

Megan.

Hi, can you hear me?

We can.

Okay, so, I mean, I agree with Karen, obviously, there are some issues that sometimes arise with directed payments and rate increases through plans. But I do appreciate your comment about sustainability and limited duration, which I think were guiding principle three and four if I was jotting them down correctly. I mean, I think we've talked to plans about this and they do very much support an effort to increase homecare wages, which I know has been discussed quite a bit since the enhanced FMAP came out. And just would otherwise worry that we would be in a similar situation with minimum wage, that this is a short-term program and funding, and don't want to be in a situation where the program is again blamed for costing a lot of money because of efforts that, you know, came out of the ARPA enhanced FMAP. I think like, one pretty targeted piece of feedback we got from plans actually about workforce investment is that they have some really hard to serve areas where there is no public transportation and something they'd be really interested in is ways to get some money to help LHCSAs help get aides out into hard to serve areas, particularly out in Suffolk county, where they just cannot get aides out to members. And then the second comment, I think we've really heard from plans - is there a way to leverage this funding, both to get it out to providers, but also to try to further the safe schools of integrated care? And I'm sorry, I have an assistant who woke up from his nap early and has decided to be talkative as soon as I unmute the phone. So, he likes your voice, I guess Brett, because he was quiet the whole time you were talking. So, you know, whether is there a way we could potentially funnel some more money through MAP and PACE, to providers to try to get that incentive to have people move over to an integrated product, or have providers give that incentive to move to integrated care. And I think you saw we sent a list of recommendations around PACE, because certainly we'd like to see the PACE dollars, consistent with what you said earlier, the dollars earned by PACE reinvested back into PACE. Either through PACE rates or capital grants, whatever is the most matchable and lines up with the other guiding principles you're talking about. So, I'll just pause.

Yeah, no, thank you. Thank you for all of those comments. I think those are all important ones. PACE was specifically called out in the CMS guidance and I would say I so appreciate your, you're consistent with the principles of MRT II alignment, moving to the integrated dual strategy is certainly something that we are amenable to. So that's very helpful.

Dan Lowenstein, if we can unmute Dan.

Hi, yeah hey, I'm sorry. Do you hear me?

Yep.

I just thought I'd put it in a chat.

Oh, sorry. Well, if you want to ask it now, that can be easier as well.

Yeah, I guess the question is, we want to be maximizing the match, which means getting it out of this year, really, to get the biggest FMAP bump. But after that, I guess the question is, does that mean we, the entity, whoever is spending it, do they have two years to spend it, I guess, could they have more? Could we envision something that got us match early and then, like, was a fund that could be used beyond two years?

Yeah, so that's an important question that we're expecting more CMS guidance on, but based on our read of the guidance, if we could get it matched by loading it into plan premium rates

sooner, right? Because that's the mechanism by which we claim the match, but then it would be spent out over a longer period of time. So that makes the plan mechanism a very attractive channel here is that because it's claimable from a match perspective quicker than it necessarily hits the delivery system - hopefully not too much before - but that's right. The money can be matched and then it just has to be spent before 2024. And if we spend it quicker, the maintenance of effort requirements go away and so that's also helpful, for other reasons.

Just one follow up, so when we're talking about through the plan rates, plan rates versus pass through type stuff?

Well, plan rates would, I mean, we wouldn't do pass-throughs, but like, let's say it's a directed payment, right? We would get approval for the payment, it would go into the plan, than it would get matched. And then it would be, you know, the plans would be, consistent with the terms of the directed payment template, working on spending the money through a program that was approved. So, it's when it goes into the plan rates, but not necessarily when the plan remits the money down to the provider network. Anything else on that one Dan or if not I can move on to Harold here.

Harold?

Yep. Can you hear me.

Yeah, now we can hear you. Yeah.

So thanks for the presentation. I want to follow up on some of the earlier questions here, because, as much as some of the permitted uses are very seemingly focused on provider investment, the plans are sitting at the bottom of the rate range, as you know, and so I would just urge DOH to be sensitive that anything that involves additional administrative costs should be factored in so that those get paid. And I would throw out the idea that there probably would be some good one-time programs that don't create underlying pressure on the overall cost of the program that could be driven through the plans. Like, different quality types of programs and things like that. And one other observation is since its May whatever date is today and we've got certifications due, that, you know, these programs like minimum wage, and Megan mentioned it, you know, sometimes when they get to the implementation phase, suddenly they have all sorts of requirements on plans to assure that funds are being spent in the way that is intended and, you know, to some degree that's fine. But as we're seeing with the certification process for wage parity and what we saw with minimum wage and what we've seen some other programs, that it's difficult and challenging to put too much of that enforcement burden on the plans who don't have direct visibility into the expenditure of those funds. Just some things to think about as you as you design this, but I think we certainly would feel that that the plan side is an area needing some investment given where the rate range is.

I mean, to respond to that, we agree that consistent with any well-structured directed payment program that there would be a component for plan admin and especially with plans to the bottom end of the rate range and plan to administer an appropriate HCBS program, we believe would be consistent with CMS guidance, we, other than PACE, you know, there isn't a specific plan category where we can support plan development in and of itself as a means of HCBS. So, we'd have to think more about that. And I guess the last point is I completely agree with you, no one wants the minimum wage enforcement audit process, like we've had the last time. And so, you know, we'll think about ways that will minimize the plan compliance burden associated with administration of the program, right? This isn't any means of saying "gotcha" to the plans in any

way shape or form. We just we want to push out the money as quickly as possible for the right uses in a way that maximizes federal reimbursement. I don't think there's going to be a proposal that's going to check all of those boxes, but we want to check as many of them as possible.

Okay, anyone else with comments or questions? I know many of you have had the benefit of hearing this before and having those conversations, I just want to say that, you know, getting your proposals and understanding the framework on which we evaluate them, I think is going to be really helpful. You know, I don't know how much more time beyond the June 12th, CMS have given us up to 30 day extension. One thing I will say is, you know, and we said this in a prior call our desire in addition to all these other principles is to make transformative investments. While the roughly two billion dollars we expect to generate, which could be matchable, so it could be as high as four billion if not more, is a lot of money. It's not a lot of money when you spread it over three years on a close to 80 billion dollar a year program. And so, there is a sense of saying, this money is finite and we want to be able to make the most sustainable and structural changes we can. So, our goal is not to spread this money out in little chunks here and there. Consistent the allocation principles, the fewer bigger uses that check the most boxes to us, both from a program management perspective, but also from a transformative change perspective, speak to us as ripe opportunities. So, I just wanted to say that, whether it's in closing or if other folks have comments.

This is Karen. Can you hear me?

Yeah.

When do you need our written comments? I know this is very fast tracked.

Yeah, I mean, really, as soon as you can get them to us. You know, the longer we have them, the more we can consider that, I guess, is the way that I'll say it. We're working internally to say how many more days beyond June 12th are we going to request from CMS. I think by the end of next week I would say anything at the end of next week is not going to get a lot of time for consideration.

Okay, thanks.

And again, you know, to the extent that you want to direct your comments to, you know, and given who's on this call, you should know who those are. But the folks who sort of operate the HCBS programs that you're interested in enhancing, because just from a departmental management perspective, you know, you get them to me and then we can triage them. But for NHTD/TBI proposals, knowing to go to Beth Gnozzio, or if it's on the DLTC side, you know, Sue Montgomery, who's on this call, each person within is helping assess and advance recommendations in their area. So, you know, if it's helpful to have sub-conversations with folks especially given how close we partner with you on a lot of things, you know, I would recommend that approach as well. We don't have a lot of time for formality here.

Alright, at 2:44 PM, I'll say, going once going, twice in terms of comments. If I don't hear any others, I wish everyone, a very restful, but rainy and chilly three-day weekend. Enjoy your Memorial Day, safe travels if you're leaving the confines of Albany or New York City or elsewhere and thank you for your time on a Friday afternoon before a long weekend. It really helps us do what's best here in this challenging, but promising federal environments. So, with that, thank you everyone and I'm sure we'll talk to you again soon.