New York HCBS eFMAP Long-Term Care Workforce Provider Attestation and Survey

As part of New York State's enhanced Federal Medicaid Assistance Percentage (FMAP) for Home and Community-Based Services (HCBS) efforts, the Department of Health (DOH) has chosen to invest in the HCBS workforce, such that licensed home care services agencies (LHCSAs) are able to implement evidence-based care interventions, improve quality, and participate effectively in value-based payment (VBP) arrangements. Specifically, investing in evidence-based programs that help LHCSAs recruit, retain, train, and support their direct care workers will help the personal care sector recover from COVID-19, prepare to meet growing demand, and become ready to participate effectively in value-based payment arrangements.

Please be aware that all funding is contingent upon CMS approval of this investment. DOH remains in the process of seeking approval from CMS for a directed payment to certain LHCSAs through Managed Long-Term Care (MLTC) plans -- inclusive of Partial Cap MLTC Plans (MLTCPs) and Medicaid Advantage Plus (MAP) plans.

In the event that CMS approves this process and funding, eligible providers will be responsible for using their awards to develop and implement programs and strategies that assist in workforce capacity building and VBP readiness. **To continue to be eligible for these awards, providers will be responsible for submitting the online attestation form and survey to the State before January 14, 2022.** Providers that do not submit this attestation form and survey by the date determined by DOH will not be eligible for funding from this workforce and VBP readiness directed payment.

Providers will also be required to submit quarterly spending reports and provider surveys to the State beginning July 1, 2022 to retain their awards and maintain eligibility for future HCBS enhanced FMAP funding opportunities. Additionally, providers that fail to expend funds, or expend funds on non-approved uses, will be ineligible for future awards and/or subject to recoupment of their award. Any funding forfeited by providers in the initial round, along with any funding issued in subsequent rounds of awards, will be allocated to providers that have complied with programmatic requirements.

Instructions

1. The attestation and survey include a combination of multiple choice, short answer, and descriptive narrative questions.
2. All questions must be completed online. Follow up questions may appear depending on the information you provide. The PDF version contains all questions, so it may include questions your agency does not need to answer.
3. You will have the option to move forward and backward between pages using the Back and Next buttons on the bottom of the page. You can also save your responses using the Save button at the bottom of the page. When you close out of the survey, a URL link will appear on the screen. Use this link to resume where you left off.
4. You must submit your responses by January 14, 2022. A reminder notice will be sent to the email address on file.
5. Failure to submit the questionnaire by the deadline will result in exclusion from the directed payment.
6. The following individuals or similar/equivalent authority within the Provider Organization may sign this attestation:

   Owner
   Chief Executive Officer
   Chief Operating Officer
   President/Officer
   Chairperson
   Chief Financial Officer
   Governing Board
7. Please make sure that the Provider Organization Name entered below matches what is on file when the organization enrolled with eMedNY.

Provider Information

Please provide the following information:

Provider Organization:

Organization/Individual Email:

NPI Number:

MMIS ID Number:

Owner/Officer Name (see instructions, #6)

Owner/Officer Name (see instructions, #6)

Attestations

I, _____, attest that I have read the directions and guidance pertaining to the New York HCBS eFMAP Long-Term Care Workforce and Value-Based Payment Readiness Directed Payment, including the instructions for this survey, and understand the requirements for eligibility for funding under this payment program.

I attest that I have the requisite authority to complete this survey and attestation in accordance with the directions that I have read, and that all information provided in response to this survey is true, accurate, and complete and that I have taken reasonable steps to verify the accuracy thereof. I understand that funds under this program are only available for categories of expenses for building workforce capacity and/or developing VBP readiness expressly identified and described by the Department herein and in related provider guidance and that I must use my award to develop at least one such program or strategy. I also understand that such funds may not be used to support or supplant any existing or planned expenses, including any portion of any settlement obligations or other liabilities owed by the provider, or any related person or entity, prior to January 1, 2022.

Further, I understand that payment under this program will be from federal and state public funds and that any false claims or non-approved use of such funds are strictly prohibited and **will result in becoming disqualified for any further funds under this program and may result in civil or criminal fines and/or prosecution under applicable federal and state laws.**

In addition, I understand that as a condition of receiving and retaining these funds I agree and attest that the provider shall maintain compliance with all applicable state and federal wage and labor laws, and shall not engage in any unlawful conduct with respect to the employment of its employees, including any practices that are impermissible under any federal or state law.

Finally, I understand that by electronically signing and submitting this attention it is the legal equivalent of having placed my handwritten signature on the submitted attestation and this affirmation.

Signature:

Date:

Activities and Budget:

Please select the programs and/or strategies that your agency will develop from the list below. Additional detail on these strategies is available in the Long-Term Care Workforce and Value-Based Payment Readiness Directed Payment Information for Providers document. Please select at least one.

For each program and/or strategy selected, please indicate how much funding your agency plans to allocate to that program and/or strategy.

☐ Workforce retention strategies
Allocation: $____

☐ Development, implementation and promotion of training programs for staff

Allocation: $____

☐ Utilizing innovative technologies that assist with VBP contracting, care management, and increasing employee satisfaction

Allocation: $____

☐ Recruit and retain a racially and ethnically diverse and culturally competent workforce

Allocation: $____

☐ Implement strategies for effective care management and reductions in health care spending associated with effective service delivery

Allocation: $____

☐ Emergency preparedness efforts

Allocation: $____

☐ Preparation for value-based payment arrangements

Allocation: $____

Spending Narrative

Please describe how you plan to use your award to implement the choices you selected above. You should describe your plan for each category selected above, including details such as known expenses, timeline for implementation, region in which the funding will be spent, etc. Please remember that you must use your awards for investments in the region(s) in which your agency qualified for funding and may use the funding to implement efforts across their full New York service area.

Survey Instructions

Please answer the following questions as accurately as possible. **Throughout this survey, "staff," "staff members," and "employees" refer to direct care workers, i.e., home health aides and personal care aides. These terms do not refer to nursing staff.**

All questions must be completed. Follow up questions may appear depending on the information you provide.

Reminder: You can move forward and backward between pages using the Back and Next buttons on the bottom of the page. You can also save your responses using the Save button at the bottom of the page. When you close out of the survey, a URL link will appear on the screen. Use this link to resume where you left off.

Provider Survey

Workforce Recruitment and Retention:

1. How many direct care workers are currently employed by your agency?
    a. Number of employees working full-time (full-time does not refer to full-time equivalents): ____
    b. Number of employees working part-time: ____
2. Of the direct care workers employed by your agency, how many of them have been employed by your agency since before January 1, 2020? Please include employees who transitioned from part-time to full-time or full-time to part-time in the category that describes their current schedule.
    a. Number of employees working full-time who began employment before January 1, 2020 (full-time does not refer to full-time equivalents): ____
    b. Number of employees working part-time who began employment before January 1, 2020: ____
3. Please list the average and range of hourly wages your agency provides to its direct care workers.

	Average ($/hour)	**Minimum ($/hour)**	**Maximum ($/hour)**
Straight Time			
Overtime			

4. Does your agency offer benefit programs to employees?

    Full-Time Employees: ☐ Yes ☐ No

    Part-Time Employees: ☐ Yes ☐ No

    Please select the benefits that you provide from the following list:

    - ☐ Paid time off
    - ☐ Health insurance
    - ☐ Vision and/or dental insurance
    - ☐ Disability insurance
    - ☐ Transportation benefits, such as:
        - ☐ Commuting costs

- ☐ Gas
- ☐ Mileage
- ☐ Parking
- ☐ Public transportation
- ☐ Ride share
- ☐ Rental cars
- ☐ Other: _____

- ☐ Childcare
- ☐ Tuition assistance
- ☐ Other: _____

5. a. Did your agency have to turn down or delay requests for services due to lack of staffing any time in the past year? ☐ Yes ☐ No

   b. If available, please select the months in which your agency had to turn down requests.

   ☐ January ☐ February ☐ March ☐ April ☐ May ☐ June ☐ July ☐ August ☐ September ☐ October ☐ November ☐ December

   c. If available, for instances of delays, please provide the typical length of time (in days) between service request and service fulfillment. _____days

6. Are you able to meet demand with the staff you currently have? ☐ Yes ☐ No
7. When you most recently hired a direct care worker, how long did it take (in weeks) between posting the position and hiring the first individual? _____weeks
8. Does your agency provide a DOH approved Personal Care Aide and/or Home Health Aide Training Program (HHATP) credentialing course? ☐ Yes ☐ No
9. If yes, please provide the number of staff who completed it in:

   Calendar year 2019: _____

   Calendar year 2020: _____

   Calendar year 2021: _____

Diversity of the Workforce:

10. Please list the number of direct care staff your agency employs by race / ethnicity.

Race / Ethnicity	Full-Time Staff	Part-Time Staff
Asian		
Pacific Islander		
Black or African American		
Hispanic or Latino		
Native American or Alaskan Native		
White or Caucasian		
Other		
Not Available		

11. Please list the number of direct care staff your agency employs by gender identity.

Gender Identity	Full-Time Staff	Part-Time Staff
Female (including Transgender Female)		
Male (including Transgender Male)		
Non-Binary		
Other/Not Available		

12. Does your agency have recruitment strategies that help build a diverse workforce that reflects its client population? ☐ Yes ☐ No

    Please list the strategies your agency employs that help build a diverse workforce that reflects its client populations. _____

13. Please list the number of direct care staff your agency employs and/or is seeking by language spoken.

Primary Language Spoken	Full-Time Staff	Part-Time Staff	Are You Actively Recruiting Staff Who Speak this Language?
English			
Spanish			
Mandarin			
Russian			
Yiddish			
Bengali			
Korean			
Haitian Creole			
Italian			
Arabic			
Polish			
Other			

Training:

14. Does your agency require direct care workers to complete any trainings beyond those required by New York State (NYS) that aim to enhance their skills and improve quality of care? ☐ Yes ☐ No

    If your agency requires direct care workers to complete any trainings beyond those required by NYS, how many hours of additional training does your agency require staff to complete? _____hours

15. Please find three categories of trainings below (required by NYS, required by your agency, and voluntary). Please list the trainings that your staff completes under the relevant categories below.

State Required	Agency Required	Additional Voluntary
a.	a.	a.
b.	b.	b.
c.	c.	c.

16. How many staff members complete at least one voluntary training per year?

    Number: ____ Percentage: ____%

17. How many staff members complete more than one voluntary training per year?

    Number: ____ Percentage: ____%

18. How does your staff access trainings?

    ☐ Directly through the agency

    ☐ Via partnerships with other organizations such as WIOs, community colleges, other higher education organizations

    ☐ Through other licensed home care services agencies

    ☐ Other: _____

19. Please describe your agency's partnerships with other organizations, including how they facilitate trainings. _____

20. Does your agency incentivize training for direct care workers? ☐ Yes ☐ No

    Please select all the strategies your agency uses to incentivize trainings.

    ☐ Compensation for training hours

☐ Childcare or other caregiver coverage during training

☐ Bonuses for training completion or certification

☐ Wage increases for training completions or certifications

☐ Career advancement or mobility within the agency

☐ Other: _____

Technology:

21. What care management technologies and/or software does your agency use to improve and streamline access to and management of personal care services? Please select from the following options.

    ☐ Scheduling management

    ☐ Incident tracking

    ☐ Referral system

    ☐ Other: _____

Emergency Preparedness:

22. In the past month, has a lack of PPE limited your agency's ability to accept new clients?

    ☐ Yes ☐ No

23. Does your agency have sufficient PPE to deliver care in next three months?

    ☐ Yes ☐ No

24. How challenging is it for your agency to source PPE? Please select the level of difficulty from a scale of 1 to 5, where 1 is comparable to ease of access before the COVID-19 emergency and 5 is almost impossible.

    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Value-Based Readiness:

25. Please indicate whether your agency is prepared for participation in value-based payment arrangements in each of the following areas:

    Collecting quality data for reporting:

    ☐ Prepared ☐ Somewhat prepared ☐ Not prepared

    Submitting data reports:

    ☐ Prepared ☐ Somewhat prepared ☐ Not prepared

    Managing agency financial risk:

    ☐ Prepared ☐ Somewhat prepared ☐ Not prepared