LeadingAge New York 2016 Federal Advocacy Agenda

1. **Home and Community-Based Services (HCBS) Settings Rule:** In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule [42 CFR §441.301(c)(4)(5)], which included new standards for what constitutes an HCBS setting, for purposes of receiving services under a Medicaid HCBS waiver program. We appreciate the spirit of the rule, which is to promote independence, autonomy and choice for individuals receiving Medicaid waiver services. We have serious concerns, however, that CMS's guidance exceeds the reach of the final rule and that this will impact nearly every Medicaid beneficiary in New York State and elsewhere. If CMS imposes exceedingly strict standards, it could actually limit choices for seniors, drive up the cost of care, and pull scarce resources away from caring for the elderly.

   We respectfully urge Congress to ensure that CMS does not exceed its authority in the HCBS settings rule implementation process and require burdensome or unnecessary standards. Further, we recommend that a separate set of guidance be developed for the senior population that appreciates the unique needs of those individuals.

2. **Pending Medicaid Determinations from CMS:** In order to make changes to their Medicaid State Plans and be eligible to receive federal financial participation for these revisions, states are required to submit Medicaid State Plan Amendments (SPAs) to CMS for approval. CMS also reviews proposed changes to Medicaid managed care capitation rates. New York is awaiting CMS action on dozens of SPAs – including at least 16 amendments affecting long term care services – and several Medicaid managed care rate changes. The resulting lengthy delays in CMS action are delaying critically important payments to Medicaid providers and managed care plans and adding to administrative complexity, both of which threaten beneficiary access to needed services.

   We respectfully urge Congress to contact CMS directly, and ask them to prioritize action on New York's pending SPAs and managed care rate changes, and to develop workable processes to ensure timely action on future State submissions.

3. **Medicare Wage Index Adjustments:** In the Medicare prospective payment systems for skilled nursing facilities (SNFs) and home health agencies (HHAs), CMS continues to utilize the Medicare hospital inpatient wage data to adjust payments to reflect regional wage differences. Historically, this approach has disadvantaged SNFs and HHAs in states like New York where paraprofessional aides (which make up the bulk of the SNF and HHA direct care workforce) are compensated at higher rates than in other states. The hospital wage index does not fully account for this phenomenon, which will be exacerbated if a proposal to increase New York's minimum wage to $15 per hour is enacted into state law this year.

   Congress should direct CMS to collect the data necessary to establish SNF and HHA wage indices that are based on wage data from SNFs and HHAs, respectively.

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4. **Rental Assistance Demonstration (RAD) for 202 PRAC Properties:** Senior housing properties built after 1990 with HUD's Section 202 Program were financed with Project Rental Assistance Contracts (PRACs). Many of these properties now face growing capital needs, but are unable to leverage new resources for facility upgrades due to built-in barriers in the PRAC contract. The Rental Assistance Demonstration has proven successful in transitioning HUD-subsidized properties to new ownership structures that allow properties to leverage new resources, including private investment. The proposed HUD budget calls for allowing 202/PRACs to apply for restructuring through RAD, which would leverage millions for needed capital improvements, secure facility viability well into the future, and improve residents' quality of life.

   Congress should approve the provision in the HUD budget that will allow 202/PRACs to participate in RAD, and authorize $50 million to enable rent restructuring for long-term viability.

5. **Home Care Face-to-Face Encounter Documentation:** Home care agencies may not bill Medicare until they obtain documentation from the physician indicating that the patient had a face-to-face encounter with that physician 90 days prior to the start of home care or 30 days after the start of home care. The physician is required to document clinical information in this process as well, which duplicates the existing plan of care developed by the agency. If the physician does not meet all of the specified documentation requirements, the agency faces Medicare payment denials due to documentation technicalities despite the fact that appropriate care is being provided. This cumbersome requirement has also created a disincentive for physicians, especially in rural areas or underserved urban areas, to order home care services.

   We ask Congress to urge CMS to streamline the existing Medicare face-to-face documentation requirement, and to provide guidance for states to streamline the Medicaid face-to-face documentation requirements that are to become effective in July 2016.

Please contact LeadingAge New York's Advocacy and Public Policy Department at (518) 867-8383 if you have any questions on this information.

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