2019 POLICY PRIORITIES

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INTRODUCTION

LeadingAge's mission is to be the trusted voice for aging, and our promise is to inspire, serve and advocate. This document spells out the policy issues we care about and the positions we support and advocate for with Congress and the Executive Branch. Thank you for your interest in our policy priorities and advocacy work.

The process we use to identify these issues, frame our positions, and guide our policy development and advocacy work begins with our 5,800 members – large and small providers who offer services across the aging continuum – and the people they serve. Most of our members offer more than one type of service because people who need supports don't fall neatly into service buckets. They use a variety of services that meet their changing needs at different times. This explains the deep commitment to integrating and coordinating care and services that you will see throughout this document. Service systems that move away from siloed approaches work better.

> *This isn't working anymore. We've got long-term services and supports over there. We've got acute care here and mental health care over there, housing over there. That drives reimbursement structures which dictates our behavior and development and the inability to adequately address the issues of the people we serve. These are the siloes, and it's a perpetual problem.*

You will hear our members' voices, and sometimes their pain, in the framing of these issues. From March through October 2018, LeadingAge National and its state affiliates convened Town Hall Conversations in 34 states. We asked what keeps our members up at night and what ideas they have to address these concerns. The regional diversity and state and local cultures of 38 member states are reflected in what they told us. But more importantly, the similarities in their experiences are clear and their mission-driven commitment to the people they serve shines through.

In the pages that follow, all 17 top issues members spoke to us about are delineated, along with the solutions we are working on in partnership with members. Members will tell you the challenges they encounter, along with some sharp insights about life and work on the ground, in aging services, to introduce each issue.

LeadingAge policy priorities fall into three groups. ***Lead*** priorities are those on which we exert maximum organizational effort. They are a primary focus of our daily advocacy work. We work on these items alone and in coalition with other organizations. The role of these partners in the multiple, diverse coalitions in which we participate must not be underestimated. It is through these collaborative efforts, this joining of mission and advocacy, that we make progress and move ahead.

Engage priorities include important work on which we collaborate with other organizations. Sometimes that collaboration is initiated by LeadingAge, sometimes by others.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

Monitor priorities are those issues where we do not expect immediate Congressional or administrative action but we continue to watch carefully.

A small number of discrete legislative and administrative actions are marked with an asterisk (*). These actions are primary areas of activity on a day-to-day basis for LeadingAge.

The objectives that drive our ***Lead*** priorities include:

- Ensuring that a qualified, committed workforce is available to work in aging services.
- Achieving the right balance between regulation and autonomy in nursing homes and enabling them to be funded, staffed, and structured to provide the most consumer centered, high quality post-acute and long-term services and supports (LTSS) to residents.
- Making sure there is an adequate supply of housing available for older individuals across the income spectrum and that needed support services are available in that housing.
- Supporting aging services providers so they can thrive in Medicare and Medicaid managed care environments and deliver innovative, integrated care.
- Creating a well-developed, high quality continuum of home and community-based services (HCBS) that complements informal caregiving for older individuals.

All of our policy work is undergirded by what we know – and what we don't know – about the future. We know that by 2030, one of every five Americans will be older than age 65. We know that even the 10,000 Baby Boomers turning 65 every day have very different needs and expectations about their later years, and that they are not as prepared economically as their parents were for retirement and the potential need for aging services.

Over time we have more people who are living in community settings, but I think we need to be conscious of the fact that we're listening to the customer or the client wanting to be home, which is absolutely right, but now we're also experiencing increased isolation, depression and people who are feeling lonely.

We are also certain that there will be disruptions – new technologies we cannot imagine today, new ways of building housing and getting from one place to another, cures and treatments for conditions that are untreatable today, changing family and household structures, and alternative service offerings and combinations.

At the same time, we are living longer than ever before and remaining independent for more of those years. Nevertheless, more than half of today's 65-year olds will need some paid long-term services and supports before they die.

LeadingAge's policy and advocacy work is undergirded by this recognition of changing demographics and infrastructures, and the need to promote policies that are flexible enough to solve today's challenges but also ready to accommodate future demands.

Our policy work starts with delivering mission driven, person-centered services and telling our stories…and with recognizing the profound responsibility with which families of today and tomorrow entrust us. LeadingAge members rise to this challenge every day, and we are honored by the opportunity to work with members of Congress and the administration to share their stories, concerns, and successes.

It's the time where we get up and tell positive stories, and so we need to be out there nationally, locally and everywhere, talking about the awesomeness that we are 98% of the time.

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LEAD: AGING SERVICES WORKFORCE

Our vision is that aging services organizations are able to recruit and retain high-quality, motivated staff at all levels.

WHAT LEADINGAGE MEMBERS SAY ABOUT WORKFORCE

- *We don't even have people to interview, let alone hire. Last year, we had 9,000 RN, LPN and CNA jobs in our state and only 2,500 applicants.*
- *A hospital nurse I know is always sent home because of low census. I suggested she work at a nursing home, but she said it would be too boring and she'd lose her skills. It's the opposite; in a nursing home, nurses get to run the show. As nursing homes, we're not selling ourselves well.*
- *Millennials – if they are coming out of school in healthcare they want to go into hospitals. We need them in this industry, because we are all aging out.*
- *55% of the nurses in this state are over the age of 50.*
- *We bring in a lot of students. Once they're in our door, they see it's a super fun place to work. We do a really good job of taking care of our employees, so they can take good care of our residents.*
- *My campus is on [a high-income island to which many people retire]. You can't find housing on this island if you make $12 an hour, and you have to drive a couple of hours each way to live someplace you can afford and work here. Housing and transportation for staff – and potential staff – are huge problems.*
- *In our city some of the affordable housing will have to be set aside for our workers, teachers and others who don't earn enough to live where they work. It's the only solution.*
- *So, drug testing. When marijuana became legal in our state, half our drug tests were coming back positive. We dropped our pre-employment drug test. But we just did a training around the hangover of marijuana and what it does to a person, when they think they're sober.*
- *Finding dining staff is really a problem. Wait staff don't earn tips, and they can't start work until background checks are finished. They really do make more money at McDonald's.*
- *It would be a great idea to add student loan forgiveness as a benefit.*
- *So much of our direct-care workforce is on Medicaid and food stamps. We have people that work for us who don't make a living wage.*

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- *We are looking for ways to empower staff, how we can get them more engaged in leadership, and accountability and resident-centered care and give them the tools to be successful.*

- *We brought in three nurses from the Philippines and it's saved us a lot of money. And they bring their families over, so we have housekeepers, CNAs and servers.*

- *Some Life Plan Communities in our state are providing housing for staff. It helps with recruitment but also promotes intergenerational community living.*

- *Geriatricians are paid the same as primary care family doctors; they are the lowest paid physicians out there. Unlike family practice docs they can't make up for it in volume. That's why no one goes into this specialty, and it takes a long time to see a geriatrician.*

- *One hundred twenty five of my 600 employees are the age of my youngest resident, 69. We have an aged workforce. We should learn about this because it's what the future is going to look like.*

- *We need a Peace Corps for long-term care, because we're feeding off ourselves. And it's vicious. If we don't do this successfully, there's no future.*

WORKFORCE POLICY GOALS

- Ensure that sufficient numbers of qualified, mission-driven staff are available and working at all levels of aging services.

- Increase the ability of aging services providers to recruit and retain qualified staff.

- Open new opportunities and eliminate barriers to training staff.

- Develop and strengthen the pipeline of individuals attracted to and motivated to work in aging services.

- Advance and promote immigration policies that expand the number of available aging services professionals and paraprofessionals.

LEGISLATIVE ACTIONS

- **Develop a guest worker program.** Develop a legislative proposal for a guest worker program in aging services. Meet with stakeholders to better understand guest worker programs and determine the best way to frame a proposal for a program that includes guardrails and protections for workers.*

- **Geriatrics workforce legislation.** Support reintroduction of legislation that addresses direct-care geriatrics workforce, such as the Geriatrics Workforce Improvement Act (S. 2888), Improving Care for Vulnerable Older Citizens through Workforce Advancement Act (HR 3461), Direct Creation, Advancement and Retention of Employment (CARE) Opportunity Act (HR 3778). These bills provide educational and grant opportunities for direct-care workers and enhance the profession.

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- **GAO study on the workforce crisis.** We will work with members of Congress to encourage that they request a study from the GAO on the LTSS workforce crisis, to raise the visibility of the problem and encourage policymakers to consider solutions.

- **Immigration reform.** Track and monitor efforts at immigration reform: Recognizing that nearly a quarter of the nursing home and home care workforce are foreign-born, we support immigration policies that enable all types and levels of LTSS workers to enter the country and work in aging service settings.

- **CNA Training**: One lead organizational priority is reintroduction of the Nursing Home Workforce Quality Act (HR 6986, 115th Congress). This legislation addresses the impact of penalties on nursing home workforce. We led the development of the Nursing Home Workforce Quality Act and will work to have legislation reintroduced in the next Congress. The bill would offer more flexibility in the relationship between nursing home surveys and CNA training programs.*

ADMINISTRATIVE ACTIONS

- **CMS regulations.** We will ensure that CMS regulations and guidance do not impede the ability of providers to recruit and retain staff.*

- **HRSA Geriatrics Training.** We will work with the Health Resources Services Administration to promote the value of geriatric training.

- **Homeland Security.** We will monitor Department of Homeland Security and other executive branch activities related to immigration that could affect the LTSS workforce.

- **Career ladders and lattices.** We will work with the Department of Labor (DoL) and others to develop and promote career ladder and lattice programs that offer movement and advancement for people in all positions in nursing homes and other provider types.

- **Operation of power lifts.** We support the Department of Labor proposed rule allowing 16 and 17-year olds to operate power lifts. This will make it easier for high school students to work in settings where power lifts are used with residents. When the rule is final, we will work with the DoL to ensure it is enforced.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **CMP templates.** We are developing a set of templates that members can work with to submit proposals for staffing improvements using Civil Monetary Penalty funds.

- **Housing and transportation solutions.** We are planning to explore policy levers in the Departments of Housing and Transportation to address challenges faced by many members in these areas.

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- **Explore creating new grant programs in the Department of Education.** We plan to explore grant opportunities that exist or could be created to support training programs in aging awareness and aging services for elementary, high school and community college students. We will seek education stakeholder partnerships in this work.

- **Materials to educate lawmakers on the role immigrants play in delivering LTSS.** We will create briefing materials on the important role immigrants play in delivering LTSS (close to a quarter of CNAs, for example, are foreign born). We will aim to tie these materials to immigration proposals, as appropriate.

- **Gain a better understanding of foreign workers.** Many members use agencies that bring nurses from the Philippines and certain African countries. We would like to gain a better understanding of the extent of this and some information about how it's done and how it is working out.

ADDITIONAL RESOURCES

- **Center for Workforce Solutions.** The Center includes research, promising practices, policy information and other resources to help providers address the workforce challenge.

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LEAD: NURSING HOMES

Our vision is that nursing homes are funded, staffed and structured to provide high-quality post-acute and long-term care services to residents with the right balance between regulation and autonomy.

WHAT LEADINGAGE MEMBERS SAY ABOUT NURSING HOMES

- *We want to do less paperwork and more person-centered care. From a national standpoint, our communication with surveyors is important. Let us learn. If there's something wrong, say something.*

- *I feel like an avalanche came and buried me, and I'm rolling down the hill like a little snowball in the avalanche. I respect my regulators and have a good relationship with them…but it's layer upon layer, upon layer of regulation. It doesn't add to the quality of the care I provide.*

- *You're operating a small standalone facility; you gear everything toward compliance, your education, your quality. We are incentivizing all the wrong things. I don't know an employee who is motivated by a pie chart. Providers need to be part of the process, and surveyors need to work with us more collegially.*

- *I had a deficiency-free survey this year, just like the last two years, but I can't promise one for next year. It's just too hard. I had to hire a nurse who is also a lawyer and does nothing but compliance. Not everyone can afford that.*

- *It has to be recognized how much we are putting into these new regulations. I'm not saying eliminate them, but they have to be tweaked.*

- *You're having to do this facility assessment every year. How many small nursing homes have $30,000 to do this every year? Now we're closing down nursing homes. If you close four or five nursing homes in a 50-mile radius, how many 85 and 90-year-old spouses can drive the distance to visit?*

- *Forty years ago I went through accrediting, and you know what? It was a proud process. You had an opportunity to showcase what you were good at and felt rewarded even if you weren't perfect. I would love the idea of deemed status; I love peer review. It's a learning opportunity. We rise the tide together, raise all ships.*

- *Surveyors are in our facilities day in and day out, and they know which are doing well and which are not. They have a distinct opportunity to share best practices, so we can all do better. We went through a hospice survey recently and it was like day and night. They helped us, they made us better.*

- *I asked CMS, "are you looking to penalize us or to change things?" Because these are two different things and changing things takes time.*

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- *Nobody wants to be a surveyor. We get new, inexperienced surveyors every time. [Surveyor] turnover is as bad as it is in nursing homes. They have a staffing crisis, too. This is not a good combination, both the nursing home and the survey team having this kind of turnover, trying to enforce the new [Requirements of Participation] RoPs.*

- *We've had nurses do the right thing and report assiduously, even when there was no harm to a resident. Then surveyors are reporting this to our State Board of Licensing, and nurses are facing the loss of their licenses. They can't afford to work in long-term care.*

- *A big thing for us is being able to train CNAs as a host site. Usually, we'll be able to watch them and nab a few of the best. If we have a bad survey and lose our ability to train CNAs, suddenly we've lost the opportunity to possibly hire people.*

- *Consolidated billing and pharmacy are a big problem. People come to us on designer cancer meds and we have to provide them. We're not getting reimbursed; we're in the hole before they walk in our front door.*

- *CMS needs to treat some of these high-cost IV medications similar to the way they treat MRIs, CT scans and some of those excluded items; have some exclusions built in for the high-cost IV medications.*

- *We lost a star due to problems reporting staffing through Payroll Based Journaling (PBJ). We had the staff, this was a reporting glitch. We fixed the error but can't get the star back for three months. Now I have to explain to residents' families why we went down in our staffing rating.*

- *I'm from a small facility, and I have to enter data by hand. It's me and my director of nursing, that's it.*

- *I had to purchase a new system to do PBJ. They think, "well, you'll just use your existing staff." We don't have staff to do it. I think CMS thinks we all have automated systems.*

- *My ratio of Medicaid to private pay is 65/35. I'd love to pay everyone $15 an hour, and dietary $12 an hour, but how, with this kind of government-funded census? It's who we are as non-profits but it's a struggle and Medicaid is not going away.*

- *Medicaid is paying $130 a day for nursing home care in [state]. You can barely get a decent hotel room for that.*

- *There's no coordination between hospitals and nursing homes. Then nursing homes get cited for things like psychotropic meds that were started in the hospital.*

- *We get at our nursing home,$227 dollars a day of Medicaid reimbursement. It costs me about $308 to $310 a day. So, I've got to make up the difference, and it's private pay, short-term rehab.*

- *There's a disconnect between acute care hospitals and SNFs. They think that SNFs can just take anyone from the ER or a Critical Access Hospital, even though the SNF might not be the appropriate setting.*

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- *We are dropping our LTC census, because we can't stay staffed enough to keep them.*
- *Where are the admissions? Where's the occupancy? How do we keep our buildings full?*
- *People, even some of us, think nursing homes are "park and die." We have to correct that notion.*
- *It's almost like the federal government wants senior care to go away, so let's not fund it. Let's close nursing homes and force society to either care for the elderly or put them on the street. Let's see them as an undervalued member of society. I think this cuts to the core.*
- *We need innovation from leaders in the nursing home community. I notice that smaller facilities are closing. What do we do about that?*

NURSING HOME POLICY GOALS

- Reduce regulatory burden – preserve the requirements necessary for safe, person-centered care and eliminate unnecessary paperwork that takes time away from residents.
- Promote alternative survey and certification strategies that assure quality and safety for high-performing providers.
- Support emergency planning and preparedness regulations that ensure that nursing home residents and staff are safe in emergency situations.
- Ensure that nursing homes are paid fairly, sufficiently and promptly to provide the person-centered care that residents and families expect. The true costs of care must be taken into account in setting payment rates.
- Eliminate barriers to staff training, recruitment and retention
- Improve quality measurement in nursing homes, including quality reporting, value-based payment and five-star components.
- Improve the public image of nursing homes as an important component of the health care system.
- Include observation stays in the three-day hospital stay required for Part A SNF admission.
- Support proposals and initiatives that enable nursing homes to finance and use interoperable electronic health records.
- Promote access to and use of appropriate palliative and end-of-life care for nursing home residents.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

LEGISLATIVE ACTIONS

- **CNA Training**: One lead organizational priority is reintroduction of the Nursing Home Workforce Quality Act (HR 6986, 115th Congress). This legislation addresses the impact of penalties on nursing home workforce. We led the development of the Nursing Home Workforce Quality Act and will work to have legislation reintroduced in the next Congress. The bill would offer more flexibility in the relationship between nursing home surveys and CNA training programs.*

- **Telehealth**: Support legislation that allows all nursing homes to use telehealth models to improve care, such as by reducing unnecessary hospitalizations. An example of legislation that we have worked on in the 115th Congress is the RUSH Act, Reducing Unnecessary Senior Hospitalizations (HR 6502), which establishes a new program to furnish telehealth services at qualified SNFs, using first responders on site. LeadingAge will advocate to include provisions that advance the LeadingAge pilot projects that allow Long-term and post-acute care (LTPAC) providers to test chronic care management using telehealth and remote patient monitoring.*

- **Improving Access to Medicare Coverage Act** (HR 1421, S 568**). (Observation Days)** We actively support this legislation, which would require all time Medicare beneficiaries spend in a hospital to count toward the three-day stay requirement for subsequent post-acute care.*

- **Seek parity in nursing home reimbursement by the Veterans Health Administration (VA).** VA-operated nursing homes typically receive higher reimbursement rates for serving veterans than the rates paid to non-VA nursing homes that are contracted to serve veterans. We will seek legislation that enables LeadingAge members and other non-VA nursing homes to receive the same level of reimbursement as VA nursing homes receive.

ADMINISTRATIVE ACTIONS

- **Requirements of Participation (RoPs).** Meet regularly with CMS and stakeholders to identify and resolve issues and to reduce regulatory burden. Track development and dissemination of Phase 3 interpretative guidance and work with CMS to resolve concerns that emerge.*

- **Payroll Based Journaling (PBJ).** Work with members to identify issues and concerns with PBJ implementation, technical issues and policy concerns. Collaborate with CMS to resolve.*

- **Emergency Planning Rules and Life Safety Regulations.** Bring emergency planning and life safety issues to CMS for resolution as they come up.

- **Survey and Certification Process.** Work with members to track survey activity and concerns and work with CMS to resolve. In addition, we will explore changes to the survey and certification process that address members' concerns about use of limited resources and the value of positive feedback in the survey process.*

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- **Prompt payment.** Work with CMS to raise member problems and concerns with the timing of payments and ensure that providers receive prompt payment.*

- **SNF Prospective Payment System.** We will identify issues that emerge as members implement the 2019 SNF PPS rules and work with CMS to resolve them. We will analyze the 2020 PPS rule when CMS publishes it in the spring.

- **Countdown to Patient Driven Payment Model (PDPM).** We will continue to monitor CMS's communications about PDPM as we work toward October 1, 2019, implementation, making comments, writing letters and engaging with CMS as needed. *

- **Value-Based Payment (VBP).** We will monitor the ongoing implementation of the SNF VBP program as it shifts to the new Potentially Preventable Readmission measure to ensure that CMS minimizes the burden on providers, provides timely data reports that allow a SNF to impact its readmission rate and delve into the root cause for readmissions, as well as understand how performance impacts the reimbursement rate.

- **SNF Quality Reporting Program (QRP).** We will continue to monitor and engage with CMS through meetings and rule comments to raise issues that cause concerns for SNFs as they work to comply with the SNF QRP. We will monitor policy changes and guidance that would have an impact on members facing potential loss of 2% of their Medicare fee-for-service (FFS) rates.

- **Unified PAC Payment system**. We will monitor and provide input into the MedPAC process for proposing a unified Post-Acute Care payment as required under the IMPACT Act.

- **Consolidated billing.** Continue to submit suggestions for drugs and services to be excluded due to their high cost through the SNF PPS rulemaking process based upon input from members on specific high-cost drugs and services.

- **Operation of power lifts.** We support the Department of Labor proposed rule allowing 16 and 17 year olds to operate power lifts. This will make it easier for high school students to work in settings where power lifts are used with residents. When the rule is final, we will work with DoL to ensure it is enforced.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **Activities to increase the image of nursing homes.** We are looking for opportunities to address the image of nursing homes in the popular press. In addition, we will explore other avenues to ensure that the public, consumers and nursing home stakeholders all acknowledge the positive role that nursing homes play in caring for some of the nation's most vulnerable individuals.

- **Comprehensive strategic plan for nursing homes.** We will work with members on a comprehensive strategic plan on nursing homes as we look to the future of aging services.

- **True cost of nursing home care and cost of survey and certification compared to RoPs estimate.** We will develop a "real life" budget showing what it takes to run a high-quality

nursing home. We will work with members to identify the true cost of complying with the RoPs, based on member experience.

- **Explore additional legislative proposals that might be necessary to pursue.** Members identified particular pain points related to surveyor staff turnover, lack of adequate surveyor training and inconsistency in deficiencies cited.

- **Work with a wide range of stakeholders and consumers to address nursing home concerns.** For example, we aim to increase collaborative work with organizations representing nursing home surveyors and with consumer advocacy groups to identify and work on areas of common policy concern.

- **Civil Money Penalty (CMP) funds.** We will track CMP fund proposals and share information with members as needed. We are developing a set of templates that members can work with to submit proposals for staffing improvements using Civil Monetary Penalty funds. We will determine if other templates would be useful and work on them as needed.

ADDITIONAL RESOURCES

- **Nursing home tools and education.** We will continue to share with members tools, compliance guidance, other supports, and a range of educational offerings to members about RoPs 3, PDPM, MDS, life safety and other topics.

- **Trauma Informed Care.** Support members with information, education, and assistance as they work to comply with the trauma informed care and behavioral health provisions of the nursing home regulations, coordinate with mental health services stakeholders and improve care for residents.

- **Emergency Planning Rules and Life Safety Regulations.** Continue to provide members information and technical assistance about emergency preparedness requirements, including when evacuations need to take place and crossing state lines.

- **Medicaid reimbursement rate tracker.** We are developing a Medicaid rate tracker for members to use to understand how their state's reimbursement rates and policies compare to others.

- **State Medicaid advocacy materials.** We are working on a series of general and state specific fact sheets that state affiliates and members can use in their state Medicaid advocacy work.

- **Grassroots Medicaid strategies.** We are developing training and providing assistance to support state Medicaid grassroots advocacy.

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LEAD: AFFORDABLE HOUSING

Our vision is that there is an adequate supply of affordable housing plus services for individuals across the income spectrum.

WHAT LEADINGAGE MEMBERS SAY ABOUT AFFORDABLE HOUSING

- *There's just not enough housing. I have a two-year wait list for a one bedroom and about one year for a studio. People have nowhere to go. I refer them to places and they say "I already called there. They have a waiting list too."*

- *I hear people in elder housing say "we can't build our way out of it." I don't agree; I think we can, but we have to start looking for other sources of funding, not just 202 and Section 8. We need to help everyone have a safe, affordable home so they can age in place.*

- *The timing of service coordinator grant program payments makes it challenging to run the program.*

- *I've had REAC [physical inspections] for both my buildings this year and have a MOR [management review] coming up. I think we need more funding for staffing to assist with all this. It's a big deal to get 74 apartments ready for inspection. And we need better standards set for the inspectors. Your overall grade and the interpretation of the rules varies tremendously from inspector to inspector.*

- *I don't have a medical team on staff. To have people coming back to our community (low-income housing) after shortened stays, that's a problem. They are low income and can't afford in-home help. But they have nowhere to go.*

- *Some of the 3,600 people on my wait list tell me, "I've applied. You have a five-, six-, seven-, eight-year waiting list. I get $1,100 a month from social security. My rent in my apartment is $900 dollars a month. I can get some SNAP (food stamps). You know, I'm eating cat food at the end of the month, what can you do for me? Nothing." That's the heartbreaking conversation that we have constantly. And 2011 was the last time Congress funded the 202 program until this year.*

- *In older projects, you can't reserve enough money to take care of capital needs if the boiler fails, or the roof fails. There's not enough Rental Assistance Demonstration for Project Rental Assistance Contract (RAD for PRAC) funds, and we're still waiting for that guidance from HUD.*

- *In addition to thinking about public funding, we need to find other ways to put together funding for development.*

- *The Low Income Housing Tax Credit has to change. The limits are so severe that housing needs cannot be met.*

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- *We serve seniors with less than 30 percent of median income. We could not support the debt associated with construction and redevelopment of our property without rental subsidy. We said we would take the Low Income Housing Tax Credit but in exchange there has to be rental subsidy. Without rental subsidy we would be providing basically zero affordable housing of any scale.*

- *We've got schools, office buildings, even big industry buildings that closed down. They could be transformed into housing – housing that includes clinics and hospice or telemedicine centers.*

AFFORDABLE HOUSING POLICY GOALS

- Expand the supply of affordable housing for older adults with low incomes.

- Preserve existing federally assisted housing.

- Ensure financing for housing-based services.

- Improve administrative efficiencies and reduce regulatory burdens.

- Ensure prompt payment for federally assisted housing providers.

- Promote partnerships with community providers of palliative and end-of-life care to ensure residents receive hospice and related services when needed.

LEGISLATIVE ACTIONS

- **Appropriations for the preservation of affordable housing.** Work to ensure the fiscal year 2020 HUD funding bill provides for the preservation of existing housing subsidized through the Section 202/PRAC, Project-Based Rental Assistance, Housing Choice Voucher and Public Housing programs. Twenty-nine percent of HUD's five million subsidized homes and 26 percent of Low Income Housing Tax Credit (LITHC) homes are headed by older adults. Ensure timely appropriations so housing assistance is not disrupted or at risk for disruption.*

- **Expanded funding for the Section 202 Housing for the Elderly account.** Expand housing assistance for new homes under HUD's Section 202 Housing for the Elderly program. Address the capital repair needs of Section 202 homes with new funding for capital repair grants. Expand Service Coordinator grants to more Section 202 communities or ensure HUD approval of adequate rents to cover service coordination (about 50% of Section 202 communities do not have a Service Coordinator). Establish a HUD-backed home modification program to help older adults age in place.*

- **Support other housing development programs.** Protect and expand funding for the National Housing Trust Fund and the Capital Magnet Fund, which provide resources for new construction, operating subsidies and housing preservation. Expand the Low-Income Housing Tax Credit and strengthen its income targeting and preservation capacity. Protect Private Activity Bonds, which

finance new construction and preservation of affordable homes for older adults. Expand Service Coordinator grants to all federally assisted communities. Expand Housing Choice Vouchers, which could be special purpose vouchers for older adults to protect older adults from homelessness; vouchers can also help support affordable housing construction. Support "Housing as Infrastructure" efforts to expand the supply of affordable housing. Within any reforms of the government-sponsored enterprises (GSE), ensure that senior housing resources and options are expanded. Support the Treasury Department's Opportunity Zones, which are designed to drive long-term capital into low income communities across the nation, using tax incentives to encourage private investment into designated census tracts through privately or publicly managed investment funds.

- **Support services coordination in housing for older adults.** Continue funding for all existing Service Coordinators and expand Service Coordinator funding to all federally assisted communities. Increase funding for Older Americans Act (OAA) programs. Many housing providers rely on OAA Supportive Services and Nutrition programs to help older adults age in place. Work with Congress to identify financing for prevention and wellness services in HUD-assisted housing.

- **Low Income Housing Tax Credits.** Support efforts to increase state LIHTC allocations by 50 percent; provide a 50 percent basis boost for LIHTC communities that serve households with extremely low incomes in at least 20 percent of their apartments; replace the current right of first refusal with a purchase option to facilitate the ability of nonprofits to maintain ownership/control of housing credit properties beyond Year 15; establish a minimum 4 percent rate for housing credits used to finance preservation acquisitions and recapitalizations and Housing Bond-financed developments; limit the rent charged to the maximum Housing Credit rent instead of the HUD-calculated fair-market rent for apartments leased by voucher holders and benefiting from either income averaging or the basis boost for communities serving households with extremely low incomes in at least 20 percent of their apartments; and, codify existing practice to include existing tenants into eligible basis as long as the property being recapitalized was a means-tested affordable housing property and the tenant's income did not rise above 120 percent of the area median income.

ADMINISTRATIVE ACTIONS

- **Work with HUD to improve communication and clarify and streamline policy guidance.** We will work closely with HUD officials in Washington, DC, and the regions, to find ways to ensure that HUD-policy guidance is interpreted consistently and articulated clearly.*

- **Respond to draft notices and regulations.** We will be vigilant about notifying members of postings to the HUD "drafting table," collecting and composing comments to relevant HUD guidance published in the Federal Register or on Regulations.gov – to include expected changes to the 4350.1 Asset Management Handbook and implementation of RAD for PRAC.

- **Promote RAD for PRAC implementation.** We will provide timely updates to states and members about the expected/new guidance, facilitating conversations on member engagement with and

areas needing more information, seek to identify and share member experiences and make recommendations HUD on improvements for future guidance revisions.

- **Address concerns with the REAC physical inspection protocol.** We will engage with HUD and other stakeholders in the planned coming revisions to the REAC physical inspection program, policies and protocols, providing feedback and recommendations to discussions about potential changes to scoring, weighting and enforcement.

- **Section 8 Project-Based Rental Assistance and Project Rental Assistance Contracts:**
    - We will work with HUD to assure accurate payments to housing providers and timely communications about funding payment and availability issues.
    - We will monitor new policy releases and engage in discussions related to changes in rental assistance subsidy eligibility and assistance levels, including implementation of Housing Opportunity Through Modernization Act changes to income calculation, asset limitation and medical expense allowances and deductions, and departmental proposals.
    - We will explore and make recommendations regarding policy changes needed to facilitate better use of Section 8bb subsidy transfer as part of preservation.
    - We will recommend changes to current residual receipts policies, exploring legislative requirements with HUD, discuss impacts of current funding priorities and clarify allowable uses for residual receipts to further owner preservation/programming needs.

- **Third-party Oversight and Online Systems Enhancements:**
    - As HUD proceeds with efforts to procure new contract administration services, we will work to ensure that processes are as nondisruptive as possible to member communities, informing and providing feedback on proposals and facilitate relationship-building with new entities as needed.
    - We will be active partners in discussions about HUD plans for needed systems improvements and online information submission and retrieval changes, including TRACS resident certification modifications, HUD data sharing / EIV requirements, electronic comprehensive needs assessments (e-CNAs) and eLOCCS payment processes.

- **Provide financing from the Centers for Medicare & Medicaid Services (CMS)** of proven housing plus services models in new, federally assisted housing for older adults.

- **Work with the CMS Innovation Center (CMMI) to identify opportunities to use Medicaid funds to pay for housing.** Picking up on HHS's announcement that Medicaid may soon be allowed to be used for housing, healthy food or "other solutions for the whole person," we will work with CMS to track CMMI demonstration projects.

- **Service coordination.** We will work with HUD to ensure timely payment for providers who participate in the Service Coordination grant and demonstration programs, and support members in identifying issues and trends needing process improvement for which we will advocate with HUD.

- **Section 202 Notices of Funds Availability.** We will work with HUD to encourage timely and effective Section 202 NOFAs in support of expanding the supply of affordable housing.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **Develop/find better information on waiting lists for senior housing.** We will seek avenues to learn more about waiting lists – how many people are on them, typical wait times – for senior housing around the country. This information will be useful in our advocacy work.

- Explore policy and financing issues related to housing models that potentially provide housing to more people, including **an entitlement to housing benefits for older adults.**

- Explore how to better understand, address and educate others on the housing conditions, including **habitability and affordability of very low-income households**.

- Educate stakeholders, including federal agencies and policy makers, on the increasing number of **older adults experiencing homelessness**. Our efforts to expand and preserve housing for older adults are key solutions.

ADDITIONAL RESOURCES

- **Center for Housing Plus Services.** The Center includes research, promising practices, policy information and other resources to help providers address the need for housing with services.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

LEAD: MANAGED CARE AND INTEGRATED SERVICES

Our vision is that aging services providers are able to thrive in Medicare and Medicaid managed care environments, as health and long-term care systems move away from fee-for-service (FFS) financing.

WHAT LEADINGAGE MEMBERS SAY ABOUT MANAGED CARE AND INTEGRATED SERVICES

- *Honestly, we don't really want to do business with these Medicare Advantage plans, but they have you over a barrel. My experience, their rates are too low to cover enough care for people that need rehab, lengths of stay are not long enough, their certs and recerts are burdensome, they don't pay you, and I have to manage six different plans with different requirements and reporting systems.*

- *When someone comes in on Medicare FFS, they have an average length of stay of about 17 days. However, when a resident comes in on Medicare managed care, the managed-care organization (MCO) will say, "Well, you have a week," and the question becomes, is the person who is on Medicare managed care receiving his or her full benefit under the Medicare program? And I think there is a moral and ethical issue there that needs to be addressed.*

- *It's getting a lot harder. I'm reluctant to take people with complex needs, because I can't keep them long enough. I discharge them, and they end up back in the hospital.*

- *We've had to divert significant resources just to get the Medicaid MCO to pay. We've added multiple full-time staff in our billing department. The MCOs kick it back and say "you did this wrong, do it right. Then someone else kicks it back again. Pretty soon they say "we're not going to pay you."*

- *It would be great to be able to negotiate with plans more easily.*

- *I'm disappointed they cancelled the Model 3 bundling initiative. Over the three years we participated, we saved Medicare $50 million. It was surprising they cancelled it. It was a really positive step, and we should revisit it.*

- *We're looking into becoming an Institutional Special Needs Plan (I-SNP). It could be the wave of the future.*

MANAGED CARE AND INTEGRATED SERVICES POLICY GOALS

- Provide supports so that aging services providers can effectively participate and thrive as partners in managed-care arrangements.
- Encourage interested providers and support their efforts to create ISNPs and/or participate in or develop other integrated services options and models.
- Identify solutions that ensure that providers are paid sufficiently to deliver quality care to Medicare Advantage (MA) and Medicaid Managed LTSS (MLTSS) beneficiaries.
- Promote policies that pay for support services under Medicare Advantage.
- Pursue opportunities for aging services providers to lead alternative payment models that integrate services and supports.
- Support states in identifying model language for Medicaid MLTSS programs that protect providers by creating a level playing field for contract negotiations, ensure adequate payment and offer alternative payment model opportunities to maximize revenue for services provided.

LEGISLATIVE ACTIONS

- **Improving Access to Medicare Coverage Act** (HR 1421, S 568**). (Observation Days**) We actively support this legislation which would require all time Medicare beneficiaries spend in a hospital to count toward the three-day stay requirement for subsequent post-acute care.*
- **MA Plans and SNPS**: Support legislative efforts to encourage Medicare Advantage plans to offer LTSS benefits through reintroduction of Community-Based Independence for Seniors Act (S 309/HR 4006).
- Support legislative efforts to **coordinate hospice services with the MA benefit** to support better integrated services and better options for all Medicare beneficiaries.
- **Value-Based Payment.** Support legislation that removes legal barriers to providers and plans pursuing contracts that have value-based payment arrangements for providers.

ADMINISTRATIVE ACTIONS

- **Bundled payment.** Work in partnership with other post-acute and LTSS provider organizations to design a bundled payment or other alternative payment model and present to CMMI to implement as a demonstration by 2020.*****
- **Supplemental benefits.** Track implementation of MA plans with home and community-based support services as supplemental benefit.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- **CHRONIC Care Act.** Monitor implementation of CHRONIC Care Act provisions of the Bipartisan Budget Act of 2018 as part of 2020 MA Call Letter.*

- **Prompt payment.** Advocate for regulations that give providers more tools or recourse to ensure plans pay promptly and limit negative impacts on payment to providers.

- **Telehealth.** We will provide comments to CMS on how Medicare Advantage plans can cover additional telehealth benefits as a Medicare Part B service.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Outreach to national plans to further utilization of value-based or alternative payment models that would ensure providers could get paid for the value being provided.

- Identify and support opportunities to explore development of HCBS supplemental benefit packages and connect LeadingAge HCBS provider members with MA plans.

- Working with state affiliates, identify state MLTSS best practices (e.g., quality measures, prompt pay, rate floor, option for alternative payment model contracts) for states to use in their Medicaid LTSS statutes.

- Monitor the evaluations of the Financial Alignment and other demonstrations and pilots for lessons that can be applied to future integrated payment and service models between CMS, states and health plans. Develop a list of guiding principles from the lessons learned that LeadingAge staff would use to advocate for the provider's perspective as savings generators to CMMI and CMS as they design future programs, pilots and demonstrations.

ADDITIONAL RESOURCES

- **Center for Managed Care Solutions and Innovations resources.** including but not limited to: content on submitting clean claims to ensure payment, develop list of consultants who can help with contract review, negotiations and other issues related to managed care; establish listservs/advisory/affinity groups for problem solving with peers.

LEAD: HOME AND COMMUNITY-BASED SERVICES

Our vision is a well-developed, high-quality continuum of home and community-based services that complements informal caregiving for older individuals of all income levels.

WHAT LEADINGAGE MEMBERS SAY ABOUT HCBS

- *I have three Money Follows the Person projects. The problem is people who come out of nursing homes are pretty frail. In the nursing home, [if] someone falls down, there are people to pick [him or her] up. In the community, someone falls down, we call 911. They say, "we can't keep coming over to your place to pick someone up every couple of hours." But I can't pay for services in my housing. Break down those siloes so we can cross-subsidize.*

- *There's no infrastructure in communities for aging in place. I was downtown and saw a light turn green. There's a lady with a walker on the sidewalk – it took her 22 seconds to step down off the sidewalk. By that time, the light had already turned. Aging in community means we have to all look beyond our siloes.*

- *Assisted living is very state specific. Some states have very little regulation versus others that overregulate it. What kind of outcomes do they get? What can we learn from these differences? That's an opportunity.*

- *It's not financially viable to do Medicaid assisted living. In my state the [Medicaid] average reimbursement is $60 a day. You can't do 24-hour care on that.*

- *The Veteran's CHOICE program needs increased funding.*

- *I provide adult day services. The HCBS Settings Rule says I have to provide more field trips into the community, but I don't have the staff or transportation to do that and my funding hasn't been increased. Why do they make these rules with no funding to go with them?*

- *My PACE program is responsible for 3,000 square miles. I have to fund and maintain enough vehicles to provide transportation in our rural area.*

HCBS POLICY GOALS

- Advance policy that promotes the availability of HCBS across funding streams, including Medicaid, Medicare, OAA and VA.

- Explore federal policy solutions that ensure Medicaid rates are adequate to cover the costs of HCBS.

- Support models of integrated care that include HCBS.

- Ensure that critical service providers, including those of adult day services, PACE and personal care, have the funding and resources they need to provide high-quality care.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- Promote federal rulemaking that ensures access and quality HCBS for beneficiaries while minimizing provider burden.

- Preserve the ability and discretion of states to regulate assisted living.

LEGISLATIVE ACTIONS

- **EMPOWER Act.** Support reintroduction of legislation extending and improving the Money Follows the Person Demonstration program and in the 115th Congress, Ensuring Medicaid Provides Opportunities for Widespread Equity, Resources and Care (EMPOWER) Act (HR 5306, S 2227).

- **Spousal Impoverishment.** Support legislation extending federal spousal improvement protections for HCBS; in the 115th Congress, The Protecting Married Seniors from Impoverishment Act (HR 7149).

- **Older Americans Act reauthorization.** The Older Americans Act will need to be authorized to continue beyond FY 2019. We will collaborate with state partners, members and external stakeholders to identify key priorities to advocate for during the reauthorization process, inclusive of financing (both funding formulas and appropriation levels) and program design.

- **Oppose efforts to federally regulate assisted living.**

ADMINISTRATIVE ACTIONS

- **HCBS Settings Rule.** We will continue to monitor the implementation of the HCBS Settings Rule and, where applicable, provide comment and information to CMS based on the experiences of LeadingAge members. We will continue to oppose the Settings Rule provision that requires that HCBS providers on Life Plan Community Campuses with SNFs be subjected to heightened scrutiny and seek an exemption for those campus-based providers. We in particular anticipate that new guidance will come out in early 2019 on heightened scrutiny.

- **CMMI Demonstration Programs.** A number of current and potential demonstrations under way in CMMI relate to Medicaid. This includes the Innovation Accelerator Program (IAP), which currently has a Medicaid LTSS component. We will monitor these demonstrations to determine how they will affect members. There has also been commentary from administration officials alluding to forthcoming demonstrations that include Medicaid funding for housing and food assistance. If such demonstrations come to fruition, we will monitor their development and provide CMS information based on LeadingAge member feedback.

- **Medicaid Waivers.** Waiver policy is a critical component in Medicaid, both with respect to HCBS and to the program more broadly. We will monitor the development and, where applicable, implementation of new/renewed 1915(c) and 1115 waivers, and other state programs (e.g., 1915(k)) and collaborate with members in affected states to determine how LeadingAge responds to proposed and approved waivers. Our waiver activity work will include both those designed to pay for LTSS as well as those that will affect coverage in other ways (e.g., waivers of retroactive coverage, waivers of medical transportation).

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- **PACE Final Rule.** A new final rule for PACE has been pending with CMS since 2016. We expect that a final rule will publish in 2019. We will advocate to CMS to publish a final rule, support legislation that calls for the final rule to publish and provide comment and information where applicable.

- **VA Mission Act Implementation.** The VA Mission Act became law in 2018 and implementation is underway. The law combines current programs and services and creates new funding streams that would facilitate provider agreements with non-VA providers. The program provides a potential funding opportunity for non-VA providers of LTSS. We will closely monitor the law as it implements and provide comments and information where applicable. We will also engage our members to support their engagement with VA, and advocate to VA on solutions that would increase access to LTSS among veterans.

- **RAISE Family Caregivers Act Implementation**. This law calls for HHS to develop a national family caregiving strategy and to convene a family caregiving advisory council. We will closely monitor the activity of the advisory council and identify opportunities to participate in the national family caregiving strategy's development and advance member feedback to HHS.

- **Medicare Advantage Supplemental Benefits**. Some HCBS are allowed as supplemental benefits to Medicare Advantage that Medicare will pay for. In the first (current) year this was available, there has been low uptake among MA plans. We will explore ways to collaborate with members, plans and other stakeholders to increase the inclusion of HCBS in MA plans, and to promote public awareness that such options exist.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **Toolkits and technical assistance on the Settings rule.** We will provide education, toolkits and technical assistance to members on overall compliance and on the anticipated guidance on the Settings rule.

- **State fact sheets**. We are developing a series of all-state fact sheets that will provide state-specific Medicaid information and data that state affiliates and members can use in their state Medicaid advocacy work. These will be created in consultation with our state partners.

- **Medicaid reimbursement rate tracker.** We are developing a Medicaid rate tracker for members to use to understand how their state's reimbursement rates and policies compare to others. In 2019, the tracker will focus primarily on adult day services and could extend to other service categories.

- **State Medicaid policy development monitoring.** We will monitor state-level activity on Medicaid policy in conjunction with state partners. There is a large cohort of new governors and legislators, and as a result, we anticipate there being more state-level Medicaid developments.

- **Workforce.** We will collaborate both with the Center for Workforce Solutions and externally on workforce issues that Medicaid policy can address.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- **PACE**. We will identify and pursue new resources to support our PACE members and our advocacy for PACE programs.

- **Adult Day Services.** We will continue to work closely with members and state partners on adult day services, including through focused group discussions, convenings with VA and other stakeholders and resource development.

- **HCBS Settings Rule.** We anticipate creating resources and providing technical assistance on the HCBS Settings Rule, in particular on heightened scrutiny processes.

- **Medicare Advantage.** We will explore conducting outreach to/convening Medicare Advantage plans to explore development of HCBS supplemental benefit packages and connecting with LeadingAge HCBS provider members.

ENGAGE: LONG-TERM SERVICES AND SUPPORTS FINANCING REFORM

Our vision is an aging services system that is fully funded and provides the services people need and want, before the Baby Boomers arrive in full force in 2030.

WHAT LEADINGAGE MEMBERS SAY ABOUT LTSS FINANCING REFORM

- *I work in an all private-pay life plan community, which no one in my family, including me, could ever afford to move into. At the same time, I'm struggling to find Medicaid and VA funding to support my dad, who has Alzheimer's. I really don't know what we're going to do in the future where fewer people can afford the kind of place I work in and most of us in the middle market have no choices.*

- *What do we do about the middle market? There's nothing in between independent living and a nursing home. And for low-income people? How do we find a way for low- and middle-income people to have that same continuum wealthier people have, where they don't have to go into a nursing home. It would save money and be better for the dignity of the person. Right now I have to serve people in my nursing home who really don't need that high level of care, but there's nowhere else for them to go.*

- *Let's face it. We [nursing homes] are selling something people don't want – until they want it. How do we offer people more options they can afford and that they really want but still be able to maintain places that care for really high-need residents? Maybe we should rethink whether aging services have to be tied to health care.*

- *We've been dealing with aging as a health care issue. That paradigm needs to shift. We have to change so we can address the system of services available to people as they age, then figure out how to pay for those services.*

- *We have to start education earlier, like for people in their 30s and 40s, maybe even their 20s, so they can start planning for their future, knowing that government isn't going to support us.*

- *What happens when the Boomers, who are not saving like their parents did, get to needing care and they all want Medicaid? Is Medicaid going to blow up?*

- *What about eliminating the cap on Social Security, keep collecting it at all pay levels and use the additional money to pay for a long-term care program.*

- *We should be doing the opposite of helping people transfer their assets. We should be educating them on asset preservation.*

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- *At the end of the day, there has to be some acknowledgment of the volume of what is coming at us, and that all people want is for their mom or dad to be well cared for.*

LTSS FINANCING REFORM POLICY GOALS

- Promote long-term services and supports financing reform to ensure that people at all economic levels are able to access services when they need them.

- Support the evolution of an aging-services continuum that builds on today's successes and helps providers keep moving toward systems and services consumers want.

- Create policies that enable consumers to transition to different types of services within the continuum.

- Identify and create solutions to [enhance] provider access to high-quality aging and long-term service and support options for the middle market.

- Support and complement family caregivers.

- Support the health of older adults with evidence-based wellness programs, nutrition services, medication management, and in-home and community options through the Older Americans Act.

LEGISLATIVE ACTIONS

- **Older Americans Act Reauthorization.** The Older Americans Act will need to be authorized to continue beyond FY 2019. We will collaborate with state partners, members and external stakeholders to identify key priorities to advocate for during the reauthorization process, inclusive of financing (both funding formulas and appropriation levels) and program design.

- **LTSS federal financing reform.** Partnering with Representative Frank Pallone to provide additional feedback and technical assistance on the substance of proposed legislation, the Medicare Long-Term Care Services and Supports Act.*

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ADMINISTRATIVE ACTIONS

- **Bundled payment.** Work in partnership with other post-acute and LTSS provider organizations to design a bundled payment or other alternative payment model and present to the Center for Medicare and Medicaid Innovation (CMMI) to implement as a demonstration.

- **Social determinants of health.** Work with CMS to develop further opportunities to address the social determinants of health within healthcare frameworks, particularly accessible, affordable housing.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Education on asset preservation and the efficient use of private and family resources for LTSS financing.

- Explore ways to add comprehensive service coordination more effectively across the continuum of services for older adults from housing through palliative and end-of-life care.

ADDITIONAL RESOURCES

- Carry the Conversation, public awareness campaign, targeting the millennial generation to engage around topics of aging and LTSS financing.

- LeadingAge's resources to support our vision of an America freed from ageism.

- 2030 Scenario Planning Toolkit to explore the future need for and delivery of aging services in the context of expectable, challenging and visionary futures.

- Continue to collaborate with LeadingAge state partners to provide information, technical assistance and grassroots support for states that seek to develop a state-specific solution to long-term services and supports financing.

- LeadingAge: A New Vision For Long-Term Services and Support Report.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ENGAGE: MEDICAID AND MEDICARE

Our vision is sufficiently funded Medicaid and Medicare programs guided by policies that promote the health and wellness of beneficiaries.

WHAT LEADINGAGE MEMBERS SAY ABOUT MEDICAID AND MEDICARE

- *I'd like to offer adult day services, but I can't make it work on the Medicaid rates this state pays.*
- *I have five nursing homes and more than half of them are going to have to close because of Medicaid reimbursement being so low.*
- *I have to increase what I charge my private-pay residents because Medicaid doesn't pay enough. Then the private pay people end up spending down faster.*
- *I have to employ two full-time social service staff to help people apply for Medicaid and follow through until they get it.*
- *I read articles about how understaffed we are. Then Medicaid comes in and tells us we are hitting our direct care nursing ceilings and we have to cut them, we're paying too much.*
- *Transportation is a real struggle. I think we have to work together to provide adequate transportation.*
- *PACE is such a great model. We need to work on ways PACE can partner with housing.*

MEDICAID AND MEDICARE POLICY GOALS

- Preserve the Medicaid safety net. Oppose block grants and per capita caps.
- Ensure that regulations governing the Medicaid and Medicare programs promote high-quality care and are not burdensome to providers.
- Align the Medicaid and Medicare programs to ensure that dually eligible individuals receive coordinated care.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

LEGISLATIVE ACTIONS

- **Track Medicaid and Medicare legislative activity, including reintroduction of the following:**
  - Nursing Home Workforce Quality Act (HR 6986)
  - The RUSH Act (HR 6502)
  - Observation Days Act (HR 1421/S 568)
  - Nursing Home CARE Act (HR 4704)
  - Community-Based Independence for Seniors Act
  - Medicare Long-Term Care Services and Supports Act
  - EMPOWER Act
  - The Protecting Married Seniors from Impoverishment Act
  - The Medicare Adult Day Services Act
  - Home Health Care Planning and Improvement Act
  - CONNECT for Health Act

- Support legislation that encourages transparency and collaboration with providers, such as the Reducing Administrative Burden and Becoming Increasingly Transparent Act (HR 7428), which amends the IMPACT Act to direct the Secretary of HHS to solicit information from providers on such questions as a unified post-acute care payment system.

ADMINISTRATIVE ACTIONS

- **Work with CMS on Medicaid and Medicare rules.**

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **Grassroots Medicaid and Medicare strategies.** We will work with state affiliates who request guidance or assistance developing and implementing grassroots efforts related to Medicaid in their states.

- **Medicaid reimbursement rate tracker.** We are developing a Medicaid rate tracker for members to use to understand how their state's reimbursement rates and policies compare to others. In 2019, the tracker will focus primarily on adult day services and could extend to other service categories.

- **State Medicaid policy development monitoring.** We will monitor state level activity on Medicaid policy in conjunction with state partners. There is a large cohort of new governors and legislators and as a result we anticipate there being more state-level Medicaid developments.

- **PACE.** We will identify and pursue new resources to support our PACE members and our advocacy for PACE programs.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ENGAGE: HOME HEALTH

Our vision is that home health agencies are reimbursed appropriately to provide quality, community-based care and with the right balance between regulation and autonomy in all parts of the country.

WHAT LEADINGAGE MEMBERS SAY ABOUT HOME HEALTH

- *One home health condition of participation we are struggling with is having to provide a care plan change for every order sending a person home; I struggle with how that helps the patient.*
- *We are struggling to prepare for the new payment changes coming and what it will mean for us and the people that we serve.*
- *The rural add-on payment is really important for many of us in rural areas as the costs, particularly in transportation and workforce, are a real challenge.*

HOME HEALTH POLICY GOALS

- Educate members with home health agencies on the changes to expect with the Patient-Driven Groupings Model and prepare them to thrive under the new payment model
- Ensure adequate reimbursement rates for home care and home health services across the variety of payers.
- Advocate for inclusion of home care services in Medicare Advantage supplemental benefits.
- Work for reasonable home health and home care regulations to allow quality, community-based care without unnecessary burdens.
- Promote access to and use of appropriate palliative and end-of-life care for home health users.

LEGISLATIVE ACTIONS

- **Support legislation allowing certain professionals other than physicians to certify Medicare beneficiaries for the home health benefit, including reintroduction of the Home Health Care Planning and Improvement Act (HR 1825/S 445).**
- **Medicare Home Health payment.** Track and support efforts to remove the behavioral assumptions included in the home health final rule for the Patient-Driven Groupings model, including bills such as the Home Health Payment Innovation Act as well as bills to amend title XVIII of the Social Security Act to improve home health payment reforms under the Medicare program.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ADMINISTRATIVE ACTIONS

- **PDGM Implementation.** Work with CMS to ensure that the Patient-Driven Groupings Model is designed and implemented in a way that is beneficial to recipients of home health services as well as providers of those services.

- **Home Health PPS.** Offer feedback to CMS through public comment periods on the design of home health regulations and payment systems.

- **Nurse practitioners and physician assistants.** Advocate with CMS for nurse practitioners and physician's assistants to be able to operate at the top of their scope of practice within home health, regarding face-to-face visits and certifying a person for home health services.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Continue to monitor and engage as necessary around planning activities for a unified post-acute care prospective payment system.
- Provide members tools, technical assistance and education resources to implement PDGM.

- Participate in Home Health CAHPS survey redesign activities with RTI and CMS

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ENGAGE: HOSPICE SERVICES

Our vision is that hospice and palliative care services are integrated as part of the whole continuum of care. This means they are reimbursed appropriately to provide quality, end-of-life care with the right balance between regulation and autonomy in all parts of the country.

WHAT LEADINGAGE MEMBERS SAY ABOUT HOSPICE

- *End-of-life care is so important. The whole team, paying attention to what's happening in the bed, the staff, the family, a sense of being in a group at the end of life. Many of us have the ability to do it, but we're too busy. I'd like to be about the simple and beautiful and profound every day in my work.*

- *We need to take a good look at the six-month prognosis for hospice, maybe it needs to be updated.*

- *We don't have a certificate of need for hospice, so for-profit hospices are popping up like mushrooms.*

- *Hospice and palliative care are a way to increase use of telehealth.*

- *One of the things that we're trying to do is to pull palliative care out to the community and help recognize what services our patients need, to push the hospice and homecare referrals from that and actually come to the patients who can't actually get out to the services, bringing other services to them.*

- *I'd like to see the hospice benefit expanded to more than six months or less to live, to expand the options for those with Alzheimer's disease to be able to be on hospice longer and to be able to benefit from all the services that go along with that*.

HOSPICE POLICY GOALS

- Work for reasonable hospice regulations to allow quality, community-based care without unnecessary burdens.

- Ensure that patients and their family members have a full understanding of their care options when they have advanced illness.

- Promote access to and use of appropriate palliative and end-of-life care in all health and long-term care settings.

- Expand hospice care in rural communities by allowing Medicare payment for services furnished to hospice patients by rural health clinics and Federally Qualified Health Centers.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

LEGISLATIVE ACTIONS

- **Nurse practitioners and physician assistants.** Seek a legislative fix to the statute that does not allow for nurse practitioners and physician's assistants from being able to certify terminal illness and provide face-to-face encounters.

- **Coordination between hospice and MA.** Support legislative efforts to coordinate hospice services with the MA benefit to support better integrated services and better options for all Medicare beneficiaries.

- **Patient Choice and Quality Care of Act of 2017 (PCQCA), (HR 2797/S 1334)** Provide access to advance care planning support tools; promote the portability of advance directives; require Medicare providers and entities to document plans made during a stay of care; promote public awareness and training to support advance care planning; and establish an advisory council to advise the Secretary on issues of advanced and terminal illness.

ADMINISTRATIVE ACTIONS

- **Hospice PPS.** Offer feedback to CMS through public comment periods on the design of hospice regulations and payment systems.

- **Nurse practitioners and physician assistants.** Advocate with CMS for nurse practitioners and physician's assistants to be able to operate at the top of their scope of practice within hospice regarding face to face visits and certifying a person for hospice services.

- **CMMI developments.** Track developments within CMMI to create and test models for an advanced illness service delivery and payment model.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Release white paper with LeadingAge Ohio and the National Partnership for Hospice Innovation about the benefits of the traditional, robust hospice model and point to differences between some newer providers and traditional community-based, nonprofit hospice providers

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ENGAGE: VETERANS AFFAIRS

Our vision is that aging providers have the resources, tools and supports to best serve those receiving LTSS benefits funded by VA.

WHAT LEADINGAGE MEMBERS SAY ABOUT VETERANS AFFAIRS

- *"Why is the VA not willing to work with new providers?"*

- *"There is a lack of relationship between the VA and adult day programs. I have had members who the VA adult day was unable to provide services to on a daily basis or handle advanced memory care needs. Because of this they had to pay out of pocket in one case and institutionalize in the other due to cost. Utilizing adult day programs would assist caregivers in keeping their loved ones at home longer, thus providing a better quality of life. It is also less expensive than placement*

- *Why can't the VA staff provide 1) training on how to prepare/submit the billing and 2) written notification of code changes with the link to the website of codes?*

- *Currently, a veteran is only allowed two service days per week and transportation is not covered. With the new case-mix structure, will there be a potential for additional service days per week?*

- *We have many rejected claims as well and have spent hours on hold. Please help! Thank you!*

VA POLICY GOALS

- Support regulations that expand community providers' partnership opportunities.

- Improve communication between VA and LeadingAge members

LEGISLATIVE ACTIONS

- **Provision of VA benefits in all settings.** Support flexibility for veterans to seek long-term services and supports outside of the VA system and opportunities for providers to partner with the VA in providing these services.

- **Seek parity in nursing home reimbursement by the Veterans Health Administration.** VA-operated nursing homes typically receive higher reimbursement rates for serving veterans than the rates paid to non-VA nursing homes that are contracted to serve veterans. We will seek

legislation that enables LeadingAge members and other non-VA nursing homes to receive the same level of reimbursement as VA nursing homes receive.

ADMINISTRATIVE ACTIONS

- **MISSION ACT implementation.** Monitor implementation of the MISSION Act, including provisions related to caregiver supports (Program of Comprehensive Assistance for Family Caregivers – PCAFC), technology and other standards development, and program modernization.

- **Assessment and reassessment.** Monitor state and regional eligibility assessment and reassessment activity and work with VA to address concerns.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Facilitate ongoing communications between with VA and LeadingAge members, including adult day services providers.

- Develop toolkit for new providers that want to work with VA that outlines the process from start to finish.

- Develop Issues briefs on Aid & Attendance and Housebound programs.

ENGAGE: BEHAVIORAL HEALTH

Our vision is an aging services system that is financed and prepared to meet the range of behavioral health (both mental health and substance use disorder) needs of older individuals.

WHAT LEADINGAGE MEMBERS SAY ABOUT BEHAVIORAL HEALTH

- *I'm in affordable housing. We're having a lot of issues getting residents the mental health services they need, because there are no services. If they're in affordable housing that says a lot about what they can afford. Some planning needs to be done to meet these needs.*

- *Every provider in every setting is concerned about behavioral and psychological needs. This is bigger than just one setting.*

- *We've got an enormous issue coming related to behavioral health. It's everything from staff training and being able to really care for them appropriately, but there's also a huge shortage of appropriate behavioral health providers in the community, from psychiatrists and other providers, and the short-term acute [psychiatric] beds to care for people with acute needs.*

- *People in mental health do not know how to take care of seniors and people in aging services do not know how to take care of mental health needs. There's a lot of misunderstanding. In mental health, they're thinking it's about bipolar and in aging services we're thinking it's dementia. And in public housing, we don't even get their diagnosis, we don't know what's happening with them.*

- *Telehealth could be a way to get geriatric psych support. But there are not enough licensed providers of mental health care, and licensure doesn't cross state lines.*

- *We are seeing a dramatic increase in the intersection between mental health and younger older adults, so folks that are in their early 60s. Something that I am seeing working in Protective Services is an increased need for training community providers, training folks in facilities in terms of how to connect individuals who have maybe had a chronic history of mental health concerns, how to appropriately connect them with resources.*

- *I come from the mental illness world. Right now, there are people out there who are sitting in holding patterns, because we can't care for them in the nursing home because of regulations, because they're regressive ones. They were – you know, they have too many comorbidities of mental illness. So, my big deal is that stigma of mental illness and being able to care for them holistically. Trauma-informed care is a great start. Starting there with PTSD (posttraumatic stress disorder) and all that stuff, because we have a group of people who have fought in wars that are going to be in our care centers who none of us are going to be able to afford to treat.*

- *We're running into a situation with mental health people. So, there's a hole between mental health and Medicaid services. If you have mental health issues, Medicaid will not step in until*

you're 65. I have a gentleman who is 60. They keep pushing him back to mental health, and mental health says, "Well, Medicaid should step in," and so they're doing this thing where they point a finger. And then, the person goes without, and so it's frustrating.

- *I think that this is an important topic to talk about, not only at the skilled nursing level of care, but also the affordable housing environment and arena. Perhaps there needs to be innovative partnerships and collaborations among the different agencies so that the people who are struggling with chronic mental health issues, those who we're trying to support in an independent affordable housing environment, we can have more resources to be able to do that. And because they shouldn't have to be in a higher level of care.*

BEHAVIORAL HEALTH POLICY GOALS

- Ensure that regulations and payment systems do not force older adults with mental and behavioral health conditions to fall between the cracks in service delivery systems.

- Advocate for appropriate reimbursement rates for providers who serve people with mental and behavioral health comorbidities.

LEGISLATIVE ACTIONS

- Monitor legislation that can address the ability of older adults to access to mental health and addiction treatment services including changes such as: care integration between mental health and aging services; home and community-based services delivered by peers and community health workers; better use of telehealth; and mobile technology, including remote sensing.

ADMINISTRATIVE ACTIONS

- **Treatment framework.** We will provide members with the treatment framework and structure of trauma-informed care which involves understanding, responding and recognizing the effects of all types of trauma. This will assist skilled nursing facilities for compliance with phase 3 of the requirements of participation in addition to informing other provider types on this important framework.

- **Implementation of Opioid legislation.** Monitor implementation of aspects of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that relate to older adults including the Preventing Addiction for Susceptible Seniors Act of 2018 and the Stop Excessive Narcotics in our Retirement Communities Protection Act of 2018 and the exemptions for substance-use disorder telehealth services from specified requirements, such as geographic restrictions, under Medicare.
- **Anti-psychotics in nursing homes.** Work with federal and state regulators to ensure the appropriate allowances and safeguards for anti-psychotic medications particularly in nursing home environments.

DEVELOPMENTAL/EXPLORATORY ACTIONS

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- Develop resources on best practices for supporting residents with mental and behavioral health conditions.

- Create strategic partnerships with organizations that focus on mental and behavioral health for older adults beginning with participants of the Leadership Council of Aging Organizations (LCAO).

ENGAGE: RURAL CONCERNS

Our vision is policy and financing arrangements that ensure equity and address unique concerns in rural places.

WHAT LEADINGAGE MEMBERS SAY ABOUT RURAL CONCERNS

- *Education and training is hard in rural areas. People have to go to cities to be trained.*
- *If facilities shut down in rural areas, there's no place for the residents to go. If something happens to my community, we say to my 98-year-old WWII resident, thanks for serving, thanks for farming here for 56 years, but find somewhere else to go.*
- *Here's how it is in rural America. After they graduate college, nobody wants to come back home. Our population just continues to age. People work for us, then they go down the road. Then they come back to us. We just keep recycling people.*
- *The working population on the nearby Indian reservation prefers to seek jobs with the Indian Health Service, because IHS pays better than we can with our Medicaid reimbursement rates.*
- *The home environment, especially on some reservations, may not have heat or running water.*

RURAL-RELATED POLICY GOALS

- Federal and state regulatory and payment policies must recognize and accommodate the special challenges facing rural providers, who have difficulty recruiting and retaining staff and often have limited financial resources.
- Remove barriers so technology can improve quality of care and quality of life for people needing long-term services and supports.

LEGISLATIVE ACTIONS

- **CNA Training**: Our lead organizational priority is reintroduction of the Nursing Home Workforce Quality Act (HR 6986, 115th Congress). This legislation addresses the impact of penalties on nursing home workforce. We led the development of the Nursing Home Workforce Quality Act and will work to have legislation reintroduced in the next Congress. The bill would offer more flexibility in the relationship between nursing home surveys and CNA training programs.*
- **Explore feasibility of amending the Rural Health Care Connectivity Act of 2016** (PL 114-182) to include home health providers. This law ensured that rural nursing home providers have affordable broadband internet access, but it did not include home health providers. We will advocate for legislation that would expand the law to include Home Health providers, just as their SNF and hospital counterparts.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- **Support reintroduction of CONNECT for Health Act** (S 1016). The legislation would further expand Medicare coverage of telehealth services, which are especially crucial to high-quality health and long-term care in rural areas. The legislation would eliminate several barriers to telehealth, including restrictions on originating sites, distant site providers, patient locations and covered Medicare codes. The legislation also would permit coverage of remote patient monitoring for Medicare beneficiaries with chronic conditions.

ADMINISTRATIVE ACTIONS

- **CHRONIC Care Act implementation.** LeadingAge will work with other stakeholders and CMS to implement provisions of the CHRONIC Care Act that expand Medicare coverage of telehealth technologies in Medicare Advantage plans and accountable care organizations. We strongly supported the legislation enacted in 2018.*

- **Special considerations for rural nursing homes.** LeadingAge will champion regulatory relief for nursing homes with special consideration for small and rural providers who cannot sustain severe penalties.

- **Impact of payment systems on rural providers.** As alternative payment systems develop, LeadingAge will work to ensure that the special challenges facing rural nursing homes and home care providers are taken into account and accommodated.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- LeadingAge will continue working through the Center for Workforce Solutions to promote best practices for recruiting and retaining the people essential for providing long-term services and supports.

- **Social isolation.** We will provide policy and advocacy leadership to address social isolation through the Social Integration Coalition.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ENGAGE: ELDER JUSTICE

Our vision is that older individuals are safe from abuse and neglect no matter where they live.

WHAT LEADINGAGE MEMBERS SAY ABOUT ELDER JUSTICE

- *This is a national epidemic, elder abuse and the exploitation of older adults.*
- *Honestly, we've got a lot of public trust to build [after a series of press exposes of problems in assisted living]. We've got to keep this in the front of our thinking in everything we do.*
- *It seems like Adult Protective Services thinks once you're in a nursing home, hey, it's [the nursing home's] problem, you figure it out. We need that extra support, especially if the family needs a power of attorney. We'd like to be able to refer them to APS.*
- *We worry about the potential for abuse, because residents in our nursing home have no one to manage their finances. Where do we draw the line? We don't want to have our hands in someone's finances.*
- *It can be hard to find a Medical Power of Attorney for our nursing home residents. Thankfully we have volunteers in the community who step up, but it's a lot of manpower to find even one person.*
- *Residents in our independent living units will ask us to write a check for them. We can't do that, but there's no one to help them if they can't see or write anymore.*

ELDER JUSTICE POLICY GOALS

- Support the principle that every older person has the right to be free of abuse, neglect and exploitation.
- Identify, develop, and promote policies and practices both at the community level and within our residential/health care organizations that prevent abuse and protect older persons who have been abused.
- Encourage and support a robust public-private infrastructure with adequate resources to prevent, detect, treat, understand, intervene in, and, where appropriate, prosecute elder abuse, neglect and exploitation.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

LEGISLATIVE ACTIONS

- **Support reauthorizing the Elder Justice Act, as in reintroduction of the Elder Justice Reauthorization Act** (HR 2639).

- **Support legislation providing additional funding for elder abuse prevention, such as reintroduction of the Stamp Out Elder Abuse Act** (HR 7061, S 3594).

- **Older Americans Act Reauthorization.** The Older Americans Act will need to be authorized to continue beyond FY 2019. We will collaborate with state partners, members and external stakeholders to identify key priorities to advocate for during the reauthorization process, inclusive of financing (both funding formulas and appropriation levels) and program design.

ADMINISTRATIVE ACTIONS

- Track enforcement of elder abuse prevention regulations.

- Track development of new elder justice regulations.

- Engage with the Elder Abuse Coordinating Council as part of improving public-private partnerships.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- **Create a LeadingAge Elder Justice Task Force.** The task force will advance elder justice within the aging services field and support LeadingAge members who are developing and implementing affirmative programs to prevent and address elder abuse.

- **Social isolation.** We will provide policy and advocacy leadership to address social isolation through the Social Integration Coalition.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

MONITOR: ALZHEIMER'S DISEASE AND RELATED DEMENTIAS

Our vision is a health and long-term care continuum that provides high-quality services for the more than 5.7 million Americans with Alzheimer's disease and related dementias (ADRD) today and is ready to serve 13.8 million in 2050.

WHAT LEADINGAGE MEMBERS SAY ABOUT ALZHEIMER'S/DEMENTIA

- *Memory care, unfortunately, is not going to go away; but more and more facilities are getting out of it. People are getting diagnosed at younger ages and coming to us on Medicaid and staying for 20 years. Being able to meet their needs is a huge challenge. It's a fallacy that private-pay residents will make up the difference, because they end up spending down to Medicaid.*

- *Nursing homes have to staff higher for a growing population of people with dementia, but there's no additional money to pay for it.*

- *There's a tremendous focus on reducing antipsychotics in nursing homes, but we've got to talk about it in other settings, like hospitals. Hospitals need to understand you can't put people with dementia on psychotics. They start them in the hospital.*

- *There's evidence that marijuana reduces anxiety in some people with dementia. We should be able to use medical marijuana in all settings.*

ALZHEIMER'S/DEMENTIA POLICY GOALS

- Promote and fund research into curing and preventing dementia.

- Ensure the best possible quality of life, autonomy and engagement for people with dementia and for their family members.

LEGISLATIVE ACTIONS

- **NIH/NIA Budget.** We support increased federal funding for Alzheimer's and dementia research through the National Institutes of Health, especially the National Institute on Aging.

- **Support legislation that improves the current public health infrastructure to address Alzheimer's and related dementias, including reintroduction of the Building Our Largest Dementia (BOLD) Infrastructure Act** (S 2076, HR 4256).

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ADMINISTRATIVE ACTIONS

- **Healthy Brain Initiative.** We support the Healthy Brain Initiative administered by the Centers for Disease Control and Prevention. The initiative takes a public health approach to advancing cognitive health.

- **National Plan to Address Alzheimer's Disease and Related Dementias.** LeadingAge supports and will monitor the National Plan to Address Alzheimer's Disease, under which the Department of Health and Human Services has partnered with the Departments of Veterans Affairs, the National Science Foundation and the Department of Defense. The plan's most recent update contains strategies for research, workforce development, public information and outreach and attention to the housing needs of people with dementia.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Many LeadingAge member organizations are at the forefront of developing innovative ways to assist people with dementia in achieving the highest quality of life. We will explore ways to gather promising practices and share them with all members.

ADDITIONAL RESOURCES

- **Healthy Brain Initiative**
- **National Plan to Address Alzheimer's Disease**
- **Comfort Matters**

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

MONITOR: TECHNOLOGY AND TELEHEALTH

Our vision is that aging services providers have sufficient resources and policies to enable their use of technology and telehealth and that internet access is equitable across the country.

WHAT LEADINGAGE MEMBERS SAY ABOUT TECHNOLOGY AND TELEHEALTH

- *We're looking at the technology that exists to help people stay at home, and the cost of it is prohibitive. It comes on the backs of HCBS providers who can't afford it.*
- *The internet is not available or is poor in some rural areas.*
- *I'd love to see more telehealth. If I have to send someone to the doctor, I pay $140 for an ambulance; take a can, because office staff won't help the person in the doctor's office; transfer the patient; the ambulance waits an hour for the doctor to see the person. By the time the person comes back to my building it's been four hours. I can't pay for this.*

TECHNOLOGY AND TELEHEALTH POLICY GOALS

- Eliminate barriers to realizing potential technology and telehealth benefits, including acquisition and training costs, inadequate standards, privacy concerns and administrative barriers.
- Promote the adoption of electronic health records, including funding and technical support.
- Promote the use of interoperable health information exchange between LTSS/PAC providers and primary/acute care providers.
- Promote the use of telehealth, especially in rural settings.
- Ensure equitable internet connectivity for all aging services providers and older adults.

LEGISLATIVE ACTIONS

- **Telehealth.** Support legislation that allows all nursing homes to use telehealth models to improve care, such as by reducing unnecessary hospitalizations. An example of legislation that we have worked on in the 115th Congress is the RUSH Act, Reducing Unnecessary Senior Hospitalizations (HR 6502), which establishes a new program to furnish telehealth services at qualified SNFs, using first responders on site. LeadingAge will advocate to include provisions that advance the LeadingAge pilot projects that allow LTPAC providers to test chronic care management using telehealth and remote patient monitoring.*

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- **Explore feasibility of amending the Rural Health Care Connectivity Act of 2016 (PL 114-182).** to include home health providers. This law ensured that rural nursing home providers would have affordable broadband internet access, but it did not include home health providers. We will advocate for legislation that would expand the law to include home health providers, just as do their SNF and hospital counterparts.

- **Net Neutrality Opportunities for Older Adults.** Older adults should have access to nondiscriminatory internet service. In December 2017, the Federal Communications Commission (FCC) voted to repeal the net neutrality rules that were intended to prevent internet providers from blocking, speeding up or slowing down access to specific online services. LeadingAge will continue to watch for any potential activities to repeal the net neutrality rules.

ADMINISTRATIVE ACTIONS

- **BBA implementation.** We will continue to monitor CMS implementation of *the Bipartisan Budget Act of 2018*, which allows Medicare Advantage (MA) plans to offer additional telehealth benefits not otherwise available in Original Medicare to enrollees starting in plan year 2020.

- **Telehealth benefits in Medicare.** We will continue to call on CMS to explore extending telehealth benefits to the broader Medicare population through demonstrations. In addition, we will provide comments to CMS on how MA plans can cover additional telehealth benefits as a Medicare Part B service.

- **FCC Lifeline program.** We will oppose efforts that reduce funding for the FCC's Lifeline Program, which offers subsidies for broadband internet and phone service to low-income Americans. Lifeline is part of the Universal Service Fund.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- We will develop a new tool to help aging services providers understand different health information exchange networks and entities, the services that they provide, their value, and how to select and join the ones that best fit their needs.

- We will continue to help services providers understand technology, its benefits, and how to plan for select and implement appropriate ones, including available revenue, reimbursement and subsidies available to provider and the populations they serve under different business models through:

    - Updating CAST Technology Selection Tools

    - Updating analysis of Medicaid waiver programs including technology provisions

- We will continue tracking technology adoption and spending among LeadingAge members.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

ADDITIONAL RESOURCES

- **Center for Aging Services Technology (CAST)**

MONITOR: MEDICAL MARIJUANA

Our vision is that residents are allowed to use all legal means to alleviate pain and symptoms of disease and providers are protected from prosecution and regulatory actions in assisting resident in accessing legal products.

WHAT LEADINGAGE MEMBERS SAY ABOUT MEDICAL MARIJUANA

- *Unfortunately, I know a lot more about medical marijuana than I ever anticipated. It's a federal Schedule I drug, and that means we can't do a lot of research about it. You can look at the way it's trending now with more than 30 states allowing it. But HHS is reluctant to do anything with the Department of Justice across town threatening enforcement.*

MEDICAL MARIJUANA POLICY GOALS

- Seek clarity from the federal government that it will not pursue civil or criminal actions against providers if they allow the use of medical marijuana pursuant to state laws and regulations.

- Work with state LeadingAge affiliates, as requested, to support legislation at the state level to enact medical marijuana statutes and regulations that will allow seniors to access it under appropriate circumstances to alleviate pain and other symptoms of diseases.

- Support federal legislation or regulations to prohibit any federal agency interference with state medical marijuana laws.

LEGISLATIVE ACTIONS

- Advocate for existing and/or new legislation on the federal level to acknowledge and protect state medical marijuana laws from federal agency prosecution or interference.

ADMINISTRATIVE ACTIONS

- **Medical marijuana guidance.** Explore options for regulatory guidance or memorandum discouraging enforcement of medical marijuana usage (example: DOJ Cole memo that was rescinded by current administration).

- **CBD Guidance.** Work with CMS to encourage clear guidance on the use of CBD in Medicare and Medicaid financed settings.

DEVELOPMENTAL/EXPLORATORY ACTIONS

- Host a webinar about medical and recreational marijuana for senior living providers.

Action steps marked with an asterisk (*) are a primary focus; we invest maximum effort.

- Draft FAQs document about current issues providers must address when determining to allow medical marijuana within their communities.

- Monitor research about the use of marijuana to address pain, anxiety and other conditions experienced by older individuals and ensure that any policy actions LeadingAge considers/recommends are based on evidence.

MONITOR: TAX POLICY

Our vision is a tax policy that maintains a strong not-for-profit sector and encourages support by individuals through charitable giving

WHAT ARE MEMBERS SAYING?

"The Low-Income Housing Tax Credit has to change. The limits are so severe that housing needs cannot be met"

TAX POLICY GOALS

- Maintain current nonprofit tax status for our members as 501(c)3 exempt organizations.
- Enhance Low Income Housing Tax Credit program to broaden its availability for use in developing low income housing for seniors.
- Support charitable donations through tax deductions.
- Support the deduction of medical expenses.

LEGISLATIVE ACTIONS

- **Monitor activity on the 2017 Tax Cuts and Jobs Act (TCJA).** House Ways and Means Committee Chairman Richie Neal (D-MA) has said that he wants to examine the 2017 Tax Cuts and Jobs Act (TCJA), and he plans a series of hearings to determine what is and is not working and what can be done to improve it. The committee will also engage in oversight activities and administration of the tax laws.
- **Monitor Senate Finance Committee activity related to the tax-exempt sector.** The tax priorities of Senate Finance Committee Chairman Chuck Grassley (R-IA) are not yet clear, but he can be expected to continue to support the TCJA. He has a long history of investigations, including a particular focus on the tax-exempt sector. Thus, he may pursue issues relating to exempt organizations, including possible legislative changes.
- **Low Income Housing Tax Credits.** Support efforts to Increase state LIHTC allocations by 50 percent; provide a 50 percent basis boost for LIHTC communities that serve households with extremely low incomes in at least 20 percent of their apartments; replace the current right of first refusal with a purchase option to facilitate the ability of nonprofits to maintain ownership/control of housing credit properties beyond Year 15; establish a minimum 4 percent rate for housing credits used to finance preservation acquisitions and recapitalizations and Housing Bond financed developments; limit the rent charged to the maximum Housing Credit rent instead of the HUD-calculated fair market rent for apartments leased by voucher holders and benefiting from either income averaging or the basis boost for communities serving

households with extremely low incomes in at least 20 percent of their apartments; and codify existing practice to include existing tenants into eligible basis as long as the property being recapitalized was a means-tested affordable housing property and the tenant's income did not rise above 120 percent of the area median income.

- **Charitable Contributions.** Maintain the incentive for charitable giving. Although the itemized deduction for charitable contributions remains in the law, the incentive it provides for charitable giving may be weakened, because fewer people will itemize as a result of the increase of the standard deduction.

  Support a "universal charitable deduction." This would provide for an "above-the-line" income tax deduction for charitable contributions and thus likely would ameliorate the expected decline in charitable giving.

- **Medical Expense Tax Deduction.** Maintain the enhanced medical expense itemized deduction (at 7.5 percent of AGI). The reversion back to a threshold of 10 percent of AGI will negatively impact seniors.

ADMINISTRATIVE ACTION

- **Nonprofit status.** Monitor efforts to clarify other implications on our not-for-profit members from the TCJA, such as tax on fringe benefits.

DEVELOPMENTAL/EXPLORATORY ACTION

- **Social Accountability.** Develop information for members related to meeting their social accountability responsibilities.

- **Nonprofit (NFP) Tax Status.** As we assist members with questions about their NFP tax status, identify solutions that could apply to many members and share them broadly.