With Major Home Care, MLTC Gains, Budget Moves to Senate & Assembly Reconciliation

With this past week's passage of state Senate and Assembly one-house budget proposals, the negotiation process now turns toward reconciliation of the two during conference committees scheduled for this week.

Both the Senate and Assembly proposals mark major gains for home care and MLTC, as well as important positioning for rejection or modification of potentially adverse

See BUDGET p. 2

DOH Releases Guidance on Minimum Wage Funding

The state Department of Health (DOH) has released a Dear Administrator Letter (DAL) that covers further Medicaid adjustments to managed care plan rates to address the recent and next increase in minimum wage.

See WAGE p. 6

HCA Calls on Congress to Oppose ACA Repeal and Replacement Bill, With Its Deep Cuts to Medicaid

As Congress continues to deliberate on the Republican-led health care plan, HCA late last week sent a letter urging New York’s Congressional Delegation to oppose the bill’s current iteration, with its dramatic proposals to overhaul the Medicaid program.

See OPPOSE p. 5
provisions, including hospice and MLTC changes, advanced by the Governor. Some of these gains include the direct incorporation of HCA’s language and funding requests in the bills.

HCA will advocate for the two houses’ adoption, modification or reconsideration of proposals accordingly. This will give home care, MLTC and hospice the best positioning going into three-way negotiations with the Governor/Executive Branch to follow. Once engaged with the Governor, the course of these proposals (adoption, modification or rejection) will be determined for the final budget, which is due April 1.

Below is a summary of the major proposals in the one house budget bills and resolutions.

**Rate adequacy for home care providers, MLTC and hospice provisions**

Both the Senate and Assembly bills include all or some of HCA’s language for MLTC and home care rate adequacy, which would ensure that vital personnel costs, operational costs (including agency capacity, training, quality, technology) and service costs are truly covered in the premiums and rates.

We have strongly advocated for minimum wage funds. The budget includes $255 million proposed for the direct costs of minimum wage for health care workers.

HCA’s language also ensures appropriate upward adjustments for regional cost variables affecting MLTCs. These variables are currently resulting in severe premium underpayments to MLTCs, which, in turn, challenges the ability to provide and pay for needed services.

The language in each bill also includes an amalgamation of additional provisions to lock-down rate adequacy, including: proposals for creation of separate MLTC “rate cells” geared to costs for nursing home enrollees and to higher cost home care enrollees; and transparency provisions for Health Care Reform Act monies that the state is obligated to pay MLTCs and providers for recruitment, training and retention of
direct-care staff. Separate provisions also include wage parity levels for consumer directed program personal assistants but funding for this provision is not known at this point.

The bills also substantially reject some of the Governor’s MLTC cuts and revisions, which were strongly opposed by HCA, including the Governor’s proposed MLTC eligibility changes, quality incentive payment reductions, and the transportation carve-out. The Governor’s proposal to ban MLTC marketing, which was administrative not legislative, is not addressed in the bills and thus far does not appear to be discussed in the resolutions. HCA will pursue a status update.

In addition, the Governor’s proposed Medicare-Medicaid liability provisions for hospice, which HCA opposed, were omitted from the Assembly bill and modified in the Senate bill.

Both bills add language seeking to tie rate adequacy to determinations of the patient assessment. HCA is confirming that the “patient assessment” means the UAS, or OASIS, or other current, official assessment in the system.

Infrastructure

As part of an all-sector funding proposal, and consistent with HCA’s calls for increased community-care infrastructure funding, the Assembly’s budget bill provides a $125 million minimum amount for community health care providers. This is a major increase over the $30 million proposed by the Governor (which we guided through our advocacy last year). The $125 million (increased) amount, which was fervently sought by HCA, more appropriately reconciles the longtime absence of community-care infrastructure investment. It also more proportionately reflects the role and needs of home and community-based providers in the changing system, given that the state relies on this sector substantially in support of reform goals to reduce hospital use by 25%.

Beyond the $125 million, the Assembly bill also increases the overall amount for all sectors under the infrastructure program (bringing the allotment to $700 million, up from $500 million proposed by the Governor).

Meanwhile, the Senate proposes $800 million for the program, but does not delineate any proportions for the institutional or community sectors at this time, pending additional information on need, prospective use and how Health Care Transformation Program funds for the 2016-17 state fiscal year will be disbursed. The Senate indicates, however, that its delineation will be specified in legislation.

If such higher appropriations are gained in the final budget, HCA will advocate for a net higher proportional minimum amount for home and community health care.

Regulation Modernization Team

The Senate modifies and narrows the Governor’s proposal for a health care Regulation Modernization Team. The Assembly bill omits this proposal.

While regulatory relief in home care is critical, the Governor’s proposal for a Regulation Modernization Team has presented both opportunities as well as risks. Our main concern is the potential for further disruption in the delicate balance of licensure and service jurisdictions in health care, which is already a growing problem that risks quality of care, as well as potential service or workforce dislocation.

As HCA has pointed out in our advocacy messages to members and to the Legislature, health care institutions and entities that are not lawfully designated providers of state and federally licensed home care services have already attempted to overstep explicit licensure and sanctioned service jurisdictions to provide home care. Without explicit language avoiding these jurisdictional entanglements, the Governor’s proposed Regulation Modernization Team brings together stakeholders from various sectors with wide-ranging latitude to remake the structure and delivery of services in ways that could exacerbate existing problems.

These concerns are only somewhat addressed in the Senate legislative language. HCA has additionally
provided a markup of the language that would truly ensure balanced representation, strict parameters and a highly responsive process on the proposed Regulation Modernization Team, also providing for a voting/recommendation process ensuring that no sector is impinged upon by another.

HCA will attempt further change to the Senate’s proposal to address these concerns, as well as seek opportunities for separate regulatory relief measures for home care that are carefully directed to facilitate our sought-after efficiencies and flexibilities, while preventing and relieving the current jurisdictional entanglements occurring in the field.

Essential Personnel, Community Paramedicine

The Senate bill also includes two measures developed or shaped by HCA as standalone legislative proposals.

The first is our “essential personnel” measure, which was recently introduced separately in both houses of the Legislature, to provide “essential-personnel” status for home care and hospice so that staff are permitted to reach patients during emergencies when transportation restrictions, curfews or evacuation orders are otherwise in effect. HCA urged the Legislature to include the “essential personnel” bill language in the budget to help better position it for possible adoption. The severe winter emergency across New York State just last week will hopefully serve as a fresh reminder to all officials of the need for this critical legislation.

A second proposal in the Senate bill supports the creation of a community paramedicine option, which HCA drafted and proposed as a way of authorizing these services in New York State in a manner that duly involves and respects all key sector roles and jurisdictions. The language, now in the Senate bill, is the culmination of HCA’s work with and support from multiple allied associations, particularly the Iroquois Healthcare Alliance (IHA).

Community paramedicine involves the use of EMS resources for non-emergent support, as well as emergent care and transport. The approach drafted by HCA and further fleshed out with partners, creates opportunities for hospitals, home care agencies, physicians and EMS to develop a coordinated plan for community paramedicine into their mutual services.

Prior versions conceived by other stakeholders generated great concerns about open-ended scope-of-practice provisions and the lack of key elements for coordination and compliance. HCA worked closely with collaborating partners on a version of a bill (which taps into the Hospital-Homecare-Physician Collaboration Law that HCA authored with IHA in 2015) to bring all partners together in a common, collaborative and mutually supportive program for community paramedicine. It allows for coordination of the various stakeholder sectors while ensuring that no Article 36 or 40 licensure or nursing scope-of-practice laws would be breached.

Further updates and analysis

There are many other critical health care provisions in the Senate and Assembly proposals that HCA will be detailing for you in follow-up communications, along with clarification or elaboration on the items summarized in this article.

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**Director of Quality Management Services & Education**

**Manhattan**

Partners in Care, a respected leader in home health care, is currently seeking a Director of Quality Management Services & Education. The Director is accountable for ensuring that Partners in Care is in compliance with corporate and licensure requirements and for providing oversight to the Education and Quality Management Departments. To qualify, you must be a Registered Nurse with New York State License, Bachelor’s Degree required. Master’s Degree with certification in Quality Management (CPHQ) preferred. The ideal candidate will have three (3) years health care experience, knowledge of licensure regulations, previous quality management and quality improvement experience, excellent organizational, interpersonal, written and verbal communications skills.

Please email resume to: *lorna.williams@partnersincareny.org*
Our letter joins the growing chorus of hospital and community health groups, insurance representatives, practitioner organizations and consumer groups “who recognize that this bill would deprive citizens of life-saving coverage, recklessly destabilize insurance markets, and create a fiscal crisis for states like New York,” writes HCA President Joanne Cunningham.

On Thursday, the U.S. House budget committee moved the bill forward for consideration by the full House. However, opposition to the bill has grown louder, with Democrats near-universally opposed to the measure and some Republicans – especially the Freedom Caucus – stating that they will be seeking amendments because the bill doesn’t move fast enough on some of the Medicaid changes sought by the more Conservative wing of the party, among other concerns.

HCA’s letter notes that the bill, intended to repeal and replace the Affordable Care Act (ACA), would undercut health care coverage for one million New Yorkers, including coverage obtained by the home care workforce and individuals who receive home care through Medicaid and Medicare.

And while supporters of the American Health Care Act (AHCA) say it will offer states flexibility to administer their Medicaid programs, HCA argues that “New York State has relied on ACA’s Medicaid expansion, and the bedrock of Medicaid’s core structure and existing waivers, to implement programs that are already are driving service and payment delivery changes,” including the Delivery System Reform Incentive Payment and Value Based Payment Programs.

Even more alarming, however, is the fact that the bill’s proposed Medicaid disinvestments would “knock a multi-billion-dollar hole in New York’s state budget for safety-net health care services and program innovation.”

Ms. Cunningham adds: “The bill’s per-capita Medicaid spending caps are expected to substantially reduce the federal-share of state Medicaid funding, resulting in major fiscal instability for New York’s health care system and, in turn, threatening dislocation of existing fund obligations, the potential elimination of Medicaid benefits impacting lower-income home care recipients, or provider funding reductions at a time when two-thirds of New York’s home care programs are already operating in the red on services to both Medicare and Medicaid beneficiaries.”

HCA acknowledges that ACA is “by no means perfect,” and it includes provisions that negatively impact home care providers, from new regulatory requirements, to unfunded labor costs, to employer penalties, to Medicare reimbursement cuts. “These elements can – and should – be addressed in a surgical way,” Ms. Cunningham says. “HCA has strongly advocated for these modifications to the ACA for many years. However, the AHCA legislation cuts deep into fundamental programs, funding mechanisms and coverage provisions that would cause massive disruption in services, financial structures and markets throughout the entire health care continuum.”


HCA will continue to keep you informed of developments.
The guidance had been requested by HCA and our managed long term care (MLTC) plan and home care provider members.


It states:

At this time, the Department strongly advises that managed care plans and home care provider agencies maintain current contracted amounts reflecting the costs of the December increase. Current plan rates on the eMedNY system reflect a minimum wage adjustment as a carryover from the prior year. This funding is expected to mitigate concerns with continued minimum wage funding and allow plans and providers to maintain current contract levels until SFY 2017-18 rates are paid.

DOH states that it intends to share “projected aggregate home care minimum wage funding” for state fiscal year (SFY) 2017-18 with Partial Capitation plans by mid-March.

The DAL also includes the following schedule of minimum wage adjustments for managed care programs:

- Partial Capitation – effective April 1, 2017, draft available March 2017
- Mainstream – effective April 1, 2017, draft available April 2017 (retroactive to January)
- FIDA (Fully Integrated Duals Advantage) – effective April 2017, draft available April 2017
- MAP (Medicaid Advantage Plus) – effective April 1, 2017, draft available June 2017
- PACE (Program of All-Inclusive Care for the Elderly) – effective April 1, 2017, draft available June 2017
- MA (Medicaid Advantage) – effective January 1, 2017, draft available June 2017

HCA is checking with DOH on whether the FIDA and PACE rates are retroactive to January 1 as was earlier indicated to us.

The guidance also states that DOH is working with plan and provider associations on “additional steps ... to ensure proper funding” that include:

- New provider cost report submissions, including for Licensed Home Care Services Agencies, Certified Home Health Agencies and Consumer Directed Personal Assistance Fiscal Intermediaries.
- Amended managed care plan cost reports.
- Provider and plan cost report audit process.
- Rate reconciliation process.

For more information, contact the HCA Policy staff.
New Date for Postponed Senior Financial Managers Forum: April 7
Earlier date was suspended due to major winter storm; HCA to transfer registrations to new date

The HCA Senior Financial Managers Forum has been rescheduled for Friday, April 7, 2017 at the same location as the original date (March 15): Renaissance Albany Hotel, 144 State Street, Albany, NY 12205.

HCA postponed the conference last week due to the major winter storm. Individuals who registered for the original date will have their registrations automatically transferred to the new date of April 7. However, if you are unable to attend this new date, please notify HCA in writing to info@hcany.org, no later than the close of business on Thursday March 23, 2017 to receive a full refund of your registration fee. After this date, the prevailing cancellation policy for this program will apply. You may substitute another staff member for the event at any time by contacting the HCA office.

We have reserved a limited number of rooms at the hotel for the night of April 6 at a special group rate of $179 per night. Use the following link to reserve your room at the HCA rate (http://tinyurl.com/kzxxvyn) or call 1-888-236-2427 and ask for the Home Care Association of NYS group rate. You must register by April 1 to receive the group rate.

Still time for new registrations

If you didn’t have a chance to register previously, or had a conflict preventing your registration for the original date of the Forum, please check out the conference brochure at the back of this week’s newsletter to learn all about the key reimbursement, financial and policy updates that will be presented to you on April 7.

Trump Budget Proposes Deep Cuts to Domestic Programs

The Trump Administration issued a blueprint of its 2018 budget proposal last week with major increases to the Defense Department that are offset by cuts to an array of domestic programs, including some provided or coordinated by home care and other health providers.

Notably, the budget blueprint is silent on Medicare, Medicaid and Social Security, which consume a big share of federal spending. This omission could be due to the major health care overhaul legislation separately underway to repeal and replace the Affordable Care Act (ACA). (See related p. 1 story.) That bill would claw-back ACA’s Medicaid expansion and pursue a Medicaid block-grant program (as opposed to an open-ended entitlement), cutting a proposed $800 billion from the program for lower-income Americans over ten years.

On a broad level, the President’s Budget blueprint would add $54 billion to the Defense Budget along with significant funding increases for national security. But many domestic programs take a major hit, with the biggest cuts affecting the Environmental Protection Agency (EPA), the State Department, and well over a dozen other agencies and departments.

The U.S. Department of Health and Human Services (HHS), which oversees the U.S. Centers for Medicare and Medicaid Services (CMS), would face a $15.1 billion (or 17.9 percent) decrease.

While further details are still needed, the HHS changes, specifically, focus “spending on the highest priority activities” in Medicare, Medicaid and the Children’s Health Insurance Program, according to the Trump Administration’s blueprint document, though it appears this concise language applies to operational aspects
of the programs under HHS – not the major funding aspects that are otherwise drawing focus in separate health care overhaul legislation.

Under HHS, President Trump also proposes to: increase the Health Care Fraud and Abuse Control Program (HCFAC) by $70 million; cut National Institutes of Health funding by $5.8 billion; and reduce $403 million in funding for health professions and nursing training programs, citing “lack [of] evidence that they significantly improve the nation’s workforce.”

The budget blueprint uses similar language as a rationale for $4.2 billion in cuts to the Low Income Home Energy Assistance Program – which provides home heating and cooling funding credits for individuals in need, supporting their ability to remain safe at home – and the Community Services Block Grant program.

President Trump also proposes cuts to the Department of Housing and Urban Development’s Community Development Block Grant program, which includes Meals on Wheels funding. Meals on Wheels helps support the nutritional needs of individuals at home and is credited with making it possible for people to avoid unnecessary institutionalization. Many home care agencies coordinate or operate these vital programs.

The budget, as proposed, appears to have a tough road ahead, with Democrats, and even some Republicans, condemning it outright or opposing pieces of the proposed budget.

Among Republicans voicing concerns were Senator Rob Portman of Ohio, citing cuts to the EPA’s Great Lakes Restoration Initiative, and Rep. Hal Rogers of Kentucky. Rep. Adam Kinzinger, of Illinois, called the State Department cuts “unteachable.” Meanwhile, New York Republican Rep. Chris Collins, an early supporter of President Trump, specifically mentioned his opposition to the Meals on Wheels cuts, saying he could not support any cuts to the program.

HCA will keep you posted about all key developments as the House and Senate further review and respond to the President’s budget proposal.

Closing Keynote at HCA Annual Conference: Understanding the Millennial Mindset for Staff Engagement, Retention and Leadership

Paul Angone, Author, Organizational Consultant, and Millennial Expert, will be the closing keynote speaker at HCA’s upcoming Annual Conference, our biggest signature event of the year, on May 3-5 in Saratoga Springs!

In 2020, Millennials will make up 50% of the workforce, growing to as much as 75% in 2025. Strategically attracting Millennials to your organization, and then successfully engaging and retaining them, is not an option, it is a necessity.

So who and what are Millennials? And more importantly, what is the Millennial mindset and motivators that actually drive retention rates, workplace engagement and Millennials’ decision-making? Author,
speaker, and “Millennial Expert” Paul Angone shares the secrets to engage, motivate, and lead this next generation in meaningful ways.

Paul Angone is one of the leading experts in the nation on the Millennial generation. He is the best-selling author of two books, a sought-after national keynote speaker, and the creator of AllGroanUp.com, which has been read by millions of people in 190 countries. With over 10 years writing, speaking, and engaging Millennials, plus a master’s degree in Organizational Leadership, Paul has worked with companies such as Intel Security, Wells Fargo, Stewart Title, and Aflac and has been featured in publications such as Bloomberg, Chicago Tribune, Business Insider, and AARP.

Paul delivers dynamic, relevant, and informative keynotes that will help all generations in your company work better together.

Look for more details and a brochure for the entire conference in the coming days. In the meantime, please register online to get a jump on learning, networking and more at HCA’s Annual Conference.


Make your hotel reservations here: https://aws.passkey.com/event/15453851/owner/3105614/home.

Seema Verma Confirmed as CMS Lead

On March 13, the Senate confirmed Seema Verma, a Donald Trump selection, by a vote of 55-43, to lead the U.S. Centers for Medicare and Medicaid Services.

Ms. Verma is assuming leadership of this agency as the newly proposed Republican health care bill and the Trump Administration budget would make significant cuts to CMS’s operations and purview. The bill would also roll back Medicaid expansion for low-income individuals, and limit overall funding for Medicare moving forward.

Ms. Verma is a former Indiana-based health care consultant who worked closely with Vice President Pence to design their state’s Medicaid expansion, which required that most beneficiaries pay premium contributions and contribute to health savings accounts, and it uses financial rewards and penalties to encourage healthy behaviors and cost reduction. During her confirmation hearing, Verma defended the use of incentives for health care decision-making among Medicaid beneficiaries. She has also been involved with the expansion plans in Indiana, Iowa, Kentucky and Ohio, giving her a considerable amount of Medicaid experience relative to previous CMS leaders.

Regarding Medicare, Verma has been on record as not supporting programmatic changes championed by Tom Price, the U.S. Secretary for Health and Human Services, which oversees CMS. Dr. Price has advocated a voucher program for Medicare beneficiaries to purchase private coverage, in line with proposals from Congressional Republicans in the past.
MedPAC Report to Congress Again Calls for Rate Reductions

The Medicare Payment Advisory Commission’s (MedPAC) annual report to Congress is again calling for steep reductions to providers. MedPAC reviews Medicare and makes recommendations to Congress in a report finalized during its March meeting, though Congress is not required to act on the recommendations. For home health and hospice, MedPAC recommends:

- Reducing home health payment rates by 5 percent in 2018 and implementing a two-year rebasing of the payment system beginning in 2019.
- Revising the Home Health Prospective Payment System (HHPPS) to eliminate the use of the number of therapy visits as a factor in payment determinations, concurrent with rebasing.
- Eliminate the increase in hospice payment rates for fiscal year 2018.

Also at its meeting in March, MedPAC said the new prospective payment system for post-acute care may be implemented sooner than initially planned and as early as 2021, with a three-year transition period.

MedPAC justifies these recommendations based on a data analysis which finds high margins and a rising number of therapy visits. The Commission cites an average margin of over 15 percent during the last ten years, noting that average margins under HHPPS, since 2000, have hovered around 16.5 percent. HCA has repeatedly taken issue with the selective sampling methods and other data methodologies which overinflate MedPAC’s findings.

In January, when these proposals were first made public, HCA President Joanne Cunningham sent a letter to MedPAC’s Executive Director, Dr. Mark E. Miller, raising “grave concerns” about MedPAC’s recommendations and the data assumptions underlying them. In the letter, also cc’d to New York’s Members of Congress, she presented some New York-specific home health agency financial findings that vary substantially from MedPAC’s aggregate national data assumptions.

As noted in the letter, MedPAC based its recommendations on a claim that free-standing home health agencies nationally had an operating margin of 15.6 percent in 2015, thus warranting payment reductions. “This national estimate alone is questionable, as it does not consider any of the 1,500-plus agencies in the U.S. that are part of a hospital or skilled nursing facility,” Ms. Cunningham said. “Nationally, facility-based agencies have an average un-weighted Medicare operating margin of -6.19 percent. In New York (where these facility-based agencies represent more than 20 percent of all Medicare certified providers), this un-weighted operating margin is -32.53 percent.”

Ms. Cunningham urged MedPAC to amend its recommendations and to urge “CMS to analyze regional differences in home health operating margins to properly substantiate any payment decisions under consideration,” especially considering the toll of past home health rebasing efforts which have failed to properly account for the financial impact on agencies in large regions of the country.

For more information, please contact a member of HCA’s Policy staff.
PHHPC Committee on Establishment and Project Review Agenda Posted

The state Department of Health (DOH) has posted the agenda for the March 22 meeting of the Public Health and Health Planning Council (PHHPC) Committee on Establishment and Project Review.

The agenda is at https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2017-03-22/.

The meeting includes applications by:

- A Certified Home Health Agency (CHHA) to become the new operator of an existing CHHA;
- Eight entities to establish a Licensed Home Care Services Agency (LHCSA);
- Five entities to establish a LHCSA affiliated with an Assisted Living Program; and
- Seven LHCSAs for a change of ownership.

The Committee’s recommendations on these applications will be forwarded to the full PHHPC which will consider them at its April 6 meeting.

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Important Upcoming Deadlines

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<td>DSRIP Networks are open for new providers</td>
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The U.S. Centers for Medicare and Medicaid Services (CMS) has released an MLN Matters article regarding the requirement that Medicare providers, including home health and hospice, revalidate through their Medicare Administrative Contractors (MACs).


CMS has completed its initial round of revalidations and will be resuming regular revalidation cycles. CMS suggests the providers take the following action:

1. Check http://go.cms.gov/MedicareRevalidation for the provider/suppliers due for revalidation. Those due for revalidation will display a revalidation due date, and all other providers/suppliers not up for revalidation will display a “TBD” (To Be Determined) in the due date field. The MAC will send a revalidation notice within two to three months prior to your revalidation due date either by e-mail or regular mail.

2. If a due date is listed, submit your revalidation within six months of your due date or when you receive notification from your MAC to revalidate through Internet-based PECOS (at https://pecos.cms.hhs.gov/pecos/login.do) or using the appropriate CMS-855 application (available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/EnrollmentApplications.html).

3. If applicable, pay your fee by going to https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do.

Providers should respond to all MAC development requests in a timely manner to avoid a hold on your Medicare payments and possible deactivation of your Medicare billing privileges.

CMS advises providers that failure to submit a complete revalidation application or respond timely to development requests will result in possible deactivation of your Medicare enrollment.

MAP Releases Final Reports

In a recently released report, the National Quality Forum’s (NQF) Measure Applications Partnership (MAP) recommends that the U.S. Department of Health and Human Services (HHS) consider removing 51 of 240 measures currently used in seven federal health care value-based purchasing, public reporting, and other programs.

On an annual basis, HHS solicits and considers MAP’s analyses and guidance in the federal rulemaking process for quality and efficiency measures used in various payment and public reporting programs run by the U.S. Centers for Medicare and Medicaid Services (CMS).

MAP also provides recommendations for improving measure sets used in nine additional federal programs. In order for CMS to act on these recommendations, it will likely need to engage in rulemaking as well as consider other programmatic needs not taken into account by the MAP process. In its 2017 guidance, MAP addresses
The importance of removing measures that are no longer driving improvements in patient care or that do not meet the rigorous scientific criteria for NQF endorsement. This includes:

- **Home Health Quality Reporting Program**: 15 measures suggested for removal out of 79 current measures.
- **End Stage Renal Disease (ESRD) Quality Incentive Program**: 4 measures suggested for removal out of 18 current measures.
- **Outpatient Quality Reporting Program**: 13 measures suggested for removal out of 29 current measures.

MAP notes that higher value measures, including outcome measures, are needed in the Merit-Based Incentive Payment System (MIPS) and Medicare Shared Savings Program (MSSP). In its specific recommendations regarding measures for MIPS, MAP stresses the importance of selecting high-quality measures that drive toward safer and more efficient care.

Convened in 2011, MAP is a public-private partnership that provides recommendations to HHS on the use of quality and efficiency measures in federal public reporting and value-based payment programs. More than 150 health care leaders from 90 organizations who regularly use measures and measurement information participate in MAP discussions.

*For further information, contact the HCA Policy Staff.*

**Upcoming NGS Education Programs**

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), will be hosting the following educational webinars this week, as listed below.

- **Provider Enrollment**: Submitting Revalidations via PECOS, Tuesday, March 21, from 10 to 11 a.m. Registration is at: [https://attendee.gotowebinar.com/register/2559732719277955587](https://attendee.gotowebinar.com/register/2559732719277955587).

- **Ordering and Certifying Medicare Home Health Services**, Tuesday, March 21, from 1 to 2 p.m. Registration is at: [https://attendee.gotowebinar.com/register/5015594193392306434](https://attendee.gotowebinar.com/register/5015594193392306434).

- **Home Health Qualifying Criteria**, Tuesday, March 28, from 12 to 12:30 p.m. Registration is at: [https://attendee.gotowebinar.com/register/8361911653085785092](https://attendee.gotowebinar.com/register/8361911653085785092).

*For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.*
Resources


- “Profile of Older Americans: 2016,” by U.S. Department of Health and Human Services Administration for Community Living
  https://aoa.acl.gov/Aging_Statistics/Profile/index.aspx

- “Caring for Your Peripherally Inserted Central Catheter (PICC): A Guide for Patients and Family Caregivers,” by Montefiore Health System and Northwell Health (United Hospital Fund grant)
  http://www.uhnyc.org/assets/1535

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org.
Senior Financial Managers Forum

April 7, 2017
9:00am – 4:00pm
Renaissance Albany Hotel
Albany, New York

$99 Registration Fee

HCA Members Only
HCA’s popular Senior Financial Managers Forum, on April 7, comes at a time of intense activity related to reimbursement issues in home care.

The state budget is due April 1, with items that have a profound impact on home care and MLTC payment rates and more. With the state’s completion of first-quarter minimum wage rate adjustments, providers and plans need to forecast these continued new, major cost obligations for the second-quarter onward, when additional state budget allotments are expected to be finalized. Meanwhile, a new Trump Administration and Congress have begun considering fundamental Medicare and Medicaid policy and reimbursement changes that impact home care’s bottom line.

At this important Forum, HCA Policy staff will provide CEOs, CFOs, finance managers and other finance staff with the latest updates on wage and non-wage related reimbursements, developments related to minimum wage and home care infrastructure. We’ve also invited state officials to drill deeper into these Medicaid reimbursement factors, along with insights from one of home care’s top consultants on highly sought-after Medicare Home Health Prospective Payment System (HHPPS) and CHHA Medicaid Episodic Payment System (EPS) benchmarking data.

The program also includes federal policy expertise and insights for what to expect from D.C. when it comes to regulatory mandates and reimbursement changes on the horizon. And, in a new area of focus, we’ve added a session on the financial implications of the new OASIS C2, which will give home care finance officers some important considerations to make in their oversight of cost factors related to clinician activities.
AGENDA

8:30am – 9:00am
HCA Registration & Continental Breakfast

9:00am – 9:45am
HCA Update
HCA’s Policy and Executive staff will provide a state legislative update, focusing on the state budget and its impact on home care, along with an update on HCA’s advocacy efforts in Albany and in Washington related to: payment adequacy; regulatory relief; and infrastructure investment. Participants will hear findings from our annual financial condition report as well as the latest on minimum wage funding (including allotments in the state budget), the Delivery System Reform Incentive Payment (DSRIP) program, Value Based Purchasing, and the 2017 Medicare HHPPS.

9:45am – 11:00am
Department of Health Update
John Ulberg, Jr., Medicaid Chief Financial Officer, Division of Finance and Rate Setting, Office of Health Insurance Programs, NYS Department of Health (Invited)

Mr. Ulberg, one of the state’s most influential reimbursement and program policymakers, will provide updates straight from the Governor’s office and Health Department on: provisions in the 2017-18 State Budget that impact home care, personal care and Medicaid MLTC care plans; adjustments for minimum wage and Wage Parity funding; QIVAPP and funding for the Fair Labor Standards Act (FLSA) costs; the Medicaid Global Cap; CHHA EPS utilization data; premium rate adjustments to MLTC plans that influence payment for network providers; the 2016 Medicaid cost reports; and other Medicaid reimbursement issues that your team won’t want to miss.

11:00-11:15am Break

11:15pm – 12:30pm
Medicare PPS and CHHA Medicaid EPS Benchmarking Data
Robert Simione, CPA, Senior Manager, Simione Healthcare Consultants

In this session, Mr. Simione will share the latest aggregate benchmarking data for the Medicare HHPPS, Medicaid EPS and managed care using comparisons from clients of Simione’s Financial Monitor here in New York versus national averages, offering detailed data on case-mix comparisons, utilization by discipline, visits, outlier episodes and more.

12:30pm – 1:15pm – Lunch

1:15pm – 2:30pm
Washington DC Health Care Policy Update
Joy Cameron, Vice President, Policy and Innovation, VNAA

With a new Trump Administration and Congress, home care providers await: potentially sweeping changes in Medicare and Medicaid payment policy; other proposals that affect state Medicaid programs; the future of regulations, given the President’s executive orders and other directives on mandates; the implications of health reform repeal or replacement actions; and other matters that have a profound impact on home health agency forecasting. Joy Cameron and her colleagues at the VNAA are closely involved in monitoring and advocating on these issues, offering critical federal updates for New York providers.

2:30pm – 3:45pm
Financial Management Aspects of New OASIS C2
Melinda Gaboury, Chief Executive Officer, Healthcare Provider Solutions, Inc.

All health care finance managers know the important connection between clinician activities and budgeting. Now that the OASIS C2 is in effect, this parallel understanding of clinician assessment procedures and their cost impact will help drive top-to-bottom improvements in the function and efficiency of your organization. During this session, Ms. Gaboury will review how to calculate the HHRRG, corresponding HIPPS code and determine case-mix weight, all of which are fundamental to a home care agency’s operation-wide understanding of the clinician’s role in patient care and financial outcomes. The session will also establish processes that agencies need to strengthen regarding OASIS-C2 completion and review, as well as the specific OASIS-C2 M items that have a direct impact on patient outcomes and costs.

3:45pm – 4:00pm HCA Closing Remarks & Adjourn
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Cancellation Policy: Cancellations received by March 27th will receive a full refund, less 25% of total due as an administrative fee. Cancellations received on March 28th or later will forfeit their registration fee, as will those who register and do not attend. Substitutions are permitted.

Special Accommodation: In accordance with the Americans with Disabilities Act or special meal needs, please let us know how we can accommodate you: ____________________________

FAX TO: (518) 426-8788

HOTEL INFORMATION
Renaissance Albany Hotel
144 State Street, Albany, NY 12205
Phone: (888) 236-2427

HCA has reserved a limited block of rooms at the Renaissance Albany Hotel for the night of April 6th at a discounted rate of $179 per night. To receive this special rate, please call 1-888-236-2427 prior to April 1st, and ask for the Home Care Association of NYS group rate.

BECOME AN HCA MEMBER

If you are not currently an HCA Member, but wish to become one so you can take advantage of this and other educational programming, please contact Laura Constable at (518) 810-0660 or at lconstable@hcany.org.