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ASK from p. 1

In June and July, we’re inviting you to meet up with us at local restaurants and other informal settings near you where there’s no pre-planned agenda: just a time and a place, over a meal or a snack, to discuss your concerns, your ideas and your input for HCA’s continued work on your behalf.

Each session, complimentary with your HCA membership, will have representatives from the HCA policy and operations teams to listen-in, discuss your ideas and answer your questions. Please visit the online link below and pick one of the locations that’s closest to you! (We’ll have more specific venue selections soon, each offering group dining and a comfortable setting to chat.)

https://www.surveymonkey.com/r/ASKHCA.

Please limit your registration to one or two people from your organization, so that this session can be a small, intimate conversation.

HCA Postpones Women’s Leadership Summit

Due to unforeseeable scheduling conflicts, HCA is postponing our Women in Healthcare Leadership Summit to a later time. The new dates for the summit are December 7 and 8, 2017 at the currently scheduled location. Look for more registration information in upcoming e-mails and in our newsletter.

It is our hope that the postponement will offer a more opportune time for our excited constituency to join us while allowing us to maintain the current program agenda of vibrant speakers, along with enhancements now under development. For each current registrant, HCA will automatically transfer your registration to the new date unless you inform us via e-mail by June 22, 2017 (to HCA.Events@hcanys.org) that you are unavailable to attend on December 7 to 8, in which case we will refund your registration. You are also welcome to make substitutions. If you have reserved an overnight room at the Courtyard Marriott, please contact the hotel at (866) 210-9325 to cancel your reservation. We will provide details regarding overnight accommodations for the new date in the coming weeks.

We thank you for understanding, and we look forward to seeing you on December 7 and 8 for a dynamic, exciting and inspirational program. If you have any questions, please don’t hesitate to contact us at HCA.Events@hcanys.org.
targeting administrative bureaus and programs for the vast majority of cuts. That blueprint also boosted defense and border security funding but had remained altogether silent on Medicare, Medicaid, Social Security and other major fiscal drivers.

This past week’s formal budget proposal for federal fiscal year 2018 takes up these core areas, and it does so largely in line with House GOP priorities to shift Medicaid from an open-ended entitlement to a capped model. The Medicaid caps (also known as “block grants”) would reduce funding by providing states with a limited lump-sum payment to administer their Medicaid programs, doing away with the federal match construct.

Trump’s budget proposal also aligns with House Republican proposals to claw back the Medicaid expansion dollars provided under the Affordable Care Act (ACA), as the House has already sought to do with its March 4 passage of the American Health Care Act (AHCA). That bill awaits Senate consideration.

Specifically, the Trump budget proposes cutting $616 billion from Medicaid and the Children’s Health Insurance Program over 10 years. However, it is unclear how this figure overlaps with the $800 billion Medicaid cut also assumed in the budget as part of the ACA repeal-and-replace effort separately underway in Congress (the AHCA). This $800 billion impact estimate comes from a recent “score” by the Congressional Budget Office, which also found that the AHCA will increase the ranks of the uninsured by 23 million, cut Medicaid by 17 percent, and raise premiums for older Americans who purchase private insurance policies prior to becoming Medicare eligible, resulting in premiums as much as five times higher than those for younger people.

The President’s budget does not appear to include any proposed cuts to Medicare. According to news reports, the budget does, however, include a repeal of the Medicare Independent Payment Advisory Board, which is charged with recommending spending actions to Congress. The budget also includes additional expenditures to address the Medicare appeals backlog.

While the Medicaid proposals are of biggest concern, other health care and research programs face cuts, including $6 billion from the National Institutes of Health (a 20 percent cut), a $1.3 billion cut from the U.S. Centers for Disease Control and Prevention, and other areas.

The budget process is a fluid one, and is uniquely contingent on negotiations over the fate of the AHCA. Congress could reject some of the President’s proposals, or consider further reductions.

HCA is redoubling our efforts on a strong advocacy push against both the AHCA and the proposed Medicaid cuts which would be devastating to home care and other providers in New York State. Working with our federal lobbyist, Brett Heimov of Envision Strategy, HCA is meeting with Congress later this week in Washington to convey the dangerous ramifications of these Medicaid proposals. Furthermore, HCA President Joanne Cunningham is part of a major coalition of over 30 health care and social service organizations working together to fight these cuts. Following up on past outreach, the coalition this week sent a letter to Congress seeking opposition from the New York Congressional Delegation on AHCA and, specifically, the bill’s disastrous assault on the Medicaid program. (See related p. 1 story.)

HCA will continue to keep you informed of all developments on this urgent matter.
The letter is the result of a coordinated advocacy strategy that HCA and the organizations — including HANYS, AARP NY, 1199SEIU, LANY and others — are participating in that aims to educate New York’s Congressional Delegation about the impact of ACA repeal legislation on New York State.

Later this week, HCA President Joanne Cunningham will continue HCA’s advocacy push with meetings in Washington, D.C. meetings with the New York Congressional Delegation. This advocacy effort follows many meetings and outreach efforts made by HCA staff and HCA’s Washington-based federal lobbyist Brett Heimov, of Envision Strategies.

In addition, joint advocacy events in Washington, D.C. are being scheduled in the coming weeks that will involve representatives from the 30 organizations that are working collaboratively to support the Medicaid program and access to health care in New York.

Please see the links below for last week’s follow-up letter and earlier communications to the New York Congressional Delegation urging opposition to ACA repeal legislation that jeopardizes New York’s Medicaid program and access to vital health insurance.


DOH Holds All-Plan VBP Meeting

The state Department of Health (DOH) held a meeting last week for all managed care plans and their member associations to discuss the status and directions of Value Based Payments (VBP).

As with the VBP project steering committee meeting a week prior (see our May 22 newsletter), the discussion again reinforced the more limited scope of VBP and shared savings potential for managed long term care plans (MLTC) currently in the Department’s vision. These limits are rooted in the confinement of MLTC partial-capitation arrangement to Medicaid payment (excluding services, such as hospitalization and emergency room care, where significant savings may be achieved).

As such, DOH suggested that VBP financial incentives for MLTCs may be derived mostly from the MLTC quality incentive payments, based on MLTCs excelling in performance targets prioritized by the VBP Clinical Advisory Group.

State Medicaid Director Jason Helgerson again underscored the imperative that MLTCs and providers work together to identify strategies aimed at these metrics and the overall VBP/DSRIP goals. He also highlighted HCA’s home and community sepsis screening and intervention initiative as an example for plan and provider collaboration. The tool, in screening for sepsis, inherently also includes at least 3 of the 5 VBP measures for MLTC for potentially avoidable hospitalizations: sepsis, urinary tract infection and respiratory infection.

HCA is concerned about the apparent limitations in incentive opportunity for MLTCs and providers in DOH’s vision for VBP progression. HCA will continue to advocate for robust investment and shared savings opportunities for plans and providers.

For further information, please contact acardillo@hcanys.org.
Legislature Moves Home Care/Hospice Bills

Prior to the Memorial Day recess, the state Legislature acted on a series of bills for the week, including bills related to home care and hospice.

The first bill summarized below relates to regulation of Fiscal Intermediaries (FI); the second relates to “essential personnel” status for home care and hospice.

Date Extension for State Authorization of Fiscal Intermediaries – S.5544 (Hannon)/A.7216 (Gottfried)

Both the Senate and Assembly passed respective bills that would extend the dates by which new and existing FIs would be required to have state authorization for their roles in the Consumer Directed Personal Assistance Program.

The adopted 2017-18 state budget established a new state requirement that such FIs be state-authorized by the Department of Health. Unless otherwise specified, provisions in the budget bill take effect April 1, 2017. In the case of the FI requirement, no other startup or transition period was specified for: when the authorization process would have to be in place; when existing and new FIs had to comply; and how existing FIs would be permitted to operate in the meantime.

The legislation passed this week amends the law created by the budget to establish effective dates for the authorization requirement.

The legislation sets January 1, 2018 as the date by which the authorization requirement would begin for an FI established after April 1, 2017 (i.e., new FIs); and ostensibly, FIs seeking to be formed after April 1 must wait for this authorization before being permitted to operate.

For FIs already operating before April 1, the legislation allows one year after the January 2018 effective date, or until January 1, 2019, for their attainment of state authorization.

<table>
<thead>
<tr>
<th>Fiscal Intermediaries</th>
<th>Proposed Effective Date of Authorization Requirement/Compliance</th>
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</thead>
<tbody>
<tr>
<td>New FIs (created after April 1, 2017)</td>
<td>January 1, 2018</td>
</tr>
<tr>
<td>Existing FIs (operating before April 1, 2017)</td>
<td>January 1, 2019</td>
</tr>
</tbody>
</table>

Since this bill was first passed by the Senate, it was returned following the Assembly’s passage. It now awaits delivery to the Governor for signature, upon the Governor’s calling.

HCA will advise the membership of next steps in the process as we determine (as possible) the positions of the Governor’s Office and State Department of Health on the proposal.

Continued on next page
Essential Personnel Bill Advances to Senate Floor – S.5016 (Lanza)/A.6549 (Cusick)

The Senate advanced to the Senate Floor HCA’s legislation to provide “Essential Personnel” status for home care and hospice personnel in public emergencies. With the Senate’s action, this bill is once again positioned for passage.

Meanwhile, the legislation – despite champion efforts by its sponsors and extremely strong support from across the state – has yet to garner the approval of Governor Cuomo. The bill is a priority in the emergency preparedness and response structure in the state, and HCA has repeatedly pointed out its increasing significance given the continued rise in the in-home population cared for by home care and hospice, particularly with the major state and federal health care reform changes.

HCA, the sponsors and supporters will be reaching to the Governor’s Office to urge his favorable consideration, and/or his indication of exactly what amendments he requests in order to provide his signature.

HCA Members Provide Feedback on LHCSA Statistical Report

This week, HCA members continued to provide feedback on the 2015 Licensed Home Care Services Agency (LHCSA) Statistical Report.

As reported in numerous communications, the state Department of Health (DOH) has established a workgroup to make revisions to the LHCSA Statistical Report. The goal of the workgroup is to “redesign and restructure the report to increase the timely and accurate submission of information by identifying areas of reporting that can be streamlined to increase compliance and accuracy in data reporting.”

The workgroup held its first meeting on May 1 and the next meeting is June 7. The first meeting was attended by DOH staff, HCA and other provider associations, and a number of HCA members.


HCA thanks members for sending us many valuable comments, both written and as part of a recent phone discussion; we will accept additional feedback until next week, at which time we will finalize a summary of the comments and send them to DOH.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org, or Patrick Conole at (518) 810-0661 or pconole@hcany.org.

DOH Extends CHHA, Personal Care Cost Report Due Dates Following HCA Inquiry

New due dates: August 15 for CHHAs, August 16 for Personal Care

In response to an inquiry and request by HCA, the state Department of Health (DOH) has extended the 2016 Medicaid Cost Report due dates for all non-hospital based CHHAs as well as for all non-New York City (NYC) personal care programs. The CHHA due date, as now revised, is August 15. The personal care due date is...
In two Dear Administrator Letters (DALs) announcing the cost reports on May 17, DOH indicated a filing due date (and auditor certification) of July 15, 2017.

HCA immediately contacted DOH and noted that the July 15, 2017 due dates appeared incorrect since, historically, the Medicaid Cost Reports have been due in mid-August or, even, mid-September, depending on the posting of the Cost Report software. HCA also noted that Section 505.14 H of Title 18 of the New York Code of Rules and Regulations (NYCRR) requires the Department to give providers no fewer than 90 calendar days to submit the cost report after its receipt.

In response, DOH sent a Cost Report Correction Notice directly to all CHHA and Personal Care providers’ Operators or Chief Administrative Officers to ensure proper official notification of the correct due dates. We appreciate the Department’s prompt response to HCA’s request on this matter.

Update on 2016 Medicaid Cost Report for LTHHCPs

Along with HCA’s inquiry about the cost report due dates, HCA also asked DOH when it would be posting the 2016 Medicaid Cost Report for LTHHCP providers.

Working with HCA and LTHHCPs in 2016, DOH reinforced the option for LTHHCPs to utilize the Episodic Billing System (EPS). This followed DOH’s posting of a new policy enabling LTHHCPs to admit and serve patients directly under CHHA criteria and billing procedures (i.e., CHHA EPS). Under this system, all LTHHCP sponsors with operating certificates may operate their LTHHCPs in this direct manner, as well as contract with MLTCs, or local social services districts or waiver programs.

HCA noted to DOH that 51 LTHHCPs submitted 2015 Medicaid Cost Reports, and it is expected that a significant number of those programs would still have data based off of Medicaid claims for the 2016 Medicaid Cost Report, with the prospect of ongoing fee-for-service (FFS) operations and billing if they choose.

In such cases, HCA noted, the Department would need to promulgate both EPS and LTHHCP FFS rates, since FFS rates would be needed in EPS LUPA situations (episodes under $500) or when LTHHCPs provide services for pediatric patients when no OASIS is available.

HCA will notify the membership when updated LTHHCP cost-report details are made available.

Revised Rule Issued on Paid Family Leave

HCA to cover Paid Family Leave at June 22 program

The state Workers’ Compensation Board has issued a revised rule with a 30-day comment period on the Paid Family Leave program that starts January 1, 2018.


The revisions are to a proposed rule that was in the February 22, 2017 New York State Register (https://docs.dos.ny.gov/info/register/2017/feb22/toc.html).

Paid Family Leave is required under legislation passed in 2016. When fully implemented, it will provide employees up to 12 weeks of paid family leave to: 1) care for a family member (including a child, parent,
grandparent, grandchild, spouse or domestic partner) with a serious health condition; 2) bond with an employee’s newborn or newly placed adoptive or foster child during the first 12 months following birth or placement; or 3) address any qualifying exigency to a spouse, domestic partner, child or parent who is serving on active military duty.

Paid Family Leave is employee-funded, through payroll deductions, with the exception of any administrative costs incurred by employers. Participation is also mandatory, with certain exceptions explained later in this article.

Full time employees become eligible after 26 consecutive weeks of work and part-time employees become eligible on the 175th day of work.

Benefits will be phased in, starting on January 1, 2018, at which time employees may receive up to eight weeks of paid benefits in 2018. Benefits will be paid at 50 percent of the employee’s average weekly wage, not to exceed 50 percent of the state average weekly wage. These benefits will gradually increase until January 1, 2021, when they will provide 12 weeks of coverage at 67 percent of the employee’s average weekly wage.

Some of the May 24, 2017 changes/additions include:

- The 26-week eligibility criteria will apply to employees who have worked 20 or more hours per week and the 175-day eligibility criteria will apply to those who work fewer than 20 hours per week. The prior proposed rule did not have a minimum number of hours associated with either criteria.

- Employees that will be working for fewer than 26 consecutive weeks or

**LHCSA “Hot Topics” Forum: 6/22**


We’ve identified three areas of focus.

First, we’ll be joined by Jackson Lewis attorney **Frank Fanshawe** who will delve into labor law issues, which are among the most alarming new developments affecting LHCSA operations. Mr. Fanshawe and HCA Vice President **Andrew Koski** will specifically address: court cases and litigation affecting 24-hour/live-in cases; Fair Labor Standards Act funding; consumer directed personal assistant services (i.e., wage parity applicability starting on July 1, the new fiscal intermediary “authorization” process in the final state budget, and any other current issues); and white-collar overtime changes, including the “salary” and “duties” tests, differences between state and federal mandates and timetables, and ways to minimize exposure.

Also, a representative from the state Workers’ Compensation Board will discuss New York’s Paid Family Leave program that starts January 1, 2018. The presentation will cover the obligations of employers and the rights and responsibilities of employees.

Lastly, HCA Board Member **Russell Lusak**, Senior Vice President, Selfhelp Community Services, Inc., will be joined by a Regional Health Information Organization (RHIO) representative to identify the merits of RHIO connectivity for LHCSAs as a step toward future success in an increasingly competitive service delivery marketplace. You’ll also learn how your agency can connect for less by accessing available funds for this purpose.

This program is specially designed for LHCSA CEOs, COOs, compliance staff, finance managers and operators.

Please join us for this unique and timely program.
175 days in a 52-week period will be able to waive coverage (and thus not pay for a benefit they will not receive).

- Employers may not count leave covered under the federal Family and Medical Leave Act (FLMA) for an employee’s own serious health condition as family leave under the state program.

- A collectively bargained plan may allow employees to establish their eligibility for benefits while working for multiple employers.

- Requirements for notifying employers are added for employees taking paid family leave.

- Provisions are included for reinstatement of the employee to the same or a comparable job upon returning from paid family leave.

HCA will be holding a program on June 22 in New York City that will include a presentation by a representative from the state Workers’ Compensation Board on New York’s Paid Family Leave program, including the obligations of employers and the rights and responsibilities of employees. The program also covers other LHCSA “Hot Topics,” such as labor law issues and health information technology integration tips. Registration for this program is at http://hca-nys.org/wp-content/uploads/2017/05/LHCSA-Hot-Topics-Forum-Registration-Form.pdf.

Register Now to Get Ready for Emergency Preparedness Federal Rule

With no implementation delay in sight, Medicare and Medicaid providers, including home health and hospice, must meet a host of new requirements by November 15 to ensure that adequate emergency preparedness plans are in place for natural and man-made disasters, with a specific focus on patients and employees.

On June 28, in Suffern, NY, HCA is holding an interactive workshop to assist agencies in understanding the four major components of this regulation: planning for continuity of operations (COOP); operationalizing policies and procedures; communication; and conducting/testing a training program of the plan. The entire plan must be built on a hazard vulnerability assessment platform using an all-hazards approach to ensure continuity of services to patients.

In addition, planning and communication should include a collaborative partnership with a health care coalition. This session will focus on the major components of COOP and its correlation to the new emergency preparedness regulations.

At the end of the program, attendees will be able to conduct a risk assessment (hazard vulnerability assessment); describe home care and hospice’s role in a local health care coalition; list key components of a continuity of operations plan; define surge capacity, patient classification, and patient transportation levels; and identify key areas of their disaster plan that require revision or enhancement.

Program Faculty

Barbara B. Citarella, RN, BSN, MS, CHCE, CSH-V (Certified in Homeland Security) is the founder of RBC Limited Healthcare and Management Consultants. Barbara and her team of expert consultants have made the company a national leader in the home health and hospice industry in addition to disaster planning. With over
25 years of experience, Barbara is internationally known for her expertise in the areas of infection control, leadership, and disaster preparedness. As the only recognized expert in the area of home care and hospice disaster planning, she specializes in emergency disaster planning, bioterrorism, health care development, and operations.

Barbara was part of the Department of Homeland Security’s (DHS’s) committee to rewrite the National Response Plan document and the DHS Disaster Preparedness Guidelines for people with special needs. She has received the highest level of certification (CHS-V) in homeland security from the American Board for Certification in Homeland Security.

Registration

HCA members may register to participate in this workshop at the discounted rate of $249. Prospective HCA members may register at the rate of $399. Visit http://hca-nys.org/events-education/upcoming-events.

Make Your Emergency Preparedness Plan CoP-Ready on June 28

June 28, 2017
Crowne Plaza Hotel
3 Executive Boulevard
Suffern, NY 10901

Webinar Outlines New MLTC Workforce Initiative

On May 25, the state Department of Health (DOH) held a webinar on its MLTC Workforce Investment program.

HCA has covered this new initiative in many previous communications and education programs, and has given extensive comments and suggestions to DOH at every stage of its development.

Under this program, as presented in this latest (and differing) iteration, DOH will make available up to $245 million for the period between 2018-2020, dedicated to “initiatives to retrain, recruit and retain healthcare workers in the long term care (LTC) sector.” Through the Workforce Investment Program, DOH will require MLTC plans to contract with DOH-designated workforce training centers (known as LTC Workforce Investment Organizations, or “LTC WIOs”) to:

- Invest in initiatives to attract, recruit and retain LTC workers;
- Develop plans to address reducing health disparities by focusing on the placement of LTC workers in medically underserved communities;
- Consistently analyze the changing training and employment needs of the area that the program serves;
- Provide for broad participation and input from stakeholders; and
- Support the expansion of home care and respite care, enabling those in need of LTC to remain at home and reduce Medicaid’s costs associated with LTC.

Continued on next page
DOH will identify a set of minimum criteria for an entity to be designated as an LTC WIO and hopes to post them for comment in June. After reviewing any comments, DOH will set the criteria and post a request for funding.

Workforce development initiatives (WDIs) must be consistent with and complementary to other state workforce development efforts, including those being carried out by Performing Provider Systems (PPSs) under the Delivery System Reform Incentive Payment (DSRIP) program and should be focused on preparing the workforce for the changing landscape of the LTC field. Desired outcomes are to align with the goals of Value Based Payment reform.

MLTC plans will receive Workforce Development Program funds which will be used to contract with WIOs for the provision of WDIs to the health care providers that participate with the plans. Plans and WIOs will also be required to collaborate on strategic planning to recruit and train new LTC workers. A portion of funds will be for retraining and redeploying health care workers in LTC.

The Workforce Investment Program will be broken into the current MLTC regions: New York City; Long Island; Hudson Valley; Northeast; Central; and Western. DOH will seek to qualify at least two LTC WIOs in each region. Plans will be required to demonstrate broad accessibility of their trainings and ensuring access to healthcare workers employed by both network and non-network providers.

DOH is considering the following criteria for LTC WIOs:

- Be a not-for-profit corporation established under the Not-For-Profit Corporation Law and incorporated within New York State.
- Demonstrate experience and expertise in the development and implementation of workforce training initiatives that are cost-effective and have resulted in measurable, positive outcomes.
- Currently offering or having the capacity to offer a training program beyond the current DOH minimum requirement.
- Incorporate adult-learner-centered training techniques into training programs.

Additional preference will be given to applicants that demonstrate:

- Solid training infrastructure in place, including existing procedures and staff to develop training and evaluate outcomes.
- A proven track record of providing training to workers in LTC settings.
- A plan to offer WDIs that are based on existing curricula where there is evidence to support positive outcomes.
A plan for sustainability for training solutions.

Commitment to training workers in alignment with DSRIP goals to move care from inpatient to outpatient settings.

Incorporation of technology to extend the reach of the training over time and geography.

Strong and diverse governance including academia, employers, trainers, providers, workers and plans.

LTC WIOs may undertake programs to increase workforce flexibility through programs which: upgrade LTC workers to titles with an increased scope of practice; and improve a worker’s ability to communicate with patients/residents and other members of the care team.

Funds will be allocated to plans based on the percentage of each plan’s enrollment relative to all plan enrollment, and distributed via increases to their capitated rates. Plans will need to notify their participating providers that they can send workers to LTC WIOs to participate without charge. Plans will distribute funds to the LTC WIOs with which they contract to reimburse them for providing WDIs.

In the first three months of the program, plans will convene a regional meeting with key stakeholders to develop a regional plan for workforce training priorities and a menu of relevant WDIs. Plans will be required to submit baseline information on compensation and benefit data, along with workforce trainings and recruitment initiatives currently offered by plans to providers and their employees.

Handouts from the May 25 program are available at http://hca-nys.org/wp-content/uploads/2017/05/MLTC-workforce-investment-program_052517.pdf. HCA will inform the membership of any further documentation and program material as it is obtained.

HCA has requested a high-level meeting with DOH to discuss the details of this revised iteration of the program, both the benefits and areas that could be very concerning. Prior versions have consistently reflected our input toward a flexible design and the inclusiveness of priority training areas that were not apparent in the webinar presentation. HCA has sought to ensure administrative simplicity and avoidance of new burdens on plans, as well as funding flexibility to ensure targeting of support to areas and disciplines in greatest need and/or shortage crisis. Neither is clear in this iteration. HCA will follow up with the membership once this further information is obtained.
## Important Upcoming Deadlines

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Effective/Due Date</th>
<th>More Information</th>
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<tbody>
<tr>
<td>State Home Care Worker Wage Parity Certification forms for entities that contract with managed care plans, CHHAs and/or LTHHCPs (for services provided in NYC, Long Island and/or Westchester)</td>
<td>June 1, 2017 for the period of June 1 to August 31, 2017</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/redesign/2016-02-17_wage_parity_alert.htm">https://www.health.ny.gov/health_care/medicaid/redesign/2016-02-17_wage_parity_alert.htm</a></td>
</tr>
<tr>
<td>Fair Labor Standards Act (FLSA) attestations due from managed long term care plans, CHHAs, LTHHCPs, LHCSAs and fiscal intermediaries</td>
<td>June 9, 2017</td>
<td><a href="https://www.health.ny.gov/health_care/medicaid/redesign/fair_labor_standards_act.htm">https://www.health.ny.gov/health_care/medicaid/redesign/fair_labor_standards_act.htm</a></td>
</tr>
<tr>
<td>“Rate Hotline” Appeals for 2017 Initial Personal Care Rates</td>
<td>June 30, 2017</td>
<td><a href="https://commerce.health.state.ny.us/public/hcs_login.html">https://commerce.health.state.ny.us/public/hcs_login.html</a> (Health Commerce System) for rate sheets; questions go to <a href="mailto:bltcpc@health.ny.gov">bltcpc@health.ny.gov</a></td>
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<tr>
<td>Executive Order (EO) 38 Disclosure Form for CHHAs</td>
<td>August 15, 2017</td>
<td><a href="https://executiveorder38.ny.gov/">https://executiveorder38.ny.gov/</a></td>
</tr>
<tr>
<td>EO 38 Disclosure Form for Personal Care Providers</td>
<td>August 16, 2017</td>
<td><a href="https://executiveorder38.ny.gov/">https://executiveorder38.ny.gov/</a></td>
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</tbody>
</table>
**New Functionality Added to UAS-NY**

The state Department of Health (DOH) has announced new functionality to be implemented in version 1.3 of the UAS-NY software associated with carrying forward an assessment previously conducted by an organization.

Effective June 1, 2017 (version1.3), when an assessor adds a new assessment to an individual’s record, the assessor will be able to choose to carry forward Medications and/or Diseases without carrying forward values in the assessment itself. Because medication and diseases lists are often lengthy, this gives organizations flexibility in their policies associated with the carry forward functionality, while remaining compliant with DOH policies.

DOH authorizes organizations to carry forward the most recent assessment conducted by or on behalf of their program or plan. Further, the Department requires that if an organization authorizes its assessors to carry forward an assessment conducted by or on behalf of the program or plan, the assessor must carefully review every assessment question, and all medications and diseases, during an in-person, face-to-face assessment with the individual, and the assessor should update all items as appropriate.

Questions can be directed to the UAS-NY Support Desk at (518) 408-1021 or uasny@health.ny.gov.

**Peterson-Kaiser Release New Dashboard Providing Key Data on Health Quality, Spending, Access, Outcomes**

The Peterson-Kaiser Health System Tracker website provides a dashboard with the latest key data measuring quality, spending, access, and outcomes in the U.S. health system.

It presents both a broad view of the system’s performance compared to similar countries, and a detailed look at specific indicators within the areas of health and wellbeing, quality of care, health spending, and access and affordability. Much of the data is fairly broad with little in the way of sector-specific information (for home care or other settings), though the dashboard does show mortality rates 30 days after admission for key health conditions such as stroke, acute myocardial infarction and heart failure, among other measures of interest.

As a whole, the tracker finds that the U.S. has improved on several measures, such as life expectancy, disease burden, and the uninsured rate, but the U.S. continues to be outperformed by other countries.

Overall, the new dashboard features more than 50 measures, ranging from life expectancy to spending by diagnosis, from prices and utilization to percent of workers in high deductible health plans. Users can explore trends over time, as well as differences and disparities across demographic groups.

The Tracker, a partnership between the Peterson Center on Healthcare and the Kaiser Family Foundation, was launched in 2014 to monitor the U.S. health system’s performance on key quality and cost measures and can be accessed at: http://tinyurl.com/y9meugv5.
Upcoming NGS Education Programs

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), will be hosting the following upcoming webinars:

- **Home Health Billing Basics**, Tuesday, May 30, from 2:30 to 4 p.m. Registration is at: [https://register.gotowebinar.com/register/4031553279526569729](https://register.gotowebinar.com/register/4031553279526569729)

- **Provider Enrollment: Submitting Revalidations via PECOS**, Tuesday, June 6 from 10 to 11 a.m. Registration is at: [https://register.gotowebinar.com/register/3679087235255421441](https://register.gotowebinar.com/register/3679087235255421441)

- **NGSConnex: Eligibility**, Tuesday, June 13 from 10 to 10:45 a.m. Registration is at: [https://register.gotowebinar.com/register/4611283980074639106](https://register.gotowebinar.com/register/4611283980074639106)

- **Home Health Qualifying Criteria**, Tuesday, June 13 from 12 to 12:30 p.m. Registration is at: [https://register.gotowebinar.com/register/922706139507003908](https://register.gotowebinar.com/register/922706139507003908)

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Resources


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