DOH Guidance Urges Immediate Contract Negotiations, Funding Obligations for Minimum Wage

The state Department of Health (DOH) on Wednesday issued a brief guidance on minimum wage coverage for managed care organizations (MCOs), including mainstream and managed long term care (MLTC), and providers. (See https://hca-nys.org/wp-content/uploads/2017/12/Minimum-Wage-MCO-Guidance-12-6-17.pdf.) The guidance comes amid questions about the exact status of state funding to plans and providers.

HCA Takes Urgent Issues and Session Priorities to Executive and Legislature

HCA brought urgent and upcoming legislative and budget session priorities to key health representatives of the Executive and Legislature in meetings this past week.

Immediate Issues

Of an immediate nature, HCA discussed the potential “shut-down” impact on home care and the system broadly from the recent

SEPSIS

HCA ‘Stop Sepsis at Home’ campaign garners national press attention. Please be sure to attend upcoming regional trainings coming to every part of the state.

RENEWALS

By now, HCA members should have received renewal information to maintain membership in 2018. Please renew today!

SCHEDULING RULE

This week, HCA held a members-only conference call to discuss the new proposed “call-in” pay rule, eliciting helpful feedback for our comments to the state and advocacy next steps.

REMINDER ON MEDICAID # REQUIREMENT

Reminder: providers must have Medicaid provider number to bill under managed care, beginning Jan. 1.

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In a meeting with the Executive this past week, HCA received confirmation that a previously suggested “cutback” in funds to MLTCs would not be occurring, and that funds are intended to be included in the forthcoming state budget to provide for the minimum wage increase/phase-in. HCA will be working to continue to confirm that the current and planned allocations are commensurate with the commitment to fund minimum wage.

DOH’s guidance directs that funds be paid out entirely for provider wage obligations and that contract amendments should “commence as soon as possible,” noting that the state has added increased funding for minimum wage compliance “uniformly” to managed care regional rates for state fiscal year 2017-18.

DOH says such contract negotiations should be finalized one week before December 31, when the required increased wage levels go into effect.

DOH’s guidance on the imminent 2018 minimum wage levels and coverage largely reiterates the standards established at about this same time last year for the 2017 wage increase.

Regarding use of funds, the guidance states that “funding may be utilized only to pay providers to meet their minimum wage obligation,” and that the aggregate additional funds paid to managed care plans “shall be paid out entirely to providers and subsequently to workers for appropriate statutory wage obligations (including the direct salary costs and related fringe benefits of minimum wage and wage parity amounts).”

To ensure that contract agreements are in motion, the Division of Long Term Care says it is issuing weekly surveys to managed care organizations to track the progress of contract development.

Furthermore, the Department says it intends to collect minimum wage data to reconcile minimum wage funding amounts in rates for “a subsequent fiscal year rate cycle based upon managed care cost report data submissions.”

Rate adequacy for managed care and contracting home care providers is a high priority of HCA’s advocacy (and was emphasized in a meeting this past week with the Governor’s office), especially in light of new and emerging wage and labor pressures that
continue to confront providers and plans independent from the payment and funding cycles established by DOH.

Among these pressures are: the ongoing limbo for providers and plans in the wake of legal proceedings concerning the wage obligation for “24-hour/live-in” cases; a newly proposed wage requirement that would apply to special scheduling circumstances (aka, the “call-in” rule), also taken up in HCA’s meeting with the Executive yesterday (see related p. 6 story); and the intersection of these changes with the baseline, “supplemental,” and “additional” wage parity law and minimum wage requirements, among other core operational and service needs for MLTCs and providers.

As previously reported, the minimum wage will increase on December 31 to: $13 per hour in New York City for entities with 11 or more employees; $12 per hour for NYC entities with 10 or fewer employees; $11 per hour for Nassau, Suffolk and Westchester; and $10.40 per hour for the rest of the state.

Please note, however, that the wage parity requirement downstate results in a $17.09/hour “rate of total compensation” for large employers in NYC ($16.09/hour for small employers) and $14.22 in Nassau, Suffolk and Westchester.

Reminder: HCA’s Annual Home Care Financial Condition Survey

Attention home care executives and finance staff: Your responses are needed on HCA’s annual financial and program survey of the home care industry.

This year’s streamlined survey, at 33 questions, is significantly shorter than in prior years, asking critical questions to help establish our advocacy on your behalf.

Please complete one survey for your organization by January 8, 2018. You may want to share parts of the survey with different staff, so we’ve prepared a PDF version of the survey (in addition to the online version). The survey can be completed here: https://www.surveymonkey.com/r/201718FinCondSurvey.

Survey results will be analyzed in conjunction with other data sources for our annual report on the home care industry, which is a centerpiece of our state advocacy documents as the legislative and state budget sessions begin early next year. Only aggregate results will be reported, and no identifying provider-level information.

We can’t stress enough how important it is to have a statistically sound survey sample. Please complete the survey as soon as possible. We greatly appreciate your taking the time to do so.

If you have any questions, please feel free to contact HCA’s Roger Noyes at rnoyes@hcanys.org.
Renewing with HCA in 2018

By now your organization should have received HCA’s membership renewal materials, including your dues invoice and our member value statement, which outlines some of the ways HCA provides value to you, including this very newsletter which is only available to you and your organization if you maintain your membership in HCA. To read our value statement, please visit https://hca-nys.org/membership/.

As announced in a special message to CHHAs earlier this week, we’ve added another incentive to the list of HCA member offerings in 2018: a comprehensive new resource, compiled by clinician experts, to help you understand and track compliance with the imminent changes to the home health Conditions of Participation (CoPs).

As you know, the CoPs are the most sweeping changes in federal home health regulations since 1989 and they impact virtually every aspect of your operation. This new “Guide to Compliance” packet has been procured by HCA through an affiliation agreement with the Home Care Alliance of Massachusetts which permits us to offer this Guide (a $500 value) exclusively to our CHHA members, and we are doing so on a complimentary basis if you renew in 2018.

This is just one of several ways that HCA supports your operation with information, technical assistance, time-saving resources, education and advocacy.

Please renew with HCA in 2018 today to continue receiving all of the great benefits that HCA offers.

If you have any questions about membership or need renewal materials, please don’t hesitate to contact HCA’s Senior Director of Membership Laura Constable at lconstable@hcanyss.org or (518) 810-0660.
PRIORITIES from p. 1

The proposed state Department of Labor rule rigidly regulating worker schedules, call-in, and schedule adjustments. (See related p. 6 article.) HCA underscored the overwhelming conflict between the proposed rule (ostensibly intended for work settings of a more predictable nature) and home care, especially the extent to which flexible scheduling and adaption is a core necessity to meeting the dynamic needs of patients and the health care system. HCA was invited to further detail and submit home care’s regulatory analysis and impact as the proposed rule is shaped.

HCA also discussed the status of reimbursement adjustments for managed care plans and providers for meeting the next increase in minimum wage. The Executive confirmed to HCA that guidance was imminent (See related p. 1 story on the guidance, which was issued shortly after our meeting) and that the projected funding for 2018 minimum wage cost increases is intended to be included in the forthcoming budget.

HCA recalled the difficulties created for plans and providers under the approach taken last year by the state to reimburse minimum wage costs, and appealed to not have this repeated, particularly with the myriad other contract amendment and mandate layers (e.g., value based payments) converging on health plan-provider contracting at this same time. We stressed that the additional requisite funding for minimum wage be clearly identifiable and provided to plans and providers.

Session Preparation

With regard to the coming session, HCA flagged the following as priorities in our meetings:

- The need for basic rate adequacy for MLTC and provider services and operations, which is a growing and increasingly urgent problem and struggle for plans and providers.

- Prompt adoption and implementation of the Administration’s Regulatory Modernization Initiative (RMI) proposals supportive to the home care system. HCA specifically referenced the proposals we have advanced to the RMI that would provide progressive regulatory streamlining, as well as: collaboration opportunities for home care, hospitals and physicians; workforce support; discharge planning improvement; and other new avenues for innovation, cost-effective care, quality and infrastructure. HCA underscored that many of these proposals would also contribute to state Medicaid and other budget efficiency needs.

- The need for specific attention to the current status and support for certified home health agencies which are under enormous pressures from the changing health system to accept sicker and needier patients sooner, manage patients at home to avert hospital and emergency episodes, and perform many public health functions. HCA further noted the increased cost and operational mandates from the new federal Conditions of Participation, workforce challenges (especially in nursing), and reimbursement adequacy issues which have not otherwise been attended to for certified agencies.

- Support for home care workforce recruitment, training and retention, and home care technology infrastructure.

HCA also discussed new opportunity areas and proposals for home care, including potential cost-saving areas in public health like sepsis, asthma, mental/behavioral health, and others.

HCA underscored the fact that the stability of the state’s fiscal and health reform
plans are substantially balanced on the existence of a functional, viable, accessible and supported home care system.

HCA is meeting again with Senate officials in the coming week.

**2018 Landscape**

New York turns toward 2018 amid serious state financial planning issues, including uncertainty about the impact of current federal tax and health reforms, as well as the overall state of the New York economy. Still-further uncertainty and risk exist from the plethora of state Department of Health redesign and reform discussions, pending court actions affecting health and labor, myriad state rule and regulatory changes, and an election year ahead for the Governor and all state legislative seats.

All of these converge to create a highly volatile and uncertain environment, and emphasize all the more the critical importance of education, information and state policy advocacy in these coming months. Providers are urged to complete and submit HCA’s Financial Condition Survey released two weeks ago (see page 3 story) and all HCA members must get ready to engage fully at the local and state levels in grassroots advocacy. Please also mark your calendars to attend HCA’s State Advocacy Day on Tuesday, February 6.

**HCA Member Call on Proposed Scheduling/Wage Rule Outlines Provisions, Garners Advocacy Input**

This past week, HCA held a members-only call on the state Department of Labor’s (DOL) newly proposed rule that would change the regulations regarding “call-in” pay.

Joseph Dougherty, a member of Hinman Straub’s Labor and Employment and Litigation departments, reviewed the intricacies of the rule that would impose the following requirements on employers (with certain exceptions):

1. An employee who reports to work for a shift not scheduled 14 days in advance must be paid an additional two hours of call-in pay.
2. An employee whose shift is canceled within 72 hours of the scheduled start time must be paid at least four hours of call-in pay.
3. An employee who is required to be available to report to work (“on-call”) must be paid at least four hours of call-in pay or pay for the number of hours in a regularly-scheduled shift.
4. An employee who is required to be “available to report to work for any shift” must receive at least four hours of call-in pay.
5. An employee who is required to contact the employer and confirm whether to report to work within 72 hours of the shift start time must be paid at least four hours of call-in pay.

The program generated an outpouring of major questions and concerns about the proposed rule, which is fundamentally contrary to the basic nature of home care service provision and the needs of the patients served.

*Continued on next page*
Among the concerns are the magnitude, prevalence or frequency of: home care cases where visits cannot (and should not) be subordinated to the rigidity of the rule (which requires scheduling 14 days in advance, with no flexibility), especially given the unpredictability and need for expeditious case admission and assignment or care plan change; cancelled services due to a patient’s change in condition, admission to the hospital, medical appointments, health improvement, or other factors beyond the employer’s control; the extreme burden the rule would create on agency scheduling and other staff; and more.

The proposed rule’s rigid cost and human resource tracking constraints are not only at complete odds with core home care agency operations and service assignment, but would undermine the state’s recent reform efforts, including the Delivery System Reform Incentive Payment (DSRIP) program and Value Based Payments, which rely on a flexible, seamless and expeditious direction of resources and case assignment.

Mr. Dougherty, HCA member providers and policy staff also discussed the many issues that need to be clarified under the proposed rule, including the exact parameters of labor contract exemptions in cases where collective bargaining agreements may meet or exceed the standards proposed in the rule. Many of the rule’s definitions also require clarification, especially certain qualifying terms like “shifts”; “acts of God”; “causes not within the employer’s control”; and the “offsets” that can be used in exchange for meeting the obligations otherwise applicable under the rule. We also seek further information on voluntary employee exchanges, scheduling notice obligations, and more.

Fundamentally, HCA strongly disagrees with the state’s cost impact statement, which suggests that the rule does not impose any mandatory costs on the regulated community. It is clear on its face that the rule would impose enormous costs and operational burdens for home care agencies and their managed care contractors – costs that must then be factored into managed care premiums and home care rates, further stressing an already critical state Medicaid funding situation.

Immediately following the call, HCA met with the Governor’s office to explain the urgent concerns with the proposal and to urge reconsideration in its application to home care. HCA also met with the office of the Assembly Health Committee Chair, and is scheduling meetings with Senate leadership and staff. HCA has also reached out to DOH officials and to colleagues in other sectors that would be seriously impacted by this rule’s effect on home care.

HCA urges both provider and MLTC members to communicate directly to us the projected impacts on your operations and costs, which we will incorporate into our analysis, and we likewise urge you to direct your comments to DOL. Please send all concerns and recommendations to Andrew Koski (at akoski@hcanys.org) by Friday, December 15. HCA will also be sharing with you some further information to assist in your own formal comments to DOL.

The slides from this week’s call are at https://hca-nys.org/wp-content/uploads/2017/12/Presentation-on-Proposed-Call-In-Pay-Regulations-Final.pdf.

The proposed rule is at https://docs.dos.ny.gov/info/register/2017/nov22/toc.html (page 8)
News Site Reports ‘How One Home Care Association is Taking on Sepsis’: Join HCA to Take Action Today

The industry-focused Home Health Care News site recently reported on HCA’s grant-funded “Stop Sepsis at Home” initiative in an article on “How One Home Care Association is Taking on Sepsis.”

Please be sure to join us in “taking on sepsis” during several upcoming training and engagement opportunities on this campaign, which seeks to promote statewide use of HCA’s sepsis screening tool by every home care provider.

All the information you need, including a link to the Home Health Care News article, is conveniently housed on our sepsis-dedicated website at www.stopsepsisathomeny.org.

There you will find a calendar with listings and registration for eight regional sepsis training sessions coming to every part of the state, including next week in Syracuse (December 15) and the following week in Buffalo (December 18).


You can also register directly online for any of the sessions at https://www.surveymonkey.com/r/SepsisRegionalTrainings or view the calendar listings at www.stopsepsisathomeny.org.

HCA is also participating in a national webinar hosted by the Sepsis Alliance to inform home care partners throughout the country about our effort. This December 12 webinar was recently publicized by our partners at the National Association for Home Care and Hospice (NAHC) and ElevatingHome. We encourage you to register for this session as well. Further details are on our website at http://stopsepsisathomeny.org/event/free-webinar-on-sepsis-intervention-initiative-in-home-care.

Supported by a grant from the New York State Health Foundation, HCA and sepsis leaders (including IPRO, national Sepsis Alliance, Rory Staunton Foundation for Sepsis Prevention, and others) are holding these eight in-depth training sessions across New York State for all home care and applicable providers on sepsis, steps for provider adoption and clinical application of the sepsis screening tool, clinical case application, integration into agency procedures and records, and more.

Hospitals, physician practices, EMS, health plans and other community partners engaged in sepsis education, prevention, intervention and treatment should also plan (and are urged) to attend. These sessions will include cross-sector collaboration segments to exchange critical information, best practices and other planning.
Managed Care Contracted Home Care Providers Must Have Medicaid Number

As previously reported, under federal legislation, all Medicaid managed care and Children’s Health Insurance Program network providers, including home care agencies, must be enrolled with state Medicaid programs as of January 1, 2018.

This is a separate requirement and in addition to the requirement that Fiscal Intermediaries (FIs), once they complete the state Department of Health (DOH) Authorization process, also have to obtain a separate Medicaid provider number for the FI.

HCA has fielded several calls from members who received notifications from managed care plan partners about the federal requirement. For those home care agencies that do not yet have the required Medicaid enrollment number, DOH had requested applications by December 1.

HCA reached out to DOH asking if providers still had time to submit this application beyond December 1, and we were told that there is still time to do so but providers should act as soon as possible so that they can receive the required program enrollment number in time for the January 1, 2018 implementation date.

Information about enrollment is at www.emedny.org/info/ProviderEnrollment/index.aspx.

HCA has heard of a few agencies that were contacted by multiple plans about the need to enroll in Medicaid when they had already done so and advises all providers to look for correspondence from their contracted plans on this issue and to advise them that they have a Medicaid provider number.

Uniform Billing Codes Delayed to April 1

As announced in a member alert this week, the implementation of uniform billing codes has been delayed until April 1 according to a Dear Provider and Plan letter by the state Department of Health (DOH). The letter is available at https://hca-nys.org/wp-content/uploads/2017/12/Universal-Billing-Codes-DAL-12-7-17.pdf.

As previously reported, myriad implementation issues have compromised readiness to go live with the new codes, which have otherwise been scheduled to take effect in January. DOH acted on moving the start date to April 1 based on concerns that the billing and payment process for home care providers could be disrupted pending resolution of these issues.

A group of HCA’s MLTC plan members, who are also providers, echoed the need for postponement in recent weeks. Our LHCSA members, meanwhile, had expressed concerns about being in a position of having to simultaneously maintain two sets of codes, thus further underscoring a need for delay.

This is not the first delay of the uniform billing code requirement. The provisions for universal billing were included in the 2015-16 state budget and initially were set to be effective January 1, 2016, but additional time was needed for development purposes and coordination with stakeholders, and to meet technical issues expressed by the U.S. Centers for Medicare and Medicaid Services regarding the codes.
HCA Completes Another Round of Emergency Preparedness Workshops With an Eye to NYC/LI Sessions Next

Over the past two weeks, HCA and the New York State Association of Health Care Providers (HCP) have completed a series of regional emergency preparedness training sessions covering the 14-county Central New York region and 7 counties in the lower Hudson Valley.

The sessions are a continuing series of meetings across the state to facilitate connections and collaboration among providers and local emergency management and preparedness officials as part of a state and federal grant.

Over the past year and a half, HCA and HCP have conducted these sessions for home care and hospice providers, as well as local emergency managers and public health directors, covering most of the state, offering a forum for exchange of key information and perspectives between the associations, providers, local managers and preparedness officers.

Beyond networking and local engagement – which is key, so that local authorities gain an understanding of home care’s role, needs, populations and overall situation in the continuum – the programs are also a pipeline for HCA and HCP to compile recommendations and ideas to take up with state officials.

Please be on the lookout for more information soon about the final leg of these workshops, which will complete our statewide coverage, next in New York City and on Long Island.

12/21 Webinar to Provide Update on Data Exchange Incentive Program, Including New and More Flexible Privacy/Security Requirements

The New York e-Health Collaborative (NYeC) is holding a December 21 webinar from noon to 1 p.m. that will provide an update on the Data Exchange Incentive Program (DEIP), including a new set of privacy and security requirements that intends to offer flexibility and therefore increase participation in DEIP.

To register for the webinar, please visit https://attendee.gotowebinar.com/register/4037720445226198787.

DEIP is an incentive program intended to increase health information exchange adoption across the state by helping to defray the cost for an organization when connecting to their local qualified entity (QE), formerly known as a Regional Health Information Organization. DEIP participants are incentivized to contribute a pre-defined set of data elements to their local QE. Limited funding is available and this program is operated on a first-come, first-served basis, with incentive funding of $10,000 per organization and open to Article 28 nursing homes, Article 36 home care agencies and programs, Article 40 hospice facilitates, Behavioral Health providers and others.

According to NYeC, the newly announced privacy and security requirements for DEIP are intended to address the barriers to DEIP participation – specifically by long term, post-acute and behavioral health providers – in
permitting options other than certification by the Office of the National Coordinator for Health Information Technology (ONC).

Moving forward, DEIP applicant must utilize an electronic health record that has obtained at least one of three sets of privacy and security assurances, including: 1) ONC certification for a minimum set of criteria; 2) a current SOC 2, Type II audit with no material findings; or 3) a current, validated HITRUST assessment or NIST cybersecurity framework assessment.

**Additional DOH VBP Program Scheduled in NYC**

The state Department of Health (DOH) will be holding a second Value Based Payment Bootcamp in New York City on **January 9, 2018** at the New York Academy of Medicine (1216 5th Ave., New York, NY 10029).

This program will provide the same information that was presented at the previous Bootcamps in October and November.

VBP Bootcamps are a regional learning series created by DOH with the goal to equip VBP contractors and interested parties (such as managed care organizations, providers, associations, and community based organizations) with the knowledge necessary to implement payment reform. The daylong VBP Bootcamp is designed to be an interactive training session that will give participants a thorough understanding of VBP.

Registration for this event will open on December 19, 2017 and will close on January 2, 2018.

This event is free and open to all interested parties. Please note that space is limited, and will be on a first-come, first-served basis. DOH requests that all organizations limit participation to no more than four persons.

Registration information will be sent shortly.

Please send any questions to VBP@health.ny.gov.

**DOH Releases Guidance on Long Term Care Workforce Investment Organizations**

The state Department of Health (DOH) has released guidance on the parameters of the Long Term Care Workforce Investment Organizations (LTC-WIOs) and managed long term care (MLTC) plan partnership development. (HCA has reported extensively about this initiative, as further summarized on the next page).


According to the guidance, designated LTC-WIOs should be developing plan partnerships in approved regions. DOH is limiting plan participation to those that have at least 5,000 members and are solvent.
DOH will require LTC-WIO/Plan partnerships to demonstrate alignment with the overall goals of the state’s Medicaid Redesign Team (MRT) Waiver Amendment, which is part of the state’s 1115 Waiver and the authorizing document for the funding to support both this program and the state’s Delivery System Reform Incentive Payment (DSRIP) program. These goals include reduction of avoidable hospital use and moving 80 to 90 percent of all managed care payments to value-based payments (VBP) by 2020.

Therefore, partnerships will be required to demonstrate a capacity and approach to support the achievement of these goals. Partnerships will be expected to support, at a minimum, MLTC Level 1 VBP arrangements; MLTC Level 2 VBP arrangements will be encouraged.

DOH intends to provide the LTC-WIOs and Plans with a contract outline which will include the minimum criteria for an acceptable contract. While it will not be providing a contract template, the outline will include the essential elements to be incorporated in the contracts executed by LTC-WIOs/Plans. DOH intends to post the contract outline, as well as information about the funding methodology, in early December.

Additional information on the LTC-WIO program, including a list of awarded LTC-WIOs and eligible MLTC plans, is at https://www.health.ny.gov/health_care/medicaid/redesign/2017/mltc_invest.htm.

HCA suggests that members reach out to the awarded LTC-WIOs to discuss how they can work together, particularly in ways to address new VBP requirements and future use of the designation for “advanced home health aides.”

Under this program, DOH will make available up to $245 million (during 2018-2020) for “initiatives to retrain, recruit and retain healthcare workers in the long term care (LTC) sector.” DOH will require MLTC plans to contract with the DOH-designated LTC-WIOs to: invest in initiatives to attract, recruit and retain LTC workers; develop plans for reducing health disparities through placement of LTC workers in high-need areas; analyze the training needs of each region the center serves; 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.

MLTC plans will receive Workforce Development Program funds which will be used to contract with LTC-WIOs for the provision of workforce development initiatives to the health care providers that participate with the plans. Plans and LTC-WIOs will also be required to collaborate on strategic planning to recruit and train new LTC workers.

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 workforce development initiatives.

HCA had provided extensive input to DOH as this program was constructed over the past year and a half. We had sought a streamlined and direct approach to determining, assessing and paying for the training, and suggested training topics that would help workers and agencies as the system evolves.
CMS Office of the Actuary Releases 2016 Report on National Health Expenditures

According to a new report by the Office of the Actuary at the U.S. Centers for Medicare and Medicaid Services (CMS), overall national health spending increased 4.3 percent in 2016, following 5.8 percent growth in 2015.

Following Affordable Care Act (ACA) coverage expansion and significant retail prescription drug spending growth in 2014 and 2015, health care spending growth decelerated in 2016. The report concludes that the 2016 expenditure slowdown was broadly based as growth for all major payers (private health insurance, Medicare, and Medicaid) and goods and service categories (hospitals, physician and clinical services, and retail prescription drugs) slowed in 2016.

Other significant highlights from the report include:

- Medicare spending grew 3.6 percent to $672.1 billion in 2016, which was slower growth than the previous two years when spending grew 4.8 percent in 2015 and 4.9 percent in 2014. The slower growth in 2016 was due to slower growth in spending for both Medicare fee-for-service (2.2 percent in 2015 compared to 1.8 percent in 2016) and Medicare Advantage managed care (11.1 percent in 2015 compared to 7.4 percent in 2016).

- Medicaid spending growth slowed in 2016, increasing 3.9 percent to $565.5 billion. State and local Medicaid expenditures grew 3.2 percent in 2016, while federal Medicaid expenditures increased 4.4 percent in 2016. The slower overall growth in Medicaid spending was much lower than in the previous two years, when Medicaid spending grew 11.5 percent in 2014 and 9.5 percent in 2015. The higher growth in 2014 and 2015 was due in part to the initial impacts of the ACA’s expansion of Medicaid enrollment during that period.

- Private health insurance spending increased 5.1 percent to $1.1 trillion in 2016, which was slower than the 6.9 percent growth in 2015. The deceleration was largely driven by slower enrollment growth in 2016 after two years of faster enrollment growth due to ACA coverage expansion.


Medicare Enrollment Fee Increases

The U.S. Centers for Medicare and Medicaid Services (CMS) has announced an application fee of $569.00 for 2018 (up from $560 in 2017) for institutional providers (including home care agencies) that are initially enrolling in the Medicare or Medicaid program or the Children’s Health Insurance Program (CHIP); revalidating their Medicare, Medicaid, or CHIP enrollment; or adding a new Medicare practice location.

This fee is required with any enrollment application submitted on or after January 1, 2018 and on or before December 31, 2018.

2018 Medicaid Transfer Penalty Rates Announced

The state Department of Health (DOH) has announced the Medicaid regional rates for calculating penalty periods due to transfers of assets made for those who apply for Medicaid in 2018.

The penalty periods apply to individuals who transfer assets during the 60-month “look-back period” and require facility services. The 2018 monthly rates are:

- New York City: $12,319
- Long Island: $13,053
- Northern Metropolitan: $12,428 (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester)
- Central: $9,722 (Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga and Tompkins)
- Rochester: $11,692 (Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates)
- Western: $10,239 (Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming)

DOH’s notice is at https://www.health.ny.gov/health_care/medicaid/publications/docs/gis/17ma019.pdf

CMS Provides Hospice Quality Updates

The U.S. Centers for Medicare and Medicaid Services (CMS) has recently provided updates/announcements on the following developments related to Medicare hospice quality:

- **Availability of Preview Reports for the Winter Hospice Compare Refresh:** Hospice Item Set (HIS) provider preview reports and Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey provider preview reports are now available. These are two separate reports available in hospices’ Certification and Survey Provider Enhanced Reports (CASPER) folder.

Hospice providers are encouraged to review their HIS quality measure results from the second quarter of 2016 to the first quarter of 2017 and their facility-level CAHPS survey results from quarter two of 2015 to quarter one of 2017. The data that appear in the Preview Reports will be publicly reported on Hospice Compare in **February 2018**. Providers have 30 days to review their HIS and CAHPS results (December 1, 2017 through December 30, 2017). A provider may request CMS review should they believe a denominator or other HIS quality metric is inaccurate or if there are errors within the results from the CAHPS survey data.

*Continued on next page*

Additional information on how to access these reports can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Downloads/Hospice-CAHPS%C2%AEProvider-Preview-Report-Access-Instructions-Final-12-1-17.pdf.

- **Links to information on CAHPS Hospice Survey Top-Box Scores and Case-Mix Adjustment Methods for CAHPS Hospice Survey Measures**: Updated documents for calculating CAHPS Hospice Survey Top-Box Scores and Case-Mix Adjustment Methods for CAHPS Hospice Survey have been posted on the Scoring and Analysis website at: http://www.hospicecahpsurvey.org/en/scoring-and-analysis/.

- **Reminder regarding submission of the Hospice CAHPS Participation Exemption for Size Application**: As a reminder, the Participation Exemption for Size Form for the calendar year (CY) 2017 CAHPS Hospice Survey data collection and reporting requirements is available at: http://www.hospicecahpsurvey.org/en/exemption. Hospices that served fewer than 50 survey-eligible decedents/caregivers in CY 2016 (January 1, 2016 through December 31, 2016, or from assignment of CCN) can apply for an exemption from participation in the CAHPS Hospice Survey for CY 2017. The form will be available to complete and submit online until December 31, 2017.

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

**Emergency Preparedness Webinars Scheduled**

The state Department of Health Office of Health Emergency Preparedness has announced trainings on the Homeland Security Exercise and Evaluation Program (HSEEP).

The trainings will be held on January 9, 2018 from 9:30 a.m. to 1 p.m. and January 16, 2018 from 9:30 a.m. to 1 p.m.

More information, including registration is on the Health Commerce System (HCS) at https://commerce.health.state.ny.us/public/hcs_login.html. Go to My Content, Documents by Group, Health Care, Calendars and LMS Calendar of Events.

Webinars on the Coalition Surge Test and Interoperable Communication drills have been scheduled for January 8, January 10, February 5 and February 6, all from 10 to 11. These drills will fulfill the requirement for participation in a full scale community-based exercise for home care providers for the period November 16, 2017 to November 15, 2018.

HCA will provide further background and information on these sessions, including registration information, as provided by the Department.
Asset Verification System Begins

The state Department of Health has posted an Administrative Directive (ADM) about the implementation of an Asset Verification System (AVS) for purposes of determining Medicaid eligibility for SSI-related (aged, blind or disabled) applicants/recipients.


Under this new system, an SSI-related applicant/recipient and his or her spouse must authorize the electronic verification of their assets as a condition of Medicaid eligibility. This requirement applies regardless of whether an applicant is attesting to the value of resources for community coverage without long-term care or seeking Medicaid coverage of community-based long-term care or nursing home care.

The applicant/recipient’s signature on the Medicaid application and renewal form is sufficient authorization to verify assets through AVS.

Generally, the AVS will electronically verify accounts held in banking institutions, and conduct searches on real property, owned by the applicant/recipient and/or spouse during the month of application and the three-month retroactive period (60-month “look-back” period for individuals applying for Medicaid coverage of nursing home care).

The provisions of this ADM are effective with AVS implementation in the local district. Since New York City will implement use of the AVS in phases, the ADM provisions are effective as each phase is implemented.

Resources

- “Report to the President and Congress The Money Follows the Person (MFP) Rebalancing Demonstration,” by the U.S. Centers for Medicare and Medicaid Services

- “Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework,” by the Government Accountability Office

- “Hospice Manual Update Only for Section 30.3,” by the U.S. Centers for Medicare and Medicaid Services

- “New York Medicare ACO Performance: Cost and Quality Results Raise Bigger Questions,” by United Hospital Fund
  http://uhfnyc.org/assets/1621

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