# '16 Legislative Retrospective

A comprehensive look at the 2016 Legislative Session

HCP
NYS Association of Health Care Providers
Representing Home & Community-Based Care

## HCP Focuses on Minimum Wage and Home Care Reimbursement Issues in 2016

As expected, the campaign to increase the minimum wage in New York to $15 an hour dominated the 2016 Legislative Session. Well before the start of the Session, Governor Andrew Cuomo announced that this would be one of his top priorities. The minimum wage proposal was not only the centerpiece of the Governor's combined State of the State and Budget address in January, he also conducted an unprecedented stump tour across the State holding rallies with union leaders, social justice activists, and local elected officials to build support for its passage.

HCP pursued an aggressive advocacy, grassroots and media strategy focusing on the impacts of the proposed minimum wage increase and the need for adequate reimbursement of home care providers. HCP Public Policy staff, retained lobbyists Reid, McNally & Savage (RMS), and HCP's members worked tirelessly leading up to and throughout the Budget process to ensure that the State allocated sufficient funding to reimburse Medicaid home care providers for any minimum wage increase. These collective efforts succeeded in securing funding in the final State Budget to support the minimum wage increase, as well as other significant budget provisions related to home care reimbursement and funding.

Casting a long shadow over the State Capitol this year were ongoing Federal investigations into fraud and corruption among top-ranking New York State government officials. In parallel proceedings, both Sheldon Silver (D-Manhattan), the former long-time Speaker of the New York State Assembly, and Dean Skelos (R-Rockville Centre), the former Senate Majority Leader, were each convicted on Federal corruption charges and sentenced to jail this spring. In early May, just as Legislators were returning to Albany after the spring recess, new reports surfaced that Federal investigators were closing in on a top aide and a close ally of Governor Cuomo. The remainder of the Session was low-key by comparison, with no major threats or significant advances for the home care industry. The State Legislature adjourned in mid-June after passing only minor ethics reforms.

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## HCP Plays Prominent Role in Securing Minimum Wage Funding

HCP played a prominent role during the State Budget process calling on the State to commit adequate Medicaid funding to support any minimum wage increase that was approved. With the minimum wage issue its top legislative priority, HCP pursued a multipronged strategy combining research, public education, direct lobbying, grassroots advocacy, coalition building, and media outreach.

HCP stayed on message throughout what was a contentious and divisive battle within the State Legislature over the proposed minimum wage increase. While agreeing that home care workers deserve a higher minimum wage, HCP consistently maintained that the success of the new minimum wage would hinge on New York's ability to responsibly implement it. HCP emphasized in all of its communications that unless there was funding in the State Budget to compensate Medicaid-reimbursed home care providers for the cost of the minimum wage increase, the impacts on New York's home care industry, the workers we employ, and the patients and families we care for would be devastating.

Well in advance of the 2016 Legislative Session, HCP began preparing for high-level engagement in the minimum wage debate. Over the fall and winter, HCP worked with other health care associations representing hospitals, nursing homes, and home care agencies to identify and calculate the direct and indirect costs of a proposed $15 an hour minimum wage in New York. The associations further refined these estimates after the Governor released the specifics of his minimum wage proposal in January, and revised them again in February after HCP reviewed more up-to-date industry data provided by HCP members.

HCP and its members urged the State Legislature and Governor to ensure that the following minimum wage provisions, critical to maintaining a viable home care industry in New York, were included in the final Fiscal Year (FY) 2016-17 State Budget:

- Full funding for the State Medicaid share of the minimum wage increase and related direct costs (payroll taxes, overtime, etc.) for Medicaid home care services;
- Delayed implementation of any minimum wage increases until full Medicaid funding, both State and Federal portions, is available to home care providers;
- Clear pass through directions for managed care plans or other mechanism to ensure that such funding reaches home care providers in its entirety and in a timely manner.

These messages were conveyed by HCP and its members in countless meetings and communications with State Legislators, legislative staff, and top officials in the Cuomo Administration throughout the Budget process. HCP member engagement during this year's Budget negotiations was critically important. Members participated in district lobby visits, HCP's annual Advocacy Day in Albany on March 1, and a barrage of calls, emails, and fax blasts in the final weeks of Budget negotiations (see **page 5** for more information). In addition, HCP significantly increased its media presence, successfully gaining coverage in the *Daily News, Newsday,* the *New York Times*, and other media outlets across the State (see **page 6** for a full listing).

HCP's aggressive advocacy, high profile in the media, and constant presence at the State Capitol as a respected source of information about the home care industry played a significant role in ensuring that the needs of the home care industry were addressed in the Final FY 2016-17 State Budget:

- The Final Budget authorized up to $58 million in FY 2016-17 to reimburse Medicaid providers for the minimum wage increase, increasing to $160 million in FY 2017-18, most of which is earmarked for home care and personal care services;
- Implementation of the minimum wage increase was pushed back from July 1, 2016, as the Governor and Assembly had proposed, to December 31, 2016, allowing more time for the State to ensure funding is in place for home care providers prior to the first year's increase;
- The initial minimum wage increase is lower than what was originally proposed by the Governor and Assembly, reducing the immediate cost impacts in the first few years of the phase-in.

While HCP had initially estimated that the State Medicaid share for the additional cost to home care providers in FY 2016-17 would be at least $119 million, the slower phase-in of the minimum wage increase adopted in the final Budget agreement, combined with the State's decision not to reimburse providers for their compression costs, means that the State's Budget authorization of $58 million in FY 2016-17, of which more than $56 million is earmarked for home care, should be sufficient. However, the costs will go up significantly in future years. HCP is working with members and other home care associations to further refine and update the home care industry's short and long-term cost projections for the final approved minimum wage increase.

### *The Next Hurdle: Implementation*

Immediately following adoption of the State Budget, New York State Medicaid Director Jason Helgerson and Deputy Secretary for Health and Human Services Paul Francis held a briefing for home care, nursing home, and developmental disabilities associations to explain the State's plans for adjusting Medicaid reimbursements to reflect the additional cost of complying with the increased minimum wage. At the briefing, Helgerson shared more details about the provisions in the final State Budget and described the State's plans to ensure that funding is passed through to plans and providers in advance of the minimum wage increases.

Helgerson announced that the New York State Department of Health (DOH) would be convening stakeholder workgroups over the summer and fall to advise the State on how to address minimum wage policy issues to modify Medicaid reimbursement rates, and to finalize rates such that resources are available for providers prior to the scheduled minimum wage increases.

HCP attended the first Minimum Wage Stakeholders Workgroup meeting on June 7, which focused on a review of the timeline, Medicaid rates impacted, and policy issues to be addressed. At the meeting, HCP was extremely concerned to hear that DOH intended to let managed care plans negotiate with home care agencies any adjustments in reimbursements for the minimum wage increase rather than directing them to pass through these funds to providers. HCP followed up with a letter to Helgerson, urging the State to issue a clear directive to managed care plans to ensure that adequate funding to support the minimum wage increase is passed through to providers prior to the scheduled minimum wage increase.

HCP will continue to work with DOH, other Administration officials, and key stakeholders on critical issues related to implementing the minimum wage increase throughout 2016 and beyond. HCP has assembled the Minimum Wage Implementation Work Group, with representation from the HCP Board of Directors, HCP Public Policy Committee, and the membership at large, which has been meeting regularly since early May to assist HCP in addressing these implementation issues, including quantifying the minimum wage cost impacts and developing recommendations for funding pass-through mechanisms. HCP has also worked with the Senate and Assembly Health Committee Chairs to raise attention to the need to adequately reimburse home care providers (see **page 3** for more information). HCP will continue to keep members informed of new developments and opportunities for engagement.

## HCP Highlights Home Care Reimbursement Challenges

HCP stepped up its efforts to educate State Legislators and the Cuomo Administration about the significant financial and regulatory challenges facing New York's home care industry. Through Budget testimony, informational materials provided at HCP Advocacy Day, legislative memos, and one-on-one conversations with Legislators and policy staff, HCP and its members emphasized the urgent need to not only provide adequate funding to support a future minimum wage increase, but to address the myriad financial pressures that home care providers across the State are already experiencing, particularly related to the transition to managed care.

Through member surveys, HCP documented that home care agencies' managed care reimbursement rates have remained stagnant or declined over the past year, despite rising labor costs in all parts of the State. HCP also informed State Legislators and Administration officials about delays, inconsistencies, and lack of transparency regarding the distribution of funds that were intended to be passed through by managed long term care (MLTC) plans to home care providers, such as the State's emergency payments for compliance with the new Federal Fair Labor Standards Act (FLSA) overtime rule.

HCP warned that steeply rising labor costs combined with continued delayed and inadequate reimbursements

from MLTC plans have caused tremendous stress and cash flow problems for home care agencies across the State, threatening their ability to continue to provide high quality home care services to elderly, disabled, and chronically ill New Yorkers, and hampering them from making critical infrastructure investments needed to participate in the new health care delivery system reforms underway in New York.

In recognition of HCP's concerns, both Senator Kemp Hannon (R-Garden City), Chair of the Senate Health Committee, and Assembly Member Richard Gottfried (D-Manhattan), Chair of the Assembly Health Committee, took a number of steps during the 2016 Legislative Session to address home care reimbursement issues, including the following:

- The enacted Fiscal Year (FY) 2016-17 State Budget included language advanced by the Assembly and supported by the Senate requiring that premium rates for MLTC plans must be "actuarially sound and adequate" to account for compliance with "all applicable laws and regulations, State and Federal, including regulations as to actuarial soundness for Medicaid managed care."

- The Senate unanimously passed S.5459 (Hannon), known as the Home Care Reimbursement Act. Introduced last May at HCP's request, this bill would require the New York State Department of Health (DOH) to hire an independent actuary to review the adequacy of reimbursement methodologies for home and community-based long term care services in both managed care and fee-for-service (FFS) settings, including consumer directed personal assistance services (CDPAS).

- The Senate unanimously passed S.8072 (Hannon), which would require that Medicaid rates paid to managed care plans be sufficient for reimbursing their contracted providers for complying with all applicable State and Federal regulations, and that managed care plans reimburse home care agencies for these costs. HCP, the Home Care Association of New York (HCA), and LeadingAge New York collaborated on this legislation as part of a strategy to secure adequate funding to support the minimum wage increase.

- Following a meeting with HCP's Long Island Chapter, Senator Hannon wrote a letter to DOH Commissioner, Dr. Howard Zucker, calling on the Department to follow through on its original commitment to distribute the emergency FLSA funds to home care providers as soon as possible.

- The Assembly advanced A.379-B (Abinanti-D-Pleasantville), which addresses prompt payment of clean claims by managed care plans to home care providers. A previous version of the bill, known as the Home Care Stabilization Act, had been introduced several years ago at the request of HCP and was one of HCP's legislative priorities in 2015.

- Assembly Member Gottfried will be sending a letter to New York State Medicaid Director Jason Helgerson expressing support for similar principles to those laid out in the Senate home care reimbursement bills.

These initiatives indicate the Legislature's strong support for adequate reimbursement for New York's home care providers for the minimum wage increase and other State and Federal mandates, and will help set the stage for ongoing minimum wage stakeholder discussions with the Cuomo Administration. They also provided a further opportunity for HCP to educate both the Senate and the Assembly about the significant financial and regulatory challenges impacting New York's home care industry.

## HCP Seeks Relief from Domestic Workers' Bill of Rights Compliance

HCP advanced new legislation this year to close a loophole in the law that has inadvertently included home care workers employed by agencies in New York's Domestic Workers' Bill of Rights (DWBR) law.

When the State enacted the DWBR law in 2010, it was clearly intended for domestic workers such as housekeepers and nannies, and explicitly excluded home care workers from the definition of "domestic worker." However, the DWBR definition referenced the Federal Fair Labor Standards Act (FLSA) rather than State laws regulating home care workers. In October 2015, when the new FLSA regulations went into effect removing home care workers from the companionship exemption, these workers then became subject to New York's DWBR because of the law's definition.

# HCP Legislative Advocacy

At the request of HCP, Senator Jack Martins (R-Mineola), Chair of the Senate Labor Committee, and Assembly Member John T. McDonald III (D-Cohoes), HCP's 2015 Legislator of the Year, introduced legislation (S.7929-A/A.10595-A) this spring to correct this problem by replacing the old definition of "domestic worker" with new language clarifying that home care workers employed by licensed home care agencies in New York are excluded from the DWBR law, as they always have been.

Most of the DWBR's requirements are duplicative with existing laws governing home care workers, such as workers' compensation, minimum wage, overtime benefits, and policies prohibiting sexual harassment and discrimination. The provisions of the DWBR that are most problematic for home care agencies are the paid leave and overtime requirements. The law provides that after one year of employment, full time domestic workers are entitled to at least three days of paid rest a year. It also requires that each worker has a designated day of rest a week, and must be compensated at their overtime rate for all hours worked on such day of rest, even if the employee has not worked 40 hours in the week.

Home care workers employed by licensed home care services agencies (LHCSA) in New York already have much stronger workplace protections than what is provided under the DWBR, and in most cases are entitled to more generous wages and benefits through a variety of State and local laws, collective bargaining

## *HCP Member Engagement Boosts Advocacy Efforts*

HCP members played a critical role in securing funding in the final State Budget to support the minimum wage increase by reaching out to State Legislators, participating in media activities, and responding promptly to *HCP Action Alerts* and surveys.

### *HCP Advocacy Day*

More than 70 HCP members from across the State attended HCP's Advocacy Day on March 1 in Albany, wearing buttons asking, "Will Home Care Be There When You Need It?" This year's HCP Advocacy Day focused on the minimum wage increase and other home care Budget priorities. Participants met with nearly 80 State Legislators to educate them about the critical issues facing the home care industry, and dropped off information packages at an additional 15 State Legislators' offices. HCP members also participated in a meeting with the Governor's office that day and a news conference on the minimum wage with other Medicaid providers.

### *HCP Member Engagement*

Throughout the spring, HCP members responded to *HCP Action Alerts* and engaged in local grassroots activities such as meeting with State Legislators in their districts, reaching out to Governor Cuomo's regional representatives, and submitting letters-to-the-editor in local newspapers. In the final weeks of March, HCP escalated its grassroots advocacy with a week of HCP members participating in daily actions, sending over 600 emails, as well as calls and fax blasts, to the State Legislature and Governor's Office to reinforce the importance of ensuring that funding was included for home care providers to support any minimum wage increase agreed upon during the State Budget negotiations.

### *Member Surveys*

HCP's advocacy efforts this year were supplemented by responses to three member surveys conducted by HCP during the Legislative Session focusing on reimbursement rates, distribution of Fair Labor Standards Act (FLSA) funds, and direct labor costs for home care aides. HCP received a rapid and robust response from members in response to these narrowly focused surveys. The surveys filled important information gaps that helped HCP effectively voice the concerns of its members to State Legislators, Cuomo Administration officials, and the news media.

agreements, and voluntary programs. As a result, compliance with the DWBR has added unnecessary and costly administrative burdens and additional unfunded mandates on home care agencies, with little or no benefit to workers.

Although the statutory amendment failed to move in either the Senate or the Assembly due to opposition from the National Domestic Workers Alliance and 1199 SEIU United Health Care Workers East, HCP succeeded in raising this as an issue that must be addressed, either through regulatory relief or additional compensation. HCP discussed its concerns with both the New York State Department of Labor (DOL) and Department of Health (DOH) and will be following up with these agencies to seek relief for home care agencies that are already providing similar or greater leave and overtime benefits, and adequate compensation for Medicaid providers that have additional direct costs resulting from compliance with DWBR.

### *HCP Garners Extensive Media Coverage During State Budget Process*

This year HCP significantly increased its media presence, successfully gaining coverage in nearly two dozen news stories and interviews during the first four months of the year. As a result of HCP's high profile in the media, several news outlets sought HCP comments in response to the final Budget agreement.

HCP's media coverage during the 2016 Legislative Session included the following:

- *City & State*
- *Crain's Health Pulse*
- *Home Health Care News*
- *Modern Health Care*
- *New York Daily News*
- *New York Times*
- *Newsday*
- *Politico*
- *Time Warner News (Capital Tonight with Liz Benjamin)*
- *WAMC, WXXI, and other NPR outlets*
- *WCNY (The Capitol Pressroom with Susan Arbetter)*
- *Westchester Business Journal*

In addition, HCP members engaged in HCP's media outreach by submitting letters-to-the-editor to newspapers across the State and speaking with reporters. A full list of HCP's news coverage is available in the **HCP News Center**.

## HCP Continues Work on Essential Personnel Bill

For the third consecutive year, HCP worked with Senator Andrew Lanza (R-Great Kills) and Assembly Member Michael Cusick (D-Staten Island) and other stakeholder groups on advancing legislation to authorize home care and hospice workers access to their clients during declared emergencies. The bill, S.6692-B/A.9381-B, passed both the Senate and Assembly late in the 2016 Legislative Session.

Previous iterations of the bill passed both houses unanimously two years in a row, and were subsequently vetoed by Governor Andrew Cuomo each year. This year, HCP reached out to opponents of the legislation, including the New York State Association of Counties (NYSAC) and the New York State Division of Homeland Security and Emergency Services (DHSES) in an effort to address their concerns, and proposed amendments and an outreach strategy to help secure the legislation's enactment this year.

The amendments introduced by the bill sponsors further clarified that local emergency managers will have the authority to reject access to restricted areas that are deemed too dangerous for home care and hospice workers to enter. Additionally, the amendments specify that processes for allowing access will also include procedures on how essential personnel will be identified.

As part of its deliverables for its emergency preparedness grant with the New York State Department of Health (DOH) Office of Health Emergency Preparedness (OHEP), HCP and its grant partner traveled to the Western New York region to facilitate in-person meetings between home care agencies and their local Offices of Emergency Management (OEM) and local health departments (LHD). The meetings aimed to foster better understanding between the stakeholders on their roles and responsibilities before, during, and after an emergency, and this legislation was discussed at length during each meeting. HCP will follow up with the New York State Emergency Management Association (NYSEMA) to further educate emergency managers on the critical nature of this legislation.

HCP has also reached out to DOH and the Governor's office to stress the importance and need for the bill to be signed into law, and will continue to educate those that oppose the legislation as it waits to be sent to the Governor.

## HCP Supports Advanced Home Health Aide Bill

After years of effort, the New York State Assembly, Senate, and Governor's office finally agreed on language creating a new "advanced home health aide" (AHHA) designation in New York during the 2016 Legislative Session. The bill amends the Nurse Practice Act to authorize AHHAs to perform certain advanced tasks, including the administration of certain medications, after satisfying all applicable training and certification requirements and under the direct supervision of a registered professional nurse.

Negotiations on the bill had appeared stalled this year, but began moving quickly in June. The legislation, sponsored by Senator Kenneth LaValle (R-Port Jefferson) and Assembly Member Deborah Glick (D-Manhattan), Chairs of the Senate and Assembly Higher Education Committees respectively, was introduced and passed in the final week of Session. The bill will now go to the Governor, who is expected to sign it, since it has been a priority for the Governor for several years and the Governor's office was engaged in negotiating the final bill language.

HCP, which actively participated in a Stakeholder Workgroup convened in 2014 by the New York State Department of Health (DOH), issued a memo in support for the final AHHA bill. Although much of the program will be developed through regulations, the bill provides a number of specific parameters concerning the tasks that an advanced aide can perform and the nursing supervision requirements, which were key points of contention during the stakeholder process.

HCP has supported the concept of creating an AHHA designation as a career ladder for home health aides (HHA) and an additional, cost-effective option for the delivery of care to elderly, disabled, and chronically ill New Yorkers in their homes and communities. However, unless home care providers are reimbursed appropriately, it is unlikely that they will choose to utilize AHHAs. HCP will be looking to the State Legislature for support in the future to ensure that adequate resources are allocated for the successful implementation of the AHHA program, including for curriculum development and training, and that such resources are distributed equitably. Many of these concerns will be further worked out during the rulemaking process and in future Budget negotiations.

The AHHA program will go into effect 18 months after enactment and will expire on March 31, 2023. The bill directs the New York State Education Department (SED) and DOH to develop regulations specifying the advanced tasks that can be performed by an AHHA, qualifications, and training and competency requirements in the next 18 months. Advanced tasks may only be performed by an AHHA after receiving an authorized health practitioner's ordered care, and only under the direct supervision of a registered professional nurse who is employed by a home care agency, a hospice program or an enhanced assisted living residence. The bill also requires that a HHA be specified as an AHHA within the Home Care Registry (HCR) after satisfying all applicable training and competency requirements.

DOH will be required to report recommendations of the workgroup convened to provide input on the tasks that could be performed by an AHHA and the qualifications by September 1, 2016, and will also be required to report on the implementation of the AHHA program along with recommendations by October 1, 2022.

HCP will actively engage in the development of the AHHA program over the next few years to ensure that the concerns of home care providers are fully represented.


# 2016-17 State Budget Overview

The State Legislature finished passing the Budget bills for Fiscal Year (FY) 2016-17 in the early hours of April 1, narrowly making it the sixth consecutive on-time budget for the Cuomo Administration. Big ticket items in the $147 billion budget included a phased-in increase to the State minimum wage, paid family leave legislation, billions in infrastructure funding, and a $4.2 billion middle class tax cut.

## *HCP Advocacy Focuses on Minimum Wage, Funding for Home Care*

Kicking off the State Budget process in January, HCP Vice President for Public Policy Laura Haight and HCP Immediate Past Board Chair Bader Reynolds testified at a Joint Legislative hearing on the Health Budget and shared the many challenges home care providers continue to face each year, including the home care industry's mounting unreimbursed labor costs, managed care plan insolvency, and the lack of resources to invest in vital infrastructure.

In its testimony, HCP highlighted the importance of home and community-based care as a central component for new models of health care delivery, aimed at achieving the State's triple aim of improving care, improving health, and reducing costs within the Medicaid system. HCP voiced concerns that the Governor's FY 2016-17 Budget proposal continued the years-long pattern of disinvestment in home care, despite the widespread recognition that home care saves money by keeping New Yorkers out of more costly health care settings. HCP focused in particular on Governor Cuomo's proposal to increase the Statewide minimum wage without including any additional Medicaid funding to pay for it. HCP urged the State Legislature to invest in home and community-based care now to ensure that these essential services will continue to be available in the future.

Because of the critical financial challenges facing the home care industry, HCP made a strategic decision in 2016 to focus its legislative advocacy on Budget issues. This year's HCP Advocacy Day focused on the following Budget priorities:

- Funding the minimum wage increase;
- Requiring adequate compensation for home care services;
- Protecting providers from plan insolvency, and;
- Investing in home care infrastructure.

HCP members, staff, and retained lobbyists Reid, McNally & Savage (RMS) fought vigorously for the inclusion of these home care priorities in advance of and throughout this year's Budget process. As a result of these efforts, the final FY 2016-17 State Budget included Medicaid funding to support the minimum wage increase, modest provisions related to adequate compensation for home care services, and new infrastructure funding opportunities for home care agencies across the State. The issue of plan insolvency remained intractable this Session, although it received widespread attention and will likely be raised again next year.

## *Summary of Budget Provisions Impacting the Home Care Industry*

### *Minimum Wage Increase*

The final FY 2016-17 State Budget included separate schedules for phasing in the $15 minimum wage in different areas of the State, as follows:

| New York City | Nassau, Suffolk, and Westchester Counties | Rest of State |
|---|---|---|
| 12/31/16: $11.00<br>12/31/17: $13.00<br>12/31/18: $15.00 | 12/31/16: $10.00<br>12/31/17: $11.00<br>12/31/18: $12.00<br>12/31/19: $13.00<br>12/31/20: $14.00<br>12/31/21: $15.00 | 12/31/16: $9.70<br>12/31/17: $10.40<br>12/31/18: $11.10<br>12/31/19: $11.80<br>12/31/20: $12.50<br>On each 12/31 thereafter, the wage will be increased by a percentage determined by the Director of DOB in consultation with the Commission of Labor, up to $15. |

# Budget Re-Cap

On or after January 1, 2019, and each January 1 thereafter until the minimum wage is $15 in all areas of the State, the New York State Department of Budget (DOB) will conduct an analysis of the state of the economy in each region and the effect of the minimum wage increases to determine whether there should be a temporary suspension or delay in the scheduled increases.

***Minimum Wage Funding and Medicaid Global Spending Cap***

The final Budget authorizes the State to appropriate up to $58 million within the Medicaid Global Cap to support the cost of the minimum wage increase for Medicaid service providers in FY 2016-17 and up to $160 million in FY 2017-18, most of which is earmarked for home care services ($56.4 million in FY 2016-17 and $154.7 million in FY 2017-18). The final Budget also authorizes DOH and DOB to increase the Global Medicaid Spending Cap if Medicaid expenditures exceed DOH disbursements with regard to the minimum wage increase.

***Wage Parity***

The final Budget amends the Home Care Worker Wage Parity law to ensure that the base wage of the total compensation for Wage Parity is not lower than the minimum wage. The supplemental benefit rates will remain as they were as of March 1, 2016 ($4.09 in New York City and $3.22 in Nassau, Suffolk, and Westchester counties). This means that as the minimum wage increase is phased in, the supplemental benefits would be required to be paid on top of the base wage increase, which is $10, or the minimum wage rate, whichever is higher.

***Adequate Reimbursement for Home Care***

The final Budget included modest language for adequate reimbursement within MLTC plan premium rates. The bill language specifies that "actuarially sound and adequate" rates shall account for compliance with all applicable laws and regulations, State and Federal wages, including regulations as to actuarial soundness for Medicaid managed care.

***Paid Family Leave***

The final Budget includes a requirement for employers to provide 12 weeks of employee-funded paid family leave, starting in January 2018. Employees will be able to earn up to 50 percent of their average weekly wage, not to exceed 50 percent of the Statewide average weekly wage, while on leave to care for an ill relative, newborn child, or when a family member is serving active military duty. The program will be fully phased in by 2021, allowing employees to be eligible to earn

## *For Fifth Year, State Ends Fiscal Year Below Medicaid Global Cap*

New York State Medicaid spending finished the 2015-16 Fiscal Year (FY) $3 million below the $17.741 billion Global Spending Cap target, while increasing Medicaid enrollment by nearly 20,000. The State has highlighted this accomplishment, particularly while moving forward with ongoing initiatives, and despite significant pressures on the Global Cap, such as the need for increased funding due to the court ruling on the Federal Fair Labor Standards Act (FLSA) that mandated higher overtime rates for home care services.

The FY ended with "other long term care spending" – including home care – coming in at $23 million above projections. Managed long term care spending through the 2015-16 FY came in at $153 million above projections, due to higher than expected enrollment (5,400, or 3.3 percent, above estimates), as well as a delay in claiming Federal receipts.

This marks the fifth consecutive year that the State has remained below the Global Spending Cap target while increasing enrollment in the Medicaid program. In addition, the Medicaid Redesign Team (MRT) moved forward with a number of initiatives, including: the transition of the nursing home and Health and Recovery Plan (HARP) recipients into managed care during the FY; the continuance of the Balancing Incentive Program (BIP) and the Vital Access Provider/Safety Net program; additional funding under the Vital Access Provider Assurance Program (VAPAP); and the implementation of the Essential Plan (EP), which offers consumers a lower-cost health insurance option through the New York State of Health (NYSOH).

Per the enacted 2016-17 State Budget, the Global Cap has been extended through March 31, 2018.

67 percent of their average weekly wage. The program will be funded through employee paycheck deductions, beginning at 70 cents per week and increasing to $1.47 per week when fully phased in. An employee must be employed for at least six months to qualify.

***Health Care Transformation Program***

The final Budget authorizes an appropriation of up to $200 million for the Health Care Facility Transformation Program to provide capital funding in support of projects that replace inefficient and outdated facilities as part of a merger, consolidation, acquisition, or other significant corporate restructuring activity. Of this amount, a minimum of $30 million of total awarded funds are required to be awarded to community-based health care providers, including certified or licensed home care providers. HCP will be closely monitoring this program and alerting members to opportunities to apply for this funding. Details of this program, which is being implemented by DOH and the State Dormitory Authority, are expected later in the summer.

***Nursing Home Transition and Diversion (NHTD)/ Traumatic Brain Injury (TBI) Transition to Managed Care***

The final Budget ensures that eligibility criteria for the NHTD/TBI waiver programs will remain as they were on January 1, 2015 and delays the programs' transition to managed care until January 1, 2018. Features for both programs are also to be kept "substantially comparable" to those available to participants as of January 1, 2015, including service coordination, which must continue to be conducted in the interest of the participant. The Budget also requires managed care programs to retain an adequate network of TBI and NHTD providers when the programs transition.

***Home Care Workforce Recruitment & Retention***

The final Budget includes continued funding for Home Care Workforce Recruitment and Retention, as follows:

- Upstate Personal Care: $22.4 million
- New York City Personal Care/Home Care Workers: $272 million

HCP raised concerns during the Budget process regarding how these funds are distributed by managed care plans and will continue to press for more transparency.

## *Support the HCP PAC!*

The 2016 Legislative Session may be over, but much remains to be done and the HCP PAC still needs your support! Help protect and promote home care in New York State — and support the HCP PAC as it seeks to meet its goal of $55,000 in contributions by the end of 2016!

***Click here to join your colleagues and make a contribution to the HCP PAC today!***

***The Health Care Providers Political Action Committee (HCP PAC)*** *is committed to protecting and furthering the goals of the State's home care industry. As the first PAC in New York State dedicated solely to the interests of home care providers, the HCP PAC has over 30 years of experience as a powerful voice in our State Capitol.*


## HCP Fights for Equitable Distribution of FLSA Funding

Changes to the Federal Fair Labor Standards Act (FLSA) companionship exemption went into effect on October 13, 2015, and over the past eight months, HCP has worked tirelessly to ensure that home care providers are fairly reimbursed for their increased labor costs resulting from the United States (US) Department of Labor's (DOL) Final Rule. Long before the Final Rule's adoption, HCP frequently communicated with key decision makers the need for additional funding to support the increased costs of doing business posed by the rule, and escalated its advocacy efforts when the US Supreme Court denied a stay of the lower court's decision in early October 2015.

Following the effective date of the FLSA changes, HCP sent a letter to Governor Andrew Cuomo's office, followed by a meeting, informing the Governor of the serious negative consequences that the new overtime pay rules will have on the provision of home care services unless the State takes immediate action to provide temporary and long-term relief. HCP also issued a news release and garnered extensive media coverage in political blogs, trade publications, and newspapers, along with an interview on Time Warner News "Capital Tonight." HCP members supplemented HCP's efforts with calls and letters to the Governor's office, sharing their stories on the impacts of increased labor costs on their agencies and clients.

As a result of HCP's aggressive advocacy, the State agreed to expedite emergency funds, to be paid in lump sum payments to the plans and distributed to providers, for the additional cost of FLSA compliance between October 13, 2015 and March 31, 2016. The New York State Department of Health (DOH) issued a *Dear Colleague Letter* informing providers and managed care plans of the steps the Department would take to modify Medicaid reimbursement rates to ensure compliance with the FLSA Final Rule, including expedited rate relief to fee-for-service (FFS) programs and managed care plans, along with a rate adjustment process for the period beyond March 31.

DOH estimated that overtime represents 10 percent of total hours worked in home care, and calculated a total per hour adjustment of 34 cents across all aide hours. The State share of this funding, totaling $22.8 million, was expected to be advanced to managed care plans by December 2015, but was actually advanced to the plans in March 2016, and not distributed to providers until April 2016, forcing providers to comply with the Final Rule for over six months without additional funding.

HCP diligently monitored the progress of the emergency FLSA funding, taking immediate action when necessary, and continuously stressing to the Department the need to advance the funding in an expeditious, equitable, and transparent manner. HCP expressed its concerns to both DOH and the Governor's office in a strongly-worded letter urging DOH to: instruct plans to pass through all of the funds to their contracted providers based on 34 cents across all workers hours; require plans to pass through the funds within 10 days of their receipt; provide guidance on how the funding can be used to comply with the Final Rule; and specify what records must be kept in order to verify compliance. Senator Kemp Hannon (R-Garden City), Chair of the Senate Health Committee, supported HCP's efforts with a letter to Dr. Howard Zucker, DOH Commissioner, calling on DOH to follow through on its original commitment to distribute the emergency funding to home care providers as soon as possible.

Further guidance from DOH gave a great amount of latitude to managed care plans, which were merely instructed to use a "reasonable methodology" when distributing the funds to their contracted providers. HCP responded with a continued push for the FLSA funds to be distributed equitably to all contracted providers based on total hours of service provided through the plan, in order to facilitate a simple and efficient distribution of the funds. Additional information issued by DOH reinforced that the plans are not allowed to retain any of the FLSA funds, however, the Department did not require plans to account for how the funds were distributed and plans were not held accountable for failure to meet the April 8 deadline for distributing the funds to providers.

As FLSA funds began to flow from the managed care plans to providers in April, HCP members reported a number of issues that raised questions on the inconsistent

methodologies used by the plans to determine funding allocations. HCP surveyed HCP members to gather more information on how much funding they received, and to identify managed care plans that may not have distributed the funding by the deadline or that may have used an unreasonable methodology. HCP also submitted a Freedom of Information Law (FOIL) request to the Department to obtain the methodologies used by the plans. HCP's survey results showed that the vast majority of respondents were not informed of the methodologies used by their contracted plans; nearly all respondents were still awaiting funds from contracted plans; and significant variations existed in the amounts of funding received.

In May, DOH released a document listing all the methodologies used by the plans as well as the date that the plan disbursed funds to providers. Of the 32 plans that submitted methodologies, eight reported distributing the funds after the April 8 deadline and three did not include a timeline for distribution. The methodologies listed in the document were inconsistent and showed that some plans used a percentage of hours, others used actual claims, and some used hours that were submitted by providers.

The State's request for the Federal share of the FLSA funds was submitted to the Centers for Medicare & Medicaid Services (CMS) in early June and is still awaiting CMS approval. The State has agreed to advance these payments while the request to CMS is still pending. Assuming the New York State Division of Budget (DOB) approves the request, providers may not see the second installment of the emergency FLSA payments until the fall, nearly a year after the revised FLSA Rule went into effect.

HCP has continued to stress the need for transparency in how the FLSA funds are allocated, and will press DOH to direct the plans to pass the Federal share of the FLSA funding through to providers more fairly and equitably. HCP has also raised concerns about the FLSA funding process during discussions on the minimum wage implementation in order to press for more effective funding pass through mechanisms.

In addition, HCP will be closely monitoring DOH's upcoming rate adjustment process, which will be informed by a survey to be conducted by Mercer, DOH's actuary, to ensure it fully accounts for the additional cost of FLSA compliance. HCP has provided extensive feedback in the development of the survey, which has yet to be issued.

## DOH Wraps Up 2014-15 QIVAPP Funding, Prepares for 2015-16 Disbursement

Nearly two years after the program's commencement, the New York State Department of Health (DOH) continued to tie up the loose ends of the 2014-15 funding for the Quality Incentive Vital Access Provider Pool (QIVAPP) program throughout the first half of 2016. HCP continued to raise concerns on the eligibility criteria for the QIVAPP funding, and pressed DOH to begin the application and disbursement process for the 2015-16 QIVAPP funds as the fiscal year came to a close.

Island Peer Review Organization (IPRO) began auditing QIVAPP applicants for compliance with the revised eligibility criteria in late 2015, with Phase II of the audits starting in February 2016. The second phase required applicants to submit additional information to support that at least 30 percent of their agency's workforce was enrolled in their health benefits coverage, with little time to gather and submit the required documentation. Those that did not submit documentation by the deadline would be removed from the pool of eligible QIVAPP providers.

Following the conclusion of the IPRO audits, DOH released a list of 64 home care agencies that were determined to be eligible for the 2014-15 QIVAPP funding, which was significantly less than the number of agencies that initially received funds from the first half of the $70 million pool. A final list of allocations for the full $70 million was made available to HCP in mid-April, and included the initial award given to the provider and the total amount of their new award. The list also includes the balance owed to the provider, or a balance that must be returned to the MLTC plan, if necessary.

Eligible providers have yet to receive the balance of their 2014-15 QIVAPP funds, though DOH staff has reported to HCP that funding requests were submitted both to the Centers for Medicare & Medicaid Services (CMS) and the New York State Division of Budget (DOB) in June. Upon receiving approval from DOB, the funds will be distributed as soon as possible to plans without waiting for further action from CMS. Due to the processing time required, providers will not likely receive these funds until the fall.

DOH will soon be coming out with guidance on how the 2015-16 QIVAPP funds will be awarded, and participation will likely be based on 2014-15 eligibility, along with an appeals process for those that were not deemed eligible. HCP will continue to push for the release of the 2015-16 QIVAPP funds as soon as possible.

## HCP Continues to Press DOH on Uniform Billing Codes

One of HCP's major legislative accomplishments last year was passage of a State law requiring uniform billing codes (UBC) for home care services for use in Medicaid managed care reimbursement. While the law was supposed to go into effect on January 1, 2016, the New York State Department of Health (DOH) is still developing the codes.

HCP and other stakeholders have been advising DOH on the development of these codes since last summer. This past May, HCP submitted a final set of recommended codes, modifiers, and service definitions prepared jointly by the home care associations. These codes are currently being reviewed by the managed care plans and DOH, with the goal of finalizing the codes by the end of July 2016. Once they have been finalized, managed care plans will be given a grace period to comply.

The new law also required managed care plans to reimburse providers using electronic funds transfer (EFT) as of January 1, 2016. HCP is continuing to urge DOH to enforce this provision of the law, with which many plans are still not complying.

## NHTD/TBI Waiver Programs Transition to Managed Care Delayed Another Year

The enacted 2016-17 State Budget delayed the transition of the Nursing Home Transition & Diversion (NHTD) and Traumatic Brain Injury (TBI) waiver programs to managed care to January 1, 2018, marking the second time that the transition has been delayed. In preparation for the previous effective date of January 1, 2017, the New York State Department of Health (DOH) convened an NHTD/TBI Waiver Transition to Managed Care Work Group in late 2015, in which HCP has taken part, to draft a transition plan for the waiver populations.

Discussions on the Transition Plan within the Workgroup and subcommittees have led to disagreements between the stakeholders and DOH staff. Workgroup members expressed disappointment in the initial draft of the Transition Plan as it was not consistent with what had been discussed and shared throughout the subcommittee meetings. A revised draft Plan has since been made available on the **MRT 90 website**, and public comments are due by August 24, 2016.

A major point of contention with the draft Transition Plan has been the use of the Uniform Assessment System for New York (UAS-NY) as the tool for assessing eligibility for waiver services under managed care. Advocates and waiver participants continue to raise concerns about the UAS-NY's lack of sensitivity when assessing cognitive impairments, and have cited numerous examples where current waiver participants were deemed ineligible by a UAS-NY assessment, despite their heavy reliance on the waivers' services. Those against the use of the UAS-NY have suggested using the OASIS assessment tool that is used for the behavioral health transition to managed care. DOH staff have moved forward with efforts to improve the UAS-NY's effectiveness through additional training for assessors.

The following services currently included under the NHTD and TBI waivers were included in the draft transition plan to be made available under managed care: Community Integration Counseling (CIC); Independent Living Skills Training (ILST); Positive Behavioral Interventions and Support Services (PBIS); Structured Day Program (SDP); and Service Coordination. Service Coordination will supplement and enhance the care management services provided under managed care, and other waiver services will be provided under the Community First Choice Option (CFCO) in order to maximize the additional Federal Medicaid Assistance Percentage (FMAP) that the State receives through CFCO (see **page 15** for more information).

Alongside the Workgroup process, a number of legislative measures have had an impact on the waiver services' transition. In addition to delaying the transition another year, the Final 2016-17 State Budget ensured that the eligibility criteria for the waiver services remain as they were on January 1, 2015, and that program features be kept "substantially comparable" to what was offered at that time. Senator Kemp Hannon (R-Garden City) and Assembly Member Richard Gottfried (D-Manhattan) also introduced legislation this year, S.6814/A.9397, which would prohibit NHTD and TBI Waiver services from being provided under managed care. The bill passed

the Senate unanimously just before the end of Session, and failed to move forward in the Assembly.

HCP will continue to take part in the stakeholder Workgroup process, and will be submitting comments on the draft Transition Plan this summer.

## HCP Advises State on Value Based Payments for Home Care

Since last year, HCP has been actively engaged in the State's efforts to develop innovative Value Based Payment (VBP) reform models in New York. The New York State Department of Health (DOH) and the Centers for Medicare & Medicaid Services (CMS) have established a goal that 80 to 90 percent of payments to providers be value-based by the end of the five-year Delivery System Reform Incentive Payment (DSRIP) program. Efforts at the national level to move toward a value-based system are also underway.

HCP has reviewed and commented on the State's "VBP Roadmap" and participated in a number of VBP subcommittees and advisory groups over the past year. While most of these groups concluded their work last winter, HCP has continued to participate in the Managed Long Term Care (MLTC) Clinical Advisory Group (CAG) throughout 2016 to develop recommendations for VBP arrangements for the MLTC subpopulation.

The MLTC CAG has focused on identifying and prioritizing key quality and outcome measures to be used in VBP contracting arrangements for long term home care and nursing homes. Recognizing the advantage of selecting measures from those that are currently in use in New York, the CAG focused on the measures for home care that are in use for the MLTC Quality Incentive that was implemented in 2014. Additionally, the CAG prioritized outcome measures that can be measured using data collected through the Uniform Assessment System for New York (UAS-NY). The MLTC CAG's recommended quality measures are currently being finalized and will be released for public review and comment later this summer.

Over the coming year, the State will be inviting proposals from home care organizations that are interested in piloting innovative VBP care models to test and further refine these measures, with the goal of delaying or preventing nursing home admissions and reducing avoidable hospitalizations. DOH has also launched a series of regional **VBP Bootcamps** to educate plans and providers on the basics of VBP and how it can be successfully implemented over the next several years.

HCP will be closely monitoring the development of the State's VBP program for long term home care and advancing recommendations to ensure that home care agencies will be able to successfully engage in future VBP arrangements.

## DSRIP Year 2 Begins, Performance Payments Flowing to Performing Provider Systems

The Delivery System Reform Incentive Payment (DSRIP) program entered Year 2 on April 1, 2016, with a goal to "proceed with fact-based optimism." In Year 2, Performing Providers Systems (PPS) have begun to focus on clinical improvements and necessary system changes. Home care agencies have continued their involvement in the 25 PPSs across the State, although confusion and uncertainty remain regarding their role within the program.

The DSRIP Independent Assessor continued to review PPSs' required Quarterly Reports, with the most recent review completed on the Year 1 Third Quarterly Report. Included with the Reports are the Achievement Value (AV) Scorecards for each PPS, which contain a summary of the AV and associated payments earned by each PPS, as well as details for each project being implemented by the PPS. During the Second Quarter, PPSs earned $165,965,413 (98.5%) of the possible $168,387,230 of the DSRIP waiver funds available, and will be eligible for the third performance payments of Year 1 following completion of the Fourth Quarterly Report of DSRIP Year 1.

Following the submission of the PPSs' DSRIP Year 2 First Quarterly Report, the DSRIP Independent Assessor will begin the Mid-Point Assessment process, which focuses on PPSs' progress toward meeting DSRIP milestones and measures. The Assessment will provide PPSs with recommended DSRIP Project Plan modifications that will be implemented at the start of DSRIP Year 3.

In May, the New York State Department of Health (DOH) hosted a Public Comment Day for Downstate PPSs and the DSRIP Project Approval and Oversight Panel (PAOP), and a similar Public Comment Day will be held in July for Upstate PPSs.

## DOH Advances Community First Choice Option in New York

In December, the New York State Department of Health (DOH) reported that the Centers for Medicare & Medicaid Services (CMS) had approved its application to offer the Community First Choice Option (CFCO) in New York, retroactive to July 1, 2015. DOH is currently in the process of developing an implementation plan for this program. Mark Kissinger, Director of the Division of Long Term Care (DLTC), Office of Health Insurance Programs (OHIP), gave a presentation on CFCO at the February 29 Home Care Forum sponsored by the Community Health Care Services Foundation (CHC), HCP's educational affiliate, providing a general overview of the program.

CFCO aims to enhance the personal care programs offered by the State, while expanding access and availability of long term care services, focusing on person-centered, individually-directed services. The program is intended to be offered in both fee-for-service (FFS) and managed care settings, although recent discussions have indicated that the Department may forgo FFS implementation in order to move forward with operationalizing the program in managed care.

CFCO will be offered through a Traditional Agency Model and an Agency With Choice Model. The Traditional Agency Model will require participants to hire an aide through a licensed home care services agency (LHCSA) or another existing provider, while the Agency With Choice Model will require participants to hire an aide directly, which is similar to the current consumer directed personal assistance services (CDPAS) program. Offering services under CFCO will allow the State to maximize the additional Federal Medicaid Assistance Percentage (FMAP) that it receives.

At this time, DOH has drafted an administrative directive (ADM) on CFCO that was sent to local districts of social services (LDSS) for public comment. The draft has also been shared with the Department's counsel, as well as the Office for People with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), and Medicaid eligibility staff. DOH also hosted a webinar on CFCO in late June to provide an overview of the program to stakeholders, and a Questions & Answers (Q&A) document is forthcoming.

HCP continues to monitor the implementation of CFCO and keep members updated on how it will impact their agencies. More information will be provided as it becomes available.

## DOH Adopts New Regulations on MD Orders, Continuous PCA/CDPAS Services, and Immediate Needs

The New York State Department of Health (DOH) has adopted three new regulations pertaining to home care since late 2015. HCP reviews the *State Register* each week for proposed rulemakings related to home and community-based care, and submits comments when necessary.

Changes were made to the minimum standards for licensed home care services agencies (LHCSA) and certified home health agencies (CHHA) in May when DOH adopted amendments to Section 763.7 and 766.4 of Title 10 NYCRR pertaining to signed physician's orders. The amendments extend the period of time in which home care agencies must obtain signed physician's orders for home care services from 30 days to 12 months, effective May 4. While the 12 month timeframe likely will not assist agencies in obtaining signed physician's orders in a timely manner, it will allow agencies to submit claims for billing after the required 90-day submission period using a delay reason code.

Following years of repeated emergency regulations, in December 2015 the Department adopted amendments to Sections 505.14 and 505.28 of Title 18 NYCRR, as well as the Personal Care Services Program (PCSP) and Consumer Directed Personal Assistance Services (CDPAS) program, to conform the State's personal care services regulations to Social Services Law §365-a(2)(e)(iv). The changes limit Level I services to no more than eight hours per week for those Medicaid recipients that need only that level of care. The regulations also revise the criteria for local districts of social services' (LDSS) authorizations of continuous personal care services (i.e., "split-shift" services) and live-in 24-hour personal care services consistent with the preliminary

injunction decision in *Strouchler v. Shah*, 891 F.Supp. 2d 504 (S.D.N.Y. 2012). Additionally, the amendments revise the definitions and provisions related to PCSP and CDPAS services, the authorization process, factors that must be included in nursing and social assessments, and requirements for the local professional director's review.

In May 2016, DOH further amended Sections 505.14 and 505.28 of Title 18 NYCRR to meet the immediate needs of Medicaid applicants and recipients for personal care services (PCS) and CDPAS. The amendments set forth expedited procedures for LDSSs' determinations of Medicaid eligibility for applicants, and expedited assessment procedures for Medicaid recipients, both with immediate needs for PCS or CDPAS.

## Transportation Assistance Levels Now Effective for Home Care; DOH Conducts Emergency Response Drill

Effective June 1, 2016, the New York State Department of Health (DOH) Office of Health Emergency Preparedness (OHEP) and Office of Primary Care and Health Systems Management (OPCHSM) require home care agencies and hospice providers to include information on the Transportation Assistance Levels (TALs) for each patient on the provider's patient roster. The current TALs category must be listed for each patient and be updated as soon as their status changes.

The TALs provide a Statewide universal tool to rapidly assess and identify home care and hospice patients' transportation needs during planned evacuations and ensure that appropriate transportation resources are deployed. HCP has been engaged in the development of the TALs since 2014, providing feedback on how to best introduce the TALs system for home care. DOH issued a *Dear Administrator Letter* (DAL) in early March that describes the following three TAL levels:

- TAL 1 – Non-ambulatory, those that require transport by stretcher
- TAL 2 – Wheelchair, those unable to walk due to physical and/or medical condition
- TAL 3 – Ambulatory, those that are able to walk without physical assistance

The DAL included an attachment in the form of a **guidance document** for the TALs, explaining the purpose and objectives of the tool, and providing additional details on the three TAL levels.

OHEP and OPCHSM held webinars to introduce the TALs in the home and community-based care setting in February and March, and to provide demonstrations on the recently amended Health Emergency Response Data System (HERDS) surveys issued prior to and during emergency events. Following the webinars, DOH's Division of Home and Community-Based Services (DHCBS) notified providers of an emergency response drill that would be held during the last week of April. Initially, DHCBS had intended to make the TALs mandatory for the drill, effectively pushing up the compliance date by more than a month. After HCP contacted DHBCS with concerns about the accelerated timetable for completing the TALs, DHCBS announced that the TALs would be an optional part of the drill.

HCP has continued to collect feedback from providers on the drill and relay information to OHEP and DHCBS regarding the TALs and HERDS surveys.

# Federal


## White Collar Overtime Exemption

On May 18, the US Department of Labor (DOL) Wage and Hour Division released its Final Rule amending the overtime compensation requirements for executive, administrative, and professional employees, known as the white collar exemption, which will have a significant impact on the home care industry. The Final Rule raises the salary level for the exemption from $23,600 per year to $47,476 per year, more than doubling the previous threshold. The amendments will go into effect on December 1, 2016.

Most businesses will likely have three options to pursue: raise the salaries of these employees to maintain their exempt status; convert their salaried employees to hourly employees and pay overtime on top of their

current salary level when they work over 40 hours in a week; or limit the converted employees' hours to 40 hours per week. In the home care industry where budgets are restricted and largely dependent upon Medicaid reimbursements, the challenges presented by the Final Rule are further complicated as no funding has been allocated for compliance at this time.

The Final Rule also adds an additional provision to automatically update the standard salary level threshold every three years to prevent the thresholds from becoming outdated. DOL will post new salary levels 150 days in advance of their effective date, beginning August 1, 2019.

## CMS Issues Final Rule on Face-to-Face Requirements for Home Health Services

In February, the Centers for Medicare & Medicaid Services (CMS) announced final changes to the Face-to-Face (F2F) Requirements for Home Health Services. The regulation aligns the Medicaid requirements with those of the Medicare program in requiring physicians to document F2F encounters for the authorization of certified home health services, and document that the encounter is related to the primary reason the beneficiary requires home health services. The documentation must occur no more than 90 days before or 30 days after the start of services. The Final Rule does not change the Medicaid regulations that require an individual's physician to review the individual's plan of care every 60 days, and only pertains to home health services, not personal care services.

Additionally, the Final Rule states that for initial ordering of medical supplies, equipment, or appliances, the physician or authorized non-physician practitioner (NPP) must document the occurrence of a F2F encounter with the beneficiary no more than six months prior to the start of services. The Final Rule provides definitions for medical supplies, equipment, and appliances which allow certain items that had not previously been covered to be covered under the state plan home health benefit, and specifies that use of these items may not be restricted to the home setting.

The Final Rule codifies guidance stemming from various court decisions as well, incorporating guidance from the *DeSario v. Thomas* (1998), *Skubel v. Fuoroli* (1997), and *Olmstead v. L.C.* (1999) decisions. As such, the Final Rule clarifies that states may not require an individual to be homebound in order to receive home health services, that these services cannot otherwise be restricted to services furnished within the beneficiary's home, and that states may have a list of preapproved medical supplies, equipment, and appliances for administrative ease, but the list cannot be used as an absolute limit on coverage.

## HCP Submits Comments on CMS Discharge Planning Rule

HCP submitted comments in early January to the Centers for Medicare & Medicaid Services (CMS) on its proposed revisions to discharge planning for hospitals, critical access hospitals, and home health agencies. The revisions stemmed from the enactment of the Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 as well as Federal and State-level initiatives to reduce avoidable hospitalizations and readmissions over the next several years.

HCP's comments focused on the administrative burdens that would result from the additional requirements for home health agencies (HHAs) proposed in CMS' revisions. The proposal requires HHAs to regularly re-evaluate patients for changes that would require revision to their discharge plan; communicate with physicians to ensure they are involved in the discharge planning process; assist patients and caregivers in selecting a post-HHA provider; and create and share discharge/transfer summaries.

HCP expressed support for the requirements' goal to prevent hospital readmissions and keep individuals in their communities, but stressed that the additional requirements would be greatly burdensome without additional financial resources being provided to HHAs. HCP cited years of rebasing cuts to the Medicare Home Health Prospective Payment System (HH PPS), as well as other reductions at the State and Federal levels that have placed HHAs across the country at risk. HCP recommended that CMS streamline its requirements for HHA discharge planning and re-evaluate its estimates regarding the cost burden of the proposed revisions.

Additionally, HCP commented that it will be difficult for HHAs to collect and share the extensive list of information required for discharge/transfer summaries as required in the proposed revisions due to insufficient information technology (IT) resources and capacity among HHAs. To reduce the burdens, HCP recommended that the following items be removed from the list of required items on the discharge/transfer summary: laboratory and diagnostic test and results; consultation results and

procedures not performed by the HHA; immunizations not provided by the HHA; and unique device identifier.

HCP also recommended that flexibility be provided regarding the involvement of the physician responsible for the home health plan of care in the ongoing process of establishing the patient's discharge plan, citing the recent revisions made to the Fully Integrated Dual Advantage (FIDA) program's Interdisciplinary Team (IDT) policy in New York State where greater flexibility in physician involvement was afforded. HCP further recommended that CMS require hospitals to include the patient's current home care provider as an option for their post-acute care in order to maintain continuity of care where possible and to support the goal of preventing hospital readmissions.

CMS has yet to finalize the discharge planning rule, and HCP will keep members notified as more information becomes available.

## CMS Issues Final Medicaid Managed Care Rule

The Centers for Medicare & Medicaid Services (CMS) published its long-awaited Final Rule on Medicaid Managed Care on May 6. The Final Rule included revisions to the Medicaid program and Children's Health Insurance Program (CHIP); Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability.

The Final Rule significantly overhauls regulations governing Medicaid managed care to reflect the expanded usage of managed care delivery systems in states across the country over the past 15 years. The rule includes a number of amendments to modernize the regulations overseeing the delivery of Managed Long-Term Services and Supports (MLTSS) through Medicaid managed care programs, such as measures designed to enhance coordination between settings of care, strengthen network adequacy standards, establish quality assessment and performance improvement programs, and provide support for beneficiaries, including training to plans and network providers on community-based resources that can be linked with covered benefits.

HCP had submitted extensive comments on the draft Medicaid Managed Care rule last July, focusing on aspects of the rule related to MLTSS. While generally supportive, HCP expressed concern that the proposed amendments did not go far enough to address the types of issues that home care providers in New York have experienced in the transition from the Medicaid fee-for-service (FFS) environment to managed long term care (MLTC). Among the key needs that HCP identified were:

- Better alignment of State and Federal regulations for home care;
- Improved standardization among managed care organizations (MCOs);
- Adequate and prompt provider reimbursement;
- Enhanced stakeholder engagement;
- Stronger fiscal oversight of plans, and;
- More protective policies for transition of care.

CMS received nearly 900 comments on the proposed rule and included a detailed summary and response. While CMS did not make any changes in response to comments that were deemed beyond the scope of the proposed rule, including some of the issues HCP raised, CMS noted that it may consider whether to take other actions based on the information or recommendations in the comments.

Much of the proposed Medicaid Managed Care rule remained unchanged in the Final Rule. While some parts of the new regulations merely codify requirements and practices that are already in place, the regulations provide for increased State oversight of managed care plans and additional requirements for plans. These changes will begin to go into effect this year and next. HCP is still reviewing the Final Rule to understand the impact of these regulations on New York's Medicaid managed care program and will share additional information with HCP members as it becomes available.

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