HCA Advocacy Sets Sights on Next Turning Point in State Budget Process

With both houses of the Legislature poised to finish their own budget bills in the coming days, HCA advocacy efforts intensified this week as we worked with the State Senate and Assembly to modify the Governor’s budget and incorporate new proposals that address priority home care concerns.

HCA continued to drive our message in support of major priorities that we have outlined for the Executive, Legislature and membership since the onset of the budget process and, even, prior to it. These include:

- Regulatory streamlining, clarification and alignment;
- Adequate financing for service delivery and mandates, including wage parity, the costs of complying with the federal Conditions of Participation (CoPs) for home care under managed care, the

See BUDGET p. 4

DOH Convenes HCA for Briefing on Wage Mandate Proposal

This morning, state Department of Health (DOH) Finance and Program staff convened HCA and our counterpart provider associations (the New York State Association of Health Care Providers and Leading Age New York) as well as the Managed Long

See WAGE p. 2

President’s 2015 Budget Proposes Copays, Market-Basket Reduction

President Obama this week released a proposed 2015 budget that includes many provisions affecting Medicare and Medicaid, including reductions in the home health market-basket and a home health beneficiary copayment similar to a proposal introduced in the past and soundly rejected by the home health community as a regressive “sick tax.”

See COPAYS p. 5
Term Care (MLTC) Coalition to discuss the Department’s latest proposal to offer partial funding in the MLTC rates to cover the worker wage mandate costs that have increased as of March 1, 2014.

DOH’s plan largely reflects a set of proposals that were previously shared with HCA and allied associations in recent days, including a plan outlined in a draft Dear Administrator Letter that was circulated to the associations but has not been finalized.

As such, the Department’s plan: grossly underfunds wage parity; does not address the core need for specific rate adjustments to Certified Home Health Agencies (CHHAs), Long Term Home Health Care Programs (LTHHCPs) and their subcontracting Licensed Home Care Services Agencies (LHCSAs) in support of wage parity; fails to assure a downstream rate to contracting direct-care providers; does not address cash flow problems faced by home care providers whose contracted rate does not sustain the new wage parity levels; and fails to alleviate major liability issues connected to the attestation mandate for wage parity, which requires providers and plans to certify their compliance with the new wage levels on a prospective basis.

Starting March 1, wages for home health aides increased substantially, along with higher taxes, worker’s compensation and other required payments.

The Department’s proposal allocates $380 million (far below the industry’s and Department’s own cost projections) for the worker wage mandate. The amount is based in part on a purported average cost-factor of $20.83 per hour for home care aide services in the MLTC premiums, and is based on a calculation that understates both the wage payment amount and the home care agency administrative and general (A&G) costs. Just 15 percent is allocated for LHCSA or CHHA A&G, which is far below the actual A&G expenses that are necessary for the delivery of services and operation of these agencies. Moreover, none of the adjusted premium is ensured as a pass-through to the LHCSA or CHHA, but is left to plans and providers to negotiate out in their contracting process.

HCA, our provider association colleagues, and individual providers have communicated to the
Department over the past weeks that this proposal represents a significant underfunding of the state’s mandate. In addition, HCA further communicated that the attestation requirements imposed on providers are untenable and unreasonable, given that funding is not available to cover costs which providers are being asked to certify in those attestations.

The Department, while acknowledging these difficulties, asserted that the state was legally obligated to require providers to submit attestations and that current provider compliance with the March 1 attestation requirement was minimal. HCA has repeatedly advocated for a reasonable level of flexibility for the attestations within those legal parameters, particularly given the lack of resolution on funding or payment.

In response to HCA’s contention that the additional funds are inadequate to cover the costs of wage parity, the Department suggested that providers and plans subject their funding questions to the contract and rate negotiation process. The Department also declined to mandate MLTC pass-through of their adjusted premium to home care agencies in order to ensure due coverage of wage parity and A&G costs.

In addition, the Department suggested that Vital Access Program (VAP) funds be made available for LHCSAs unable to be fiscally viable when complying with the mandate. The Department posited that such LHCSAs seek VAP funding in order to transition their patients to alternative LHCSAs while implementing a closure plan. Consolidation of the LHCSA community is a stated policy goal of the Department, which HCA took strong issue with.

The Department suggested that it would attempt to work with HCA and the other associations on issues of concern to the home care provider community and agreed to a follow-up meeting next week to discuss these issues.

HCA has repeatedly pointed out the flaws, shortcomings and inequities of the Department’s draft proposals for wage parity. We will continue to push at all levels in the current budget negotiations for a payment and financing structure that appropriately reimburses both the MLTC plans and the home care providers employing direct-care workers. We will also notify the membership of any formal announcement from DOH on a wage parity funding proposal.

For more information, contact the HCA Policy staff.

**Seeking a brighter future at one of New York’s top-tier homecare agencies?**

*Then come grow with us!!*

Dominican Sisters Family Health Service, Inc. is seeking an experienced and visionary Chief Financial Officer to join the executive team to develop the Agency’s strategy and positively impact the financial viability across the organization. The CFO will assure that fiscal policies and practices are consistent with professional standards, and goals are in compliance with applicable laws and regulatory requirements. He/she will also carry out the Agency’s mission, philosophy, goals and objectives within guidelines of the Agency policies and position function. The successful candidate will possess a strong strategy and analysis skill set, financial and business acumen, 10+ years of progressive senior financial management, ability to form relationships with internal and external customers, and financial business management of health services. He/she must also have demonstrated experience in the operation of a finance department, creating strategy and systems design in accounting, preferably in a non-profit setting. **Must have home health care experience.** Master’s degree in business administration, finance or accounting, CPA preferred.

Please visit us at [www.dsfhs.org](http://www.dsfhs.org) – Careers Opportunities – for further position details. We look forward to hearing from you so please email resume and cover letter to careers@dsfhs.org or fax to 914-941-4787

**We Welcome Diversity**

DSFHS is an equal opportunity employer
reinvestment of Health Care Reform Act funding into home care, hospice and managed long term care, and discontinuation of prior-year cuts, like the two percent across-the-board Medicaid reduction, as is now under consideration;

- Opportunities for home and community based care under the coming Medicaid reinvestment waiver and the design of Delivery System Reform Incentive Payment collaboration models;

- “Essential Personnel” status for home care and hospice personnel in emergency conditions; and

- Other issues, such as support for telehealth continuity and our opposition to a proposal by the Office of the Medicaid Inspector General (OMIG) to expand the preclaim review/visit verification system to home care-managed care encounters.(See related p. 8 story.)

In our advocacy meetings, calls and other outreach this week, HCA concentrated on our recommendations and appeals for a solution to the March 1 wage parity implementation (including funding, rate payment adequacy, realistic attestation requirements), funding for the CoP requirements in managed care-home care, the insertion of budget amendments addressing the above list of issues, and the rejection of flawed or new burdensome proposals in the Governor’s budget.

Both houses of the Legislature will next move to reconcile their individual budget proposals and then proceed with a platform for engagement of the Executive in negotiating a final budget.

HCA will continue to work throughout the day and weekend ahead to press for home care’s needs and concerns in the developing one-house Senate and Assembly budget bills and resolutions.

It is essential that every HCA member – and your Boards and other local supporters – remain diligent in your grassroots advocacy. Please continue to use HCA’s talking points and other resources at www.powerofhomecare.org for your engagement with the Legislature.

For further information, please contact a member of the HCA Policy Team.

HCA Member Renewal
Time is Here

Contact HCA’s Membership Director Laura Constable for all membership questions at lconstable@hcanys.org or (518) 810-0660.

Nobody wants to walk around with a little bow on their hand. Submit your HCA membership renewal today to keep your ASAP circulation going – and a healthy finger on the pulse of all that’s happening in home care!
The President’s proposed budget was released at the same time that Congress is poised to consider legislation addressing the Sustainable Growth Rate (SGR) cuts in physician payments and other related health policy actions.

For several years, Congress has passed short-term legislative patches – called the “doc-fix” – to incrementally roll back the scheduled SGR cuts to physicians. Those negotiations have routinely put other health care sectors, like home care, at risk for more cuts, taxes or other revenue raisers as a funding offset for the doc-fix.

Legislation now under consider in the House does not currently include funding offsets that would directly affect the home care sector. Instead, GOP House leaders have sought to leverage a delay in implementation of the Affordable Care Act (ACA) as a way of generating funds for a longer term overhaul of the SGR. Such a bill has no future in the Democrat-controlled Senate whose leaders said they would not take up a bill to defund or delay the President’s signature health policy law.

Meanwhile, in the continued volley of election-year politics, the President’s $3.9 trillion budget in turn has little chance of being supported by the GOP-led House. House Budget Committee Chairman Paul Ryan said the plan “isn’t a serious document, it’s a campaign brochure,” drawing a stark line between the Obama proposal and the Republican plan that Rep. Ryan will be issuing next month and which will likely include deeper tax and spending cuts, distinct from the President’s proposal which provides tax credits for lower-income Americans, funded by higher taxes on the wealthy. In the past, Rep. Ryan has also endorsed a voucher-like program for Medicare and a block-grant proposal for Medicaid.

Some of the specific proposals in the President’s budget affecting home care include provisions that would:

- Reduce market basket updates for home health agencies by 1.1 percent in each year from 2015 through 2024.

- Institute home health copayments for new beneficiaries of $100 per home health episode of care, starting in 2018. The copayment would apply to episodes with five or more visits not preceded by a hospital or inpatient post-acute stay. It is estimated to save Medicare $820 million over ten years.

- Implement bundled payment for post-acute care providers, including home care, starting in 2019. Payments would be bundled for at least half of the total payments.

- Implement a budget neutral value-based purchasing program for several additional providers, including home health agencies beginning in 2016. At least two percent of payments would have to be tied to quality and efficiency of care.

- Expand Medicare data sharing to allow qualified entities to use the data for fraud prevention and allow such entities to release raw claims data (instead of summary reports) for purposes of care coordination and practice improvement.

- Create a pilot demonstration to expand eligibility for the Program of All-Inclusive Care for the Elderly (PACE) to individuals age 21 to 55.

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- Invest additional monies for Medicare and Medicaid fraud prevention and the reduction of improper payments.

- Allow civil monetary penalties for providers and suppliers who fail to update their Medicare enrollment records.

- Allow Medicaid Fraud Control Units to receive federal matching funds for the investigation or prosecution of abuse and neglect in non-institutional settings, including home care.

- Provide home and community-based waiver services to children and youth eligible for psychiatric residential treatment facilities.

Some proposals affecting Medicare beneficiaries would:

- Increase income-related premiums for Medicare beneficiaries under Medicare Part B and Part D beginning in 2018.

- Establish a Part B premium surcharge for new beneficiaries who purchase Medigap policies with low cost-sharing requirements starting in 2018

- Increase Medicare Part B deductible for new beneficiaries starting in 2018.

- Integrate the appeals process for individuals dually eligible for Medicare and Medicaid.

More information on the budget is at http://www.hhs.gov/budget/index.html#brief.

As all of these proposals and other budget recommendations occupy the attention of Congress and legislative health staffers in the coming weeks and months, it is essential that the home care community continues to brief New York’s Congressional Delegation on the current fiscal condition of home care providers in New York State and the disastrous impact of further cuts or a copayment on the system and beneficiary access to care.

HCA will be bringing our federal message to Washington on March 25 in conjunction with the National Association for Home Care and Hospice (NAHC) March on Washington and policy conference. HCA members who are already attending the NAHC conference during that week are encouraged to also join HCA policy staff and our government affairs team on March 25 for a special day of legislative visits on Capitol Hill where federal budget issues will be a core focus of our home care advocacy efforts.

If you are already planning to be in Washington on March 25, please notify HCA so that we can provide you with resource documents and schedule appointments for you. Simply contact Jenny Kerbein at jkerbein@hcanys.org as soon as possible and HCA will work with you on logistics.

For more information, please contact the HCA Policy team.
Regional Provider Meetings on Home & Community-Based Care Emergency Preparedness

Starting in April, HCA will be conducting regional emergency preparedness meetings for home care providers across the state to focus on a range of critical topics.

Specific locations will be announced shortly, but meeting dates and regions are below – please save these dates:

Long Island
April 1
9am – 12noon

NYC
April 1
1:30pm – 4:30pm

Syracuse
April 9
1pm – 4pm

Capital District
April 17
10am – 1pm

Hudson Valley
April 25
10am – 1pm

HCA has been collaborating with the state Department of Health’s Offices of Health Emergency Preparedness (OEHP) and Health Systems Management (OHSM) on several areas, including:

- Connection between providers and regional Health Emergency Preparedness Coalitions (HEPCs)
- Addressing regulatory barriers in emergency conditions
- Identifying and addressing special issues associated with flood/coastal zones and other geographic challenges
- Training, competency and use of the Incident Command System in home and community based care
- Transportation Assistance Level (TAL) categories for planned evacuation of patients before an emergency

HCA has also been working with individual HCA members and the Home Based Care Alliance Executive Committee on other areas of need, including: “Essential Personnel” status for home care and hospice workers to access patients in restricted zones and curfews; emergency preparedness and response coordination throughout an integrated health system; special models for emergency response care management; issues for access and care of patients in shelters; and emergency preparedness/response financing.

These and other issues will be discussed during the sessions, which will also provide a critical forum for provider input and recommendations on emergency preparedness and response policies. Member suggestions are welcome in advance of the meetings for any additional items you would like addressed.
HCA Meets with OMIG on Pre-Claim Review Expansion Under Managed Care

Late last week, HCA met with staff from the Office of the Medicaid Inspector General (OMIG) to discuss a proposal in the Governor’s budget to subject managed care claims to pre-claim review.

The specific proposal would extend “pre-claim review” requirements by a verification organization to home care providers, including Certified Home Health Agencies, Long Term Home Health Care Programs or Personal Care providers who have total Medicaid reimbursements—including payments from managed care plans—that exceed $15 million per year. It would also subject “encounters,” in addition to the existing claims requirement, to pre-claim review.

At the meeting, HCA argued against extending pre-claim review to managed care because it was contrary to managed care reimbursement, which is based on monthly premiums and not per service or claim. We contended that any such encounter verification should be left to plan and provider negotiation, which would otherwise represent yet another unfunded mandate when home care providers are reeling from the costs of the worker wage parity, reimbursement cuts, limits on executive compensation and administrative expenses, as well as seismic and costly structural changes due to the shift to managed care.

While OMIG estimated that pre-claim review of home care aide services had yielded annual savings of $100 million, officials said that it could not estimate any projected savings from extending this requirement to managed care services. If the proposal is enacted in the final budget, OMIG will have to determine how it calculates a managed care entity’s “reimbursements” towards the $15 million threshold.

HCA has also had initial discussions with plan and provider associations on this issue and will continue to reach out to other associations.

For more information, please contact the HCA Policy staff.

Upcoming HCA Webinars Focus on Enhancing Your Operation, Surviving a Home Health Survey & More

In today’s challenging health care environment, HCA assists you every day by providing the latest information and guidance on major health care policy issues. Another important way we can help is to provide you with tools to support your overall business operation, so that it is lean, flexible, prepared and efficient enough to succeed during times when resources are tight.

This is another reason why HCA strives to offer you education programming in the most direct way possible: straight to your computer screen via webinar. Webinars save time out of the office, and their low cost provides even greater value when multiple staff participate at once via speaker phone.

See below some of the great webinars coming up in March and April that will support your home care operation. More information and registration are at www.hcany.org/events.cfm.

Surviving a Survey, Avoiding Sanctions: What Every HHA Needs to Know (March 28, April 4, and April 11)

Learn what to expect in a survey to ensure compliance and provide a foundation for quality care. This program will look at new sanctions and help you identify your risks.

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Enhancing Your Home Care Operation: a Four-Part Series

Choose one or more programs below or save by purchasing the series!

April 2: Lean 101

Hear examples of successful outcomes achieved by a provider who implemented “lean thinking” processes that resulted in streamlined paperwork, reduction of unnecessary steps and improved outcomes.

April 17: Strategic Planning

Learn how strategic planning can help you remain successful in today’s post-acute environment. Agency leaders will learn about specific and actionable items that can be implemented immediately as well as how to create a roadmap for success.

April 25: Executing a Plan for a 100% Paperless Agency

Learn how a home health agency formulated and executed a 100 percent paperless office resulting in increased profit margins, streamlined job processes and greater job satisfaction.

May 15: A Life Skills Advocate Program to Improve Staff Retention

Home health aides are a vital asset in improving the health and quality of life of the patients they care for, yet job turnover is often high in this occupation, due to multiple factors. To address turnover rates, Visiting Nurse Service (VNS) of Rochester has successfully implemented a Life Skills Advocate Program that works to prevent the kind of issues which would otherwise place an aide in disciplinary action. Learn more about this proven program, which has decreased turnover and improved the work environment of aides.

Leadership Skills for Success (April 16)

This is the last program in a series to help you improve your agency. This program will review what skills a leader needs in these demanding times in health care.

Development, Implementation and Evaluation of a Psychiatric Home Care Evidence Based Practice (April 30)

Discuss the prevalence of psychiatric symptoms in the home-bound elderly and learn how to launch an effective depression care evidence-based practice in your organization.

Registration information for each of these programs is available at www.hcanys.org/events.cfm. Phone lines are limited for each program, so early registration is encouraged. Prior to each webinar you will receive an e-mail containing your log-in information and handout materials.
State Initiating MLTC Quality Incentive Program

The state Department of Health (DOH) is initiating a quality incentive payment program for Managed Long Term Care (MLTC). In its present concept, the initiative would provide a payment to MLTC plans based on a composite score of quality, satisfaction, compliance and efficiency performance measures.

HCA is participating in a DOH-convened workgroup charged with advising DOH on the selection and use of the quality measures for this program. The workgroup met for the first time last Friday afternoon.

The workgroup discussed data sources and preliminary criteria. These include data from: the Universal Assessment System; satisfaction measures from biennial surveys of members; compliance measures based on timely submissions of required reports or assessment information; and efficiency measures such as potentially avoidable hospitalizations.

DOH’s current timeline would have the quality incentive run in September 2014, with an October 2014 release of results. Proposed retroactive rate adjustments would be applied for the April 1, 2013 through March 31, 2014 period, to be processed on or before January 1, 2015.

HCA Quality Committee Input

HCA will be bringing this initiative to the HCA Quality Committee to help shape our input.

The HCA Quality Committee worked last summer and fall to pinpoint and analyze quality measures for the managed care-home care service delivery model. HCA engaged the Department’s Office of Quality and Patient Safety in that process, which led the Department to invite our recommendations. HCA and Committee members presented those recommendations last November and have been pursuing additional ideas with the Department since that time.

Quality measurement and quality of care issues have been a focus area of HCA and the home care community, particularly with the major transition of home care to managed care – a subject of significant HCA legislative, policy, budgetary and grant initiatives, as well as our education programing.

Look for more information on this new MLTC initiative as well as other elements of HCAs quality agenda.

For further information, please contact Al Cardillo at acardillo@hcanys.org.

PRI/SCREEN Not Required for NHTD after April 1

During a Traumatic Brain Injury/ Nursing Home Transition Diversion (NHTD) Stakeholder call with the state Department of Health (DOH), DOH reported that the PRI/SCREEN assessment instrument will no longer be required for NHTD participants as of April 1. The U.S. Centers for Medicare and Medicaid Services (CMS) has approved New York’s request to replace the PRI/SCREEN with the Uniform Assessment System tool. DOH will be releasing instructions sometime this month and providers should wait for this guidance before changing their practices.

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

DOH Posts FAQs on ICD-10 Implementation

This week, the state Department of Health (DOH) posted updated frequently questions and answers (FAQs) to its eMedNY website regarding the upcoming ICD-10 implementation. The ICD-10 FAQs can be found at https://www.emedny.org/icd/FAQs.aspx and provide extensive information on ICD-10 and a variety of available resources. The October 1, 2014 ICD-10 implementation date is less than seven months away and providers who may be behind with their transition really need to expedite their efforts to ensure compliance.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.
State Explores Use of ACOs as Managed Care Option

HCA participating in legislatively-established ACO workgroup

Under a state legislative directive, the state Department of Health (DOH) is exploring the potential use of Accountable Care Organizations (ACOs) as a consumer enrollment option in addition to traditional managed care. The Department is examining this issue at the same time as it is also working to formulate, refine and issue regulations for ACO models in the state.

State legislation, Chapter 461 of 2012, as amended by Chapter 6 of 2013, established a workgroup to consider whether ACOs should be enabled to serve, in place of a managed care plan, Medicaid enrollees otherwise required to participate in managed care, care management or care coordination, as well as enrollees of the state’s Family Health Plus and Child Health Plus health plans. HCA has been selected to participate on the workgroup.

This week, representatives of the Department of Health and the Department of Financial Services (DFS) – formerly the Department of Insurance – convened the first meeting of this workgroup. In the meeting, the state agencies presented an overview and status report on ACO development, operation and requirements in New York State.

DOH and DFS officials reviewed an extensive set of organizational, consumer, quality and financial requirements applicable to ACOs. A discussion point centered on permissible financial risk arrangements for ACOs, and the extent to which ACOs could accept risk in their own right, versus only being permitted to do so as a subcontractor to managed care or by meeting insurance plan qualifications.

A representative of the Montefiore Health System in the Bronx presented its ACO and experiences to date, showing the opportunities for system efficiency, value and quality as result of the networking and partnership achievable through an ACO.

Assemblyman Richard Gottfried, Chair of the Health Committee and sponsor of the ACO legislation, stated his interest (commensurate with the workgroup’s charge) in exploring the ability of ACOs to serve as an option alongside managed care, including as a direct contractor with the state, instead of as a subcontractor to a health plan. Workgroup members offered some preliminary perspectives on this option.

The issue seems highly reminiscent of the 2011-12 discussions that surrounded “Care Coordination Models” under the mandatory managed care enrollment plan and whether such models – like Long Term Home Health Care Programs, ACOs and health homes – could operate as provider-based options alongside managed care. Nevertheless, DOH ultimately took a different route, publishing criteria for Care Coordination Models to effectively match the managed care plan model, meeting all of the requirements under the insurance law.

DOH asked for further input by mid-March and is expected to republish its proposal in revised form and with a summary of public comments. ACO representatives on the workgroup encouraged DOH to pursue finalization of the ACO regulations, while also continuing to discuss the ACO option under the workgroup charge.

The DOH presentation can be viewed at http://www.hca-nys.org/documents/ACOPP.pdf.

The next workgroup meeting is currently planned for April, but may shift depending on the timetable for the regulations.

ACOs are one of several new models evolving within the state’s health care system. HCA will be convening a special conference providing background on these models and the opportunities for home care.

For further information, please contact Al Cardillo at acardillo@hcanys.org.
Submit Nominations Now for HCA Awards

Exceptional people are pretty easy to find in the home care world. Think for a moment about the top five people at your agency who inspire you and surely that list gets filled up pretty quickly.

You recognize the great work that these people do, their patients know it, patients’ families know it ... but the public doesn’t always get to hear such wonderful stories of heroism, compassion and dedication. As a community, it is important for those of us in the home care field to recognize and honor the excellence that is among us, and to tell the public about it.

HCA has opened up the nomination process for our 2014 annual awards in three categories: our Caring Award, our Advocacy Award and our highest honor, the Ruth F. Wilson Award, for a nominee who has made a lasting and profound difference in the home care arena on a broad level.

Virtually any level of direct-care, management, and leadership staff are eligible for one of these awards, which will be presented to winners at the HCA Annual Conference on May 9 in Saratoga Springs. The theme of this year’s conference is Harnessing the Power of Home Care.

In keeping with this theme, we invite all members to nominate staff or a colleague to take the podium as an honoree at our “Winners Circle” on May 9. (A preliminary agenda and registration form for the conference are already posted at www.hcaannualconference.com.)

In submitting award nominations, members should give consideration to an individual, group of people or an organization that has made an impact on the home care industry, and the patients and clients you serve.

Recent award winners have even gotten great attention in the press, which is an important way to tell the home care story to the public. For instance, click http://youtu.be/RjLAQvLAcA to see a YNN news report about HCA’s 2012 Caring Award winner Patricia Scully, a home health aide at St. Francis Home Care Services. Ms. Scully’s story provides a great example of the kind of candidates we are looking for as you consider exceptional staff at your agency to nominate for an HCA award.


HRA Clarifies Spousal Refusal Policy

The New York City Human Resources Administration (HRA) has issued instructions to clarify that a community spouse of a nursing home resident is entitled to the community spouse monthly income allowance (CSMIA) even if the community spouse submits a spousal refusal to contribute resources.

The instructions change HRA’s practice to deny the community spouse this income allowance if he or she executed a spousal refusal.

The new directive, at http://www.wnylc.com/health/download/465/, indicates that the community spouse is entitled to the CSMIA even if he or she does a spousal refusal and provides complete information regarding income and resources.


OMIG Posts FAQs on Governing Boards and Program Integrity

The Office of the Medicaid Inspector General (OMIG) has posted frequently asked questions (FAQs) for Webinar No. 19, “Governing Board’s Role in Program Integrity.”


The FAQs cover the role of boards of directors in approving all policies and procedures; compliance training for boards; and practical tools used by compliance officers to get board engagement.
HCA’s CFO Forum is Next Week: Don’t Miss Out on Vital Finance Updates to Help in Your Strategic Planning

Are you looking for the latest update on the state’s complex plan to fund wage parity levels in the state budget so that you know what these factors mean for your agency’s bottom line in the year ahead?

Would it be helpful for your finance manager to gain – all in one place – technical information directly from the state Department of Health on: the Medicaid rate and cost report process, Certified Home Health Agency (CHHA) Episodic Payment System, the premium rate calculations for managed care, and other state budget updates that will inform your budgeting expectations?

Has Medicare rebasing left you wanting answers, benchmarks and best-practice tips on how to operate most efficiently and sustainably in the current Medicare Prospective Payment System (PPS) environment?

Would you benefit from hearing what Managed Long Term Care finance managers have to say about their financing expectations and prominent system developments affecting their decisions today and in the future?

HCA’s CFO Forum will grapple with all of these issues and more on March 13 – just a few days away and right in the thick of state budget negotiations, providing you and your finance staff with the latest information on the landscape ahead.

Be sure to register now for this important event that will benefit all home care executives, finance managers and other staff involved in the fiscal management and finance-related strategic planning at your organization. A registration form and agenda are available at the end of this week’s ASAP.

This important Forum is for HCA members only. A nominal registration fee of $40 will help HCA cover the costs of the Forum speakers, lunch and valuable handout materials. However, as a special offer, attendees who also register this fall for HCA’s Senior and Financial Managers Retreat on September 9 and 10 in New Palz will have the opportunity to receive a special rebate deducting this $40 fee when registering for the Retreat. (More information on this rebate will be provided at next week’s Forum.)

DOH Approves Hospice Medicaid Rates

The State Department of Health’s (DOH’s) Bureau of Long Term Care (BLTC) Reimbursement this week approved and published Medicaid Hospice Residence base rates and the Recruitment, Training and Retention (RTR) add-ons, for each calendar year from January 1, 2010 through December 31, 2013.

DOH’s BLTC Reimbursement also approved and published the Medicaid Hospice Care and Medicaid Hospice Supplemental Financial Assistance Program base rates and both the Worker Recruitment and Retention (WRR) and Recruitment, Training and Retention (RTR) add-ons, for the periods October 1, 2012 through September 30, 2013 and October 1, 2013 through September 30, 2014.

DOH mailed each Hospice in the State a Dear Administrator Letter (DAL) which provides additional details about these updated Medicaid rates and attached the hospice specific Medicaid rates to each DAL.

Continued on next page
OMIG Resumes Semiannual TPL Process Using Traditional Appeals

The state Office of the Medicaid Inspector General (OMIG) is resuming its semi-annual demand billing process for claims in the second half of Federal Fiscal Year (FFY) 2013.

With the expiration of the Third Party Liability (TPL) Demonstration Project after FFY 2010, OMIG has returned to a traditional Medicare appeals process for FFY 2011, 2012 and 2013 claims.

Details of this ongoing traditional appeals process are outlined in a letter that most Medicare-certified home care providers (Certified Home Health Agencies and Long Term Home Health Care Programs) should have received from OMIG and its TPL contractor, the University of Massachusetts Medical School (UMMS).

The letter identifies which cases have been selected to undergo appeals. The “Case Selection Report” accompanying the OMIG/UMMS letter will seek demand bills for cases that occurred in the third and fourth quarter of FFY 2013 only (April 1, 2013 through September 30, 2013).

If your agency is selected for future quarterly initiatives, a separate notification letter and “Case Selection Report” will be sent at that time.

For specific questions about the letters, contact UMMS’s Laurie Burns at (866) 626-7594.

HCA’s Advocacy

HCA continues to stress to federal officials at the U.S. Centers for Medicare and Medicaid Services (CMS) that a permanent solution is needed to mitigate the burden of this traditional appeals process. We will keep the membership closely apprised of any developments in this process.

In the past few days, HCA has heard from more than a handful of members who have seen a dramatic increase in the number of cases selected as compared to the first half of FFY 2013 or in FFY 2012. If you have seen a significant increase in the number of cases selected, please e-mail pconole@hcanys.org with additional details. HCA has a call and e-mail into UMMS to see if anything has changed in its overall selection process.

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

DOH will also be posting in the near future the updated Medicaid hospice rates for each hospice to its public website located at: http://www.health.ny.gov/facilities/long_term_care/reimbursement/hospice/.

Finally, DOH has sent all of the updated Medicaid hospice rates to the Division of Program Operations and Systems for payment. Providers can usually expect these rates to hit the Medicaid system in the next two to three weeks.

For specific questions about your updated Medicaid Hospice rates, contact DOH’s Timothy Casey at (518) 473-4421.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.
HRA Issues Two Medicaid Alerts on HIPAA, Spousal Impoverishment

This week, the New York City Human Resources Administration (HRA) posted two Medicaid Alerts – one on the Health Insurance Portability Accountability Act (HIPAA) and the other on spousal impoverishment and transfer of asset rules.

Both Alerts are at http://www.nyc.gov/marc (sign in required).

The first Alert informs providers that there is a new mailing address for submitting record requests to the Medical Assistance Program and the Home Care Services Program. The address is Human Resources Administration, MICS, 785 Atlantic Avenue, Brooklyn, NY 11238, Attention: MICS HIPAA Official.

The second Alert advises that all individuals enrolled in a Managed Long Term Care (MLTC) plan with a spouse residing in the community who is not participating in a home and community-based services (HCBS) waiver program or enrolled in an MLTC must have Medicaid eligibility determined under the spousal impoverishment rules that apply to HCBS waiver participants if that is the most favorable budgeting.

The Alert also discusses the treatment of patients with a monthly surplus and the applicability of transfer of asset rules for individuals who receive long term nursing facility services.

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

DOH Issues Guidance to MLTCs on Disbursement of Health Recruitment & Retention Funding

The state Department of Health (DOH) this week posted within its Medicaid Redesign Team (MRT) website a policy guidance to Managed Long Term Care (MLTC) plans to clarify the appropriate use of Health Recruitment and Retention (HR&R) funding, as per New York State Public Health Law (PHL) Section 3614.10.

DOH’s guidance also establishes a process requiring plans to separately account for the receipt and disbursement of HR&R funds for each funding cycle and the reporting of such to DOH.

Furthermore, the guidance states that in accordance with PHL Section 3614.10, MLTC plans that have their capitation premium rates adjusted pursuant to this subdivision are required to ensure that the use of such funds are solely for the purposes of recruitment, training and retention of non-supervisory home care services workers or other personnel with direct patient care responsibility.

This also applies in cases where these services are provided by agencies or programs through contracts with providers to support the recruitment, training and retention of non-supervisory home care services workers or any worker with direct patient care responsibility employed by Certified Home Health Agencies (CHHAs), Licensed Home Care Services Agencies (LHCSAs), Long Term Home Health Care Programs (LTHHCPs) and personal care services agencies under contract with MLTC plans.

Additionally, MLTC plans are required to submit to DOH a written certification attesting that such funds will be used solely for the purposes of recruitment, training and retention of non-supervisory home health aides or other
personnel with direct patient care responsibility and shall maintain in their files expenditure plans specifying how such funds will be used for such purposes.

Finally, the Department is authorized to audit each MLTC Plan to ensure compliance with the written certification and recoup any funds determined to have been used for purposes other than that described above. The recoupment shall be in addition to any other penalties provided by law.

DOH’s policy guidance to MLTCs can be downloaded at:

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

HCA Participates in NGS Home Health Advisory Meeting

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC) for Jurisdiction 6 (J6), conducted a Home Health Advisory Meeting yesterday via conference call for the state associations in U.S. Centers for Medicare and Medicaid Services (CMS) Regions I, II, V, IX and X. HCA participated in the meeting and received important updates, posed questions and advocated on behalf of the membership.

HCA today shared with the membership a memorandum summarizing key updates provided by NGS staff at the meeting as well as information acquired by HCA on issues of particular importance to New York State, including:

- Comprehensive Error Rate Testing (CERT) data review
- Medicare home health utilization data and top diagnoses codes
- NGS advisory group review of upcoming education sessions
- Remaining NGS Fiscal Year 2014 Education Sessions

Other NGS News

NGS has also posted the following news/education programs to its website.

- April 2014 Release “Dark” Days for the Common Working File (CWF) – For the upcoming April 2014 Release, CWF Part A Claim Record Expansion, the CWF Hosts will be performing a history conversion. Due to the anticipated duration of this activity and to ensure the completion of the history conversion, there will be one “gray” day occurring on Thursday, April 3, 2014, and two “dark” days on Friday, April 4, 2014 and Saturday, April 5, 2014, while the CWF Host gets updated.

- Providers Submitting Electric Claims Are Not Permitted to Submit Paper Claims – The Administrative Simplification Compliance Act (ASCA) requires providers, with limited exceptions, to submit all initial claims for reimbursement under Medicare electronically. If a provider is reviewed and determined to meet the exceptions to ASCA, they may bill Medicare using paper claims. However, if providers do not meet the ASCA exceptions, they must file Medicare claims electronically.

Please note that if you are established to submit Medicare claims electronically, you are not permitted to submit paper claims unless you meet the requirements of an ASCA-approved waiver (e.g., breakdown or interruption in telephone or communication service or another approved unusual circumstance
preventing electronic claim submission). Violation of the ASCA statute or rule can subject a provider to claim denials, overpayment recoveries, and applicable interest on overpayments. For more information on ASCA, please visit the ASCA section of NGS’ website.

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

Publications

“Spousal Impoverishment Protections Available in Managed Long Term Care and other ‘Waiver’ Programs,” by the New York Legal Assistance Group

http://www.wnyc.org/health/entry/165/
HCA’s CFO Forum is a must-attend session for home care financial managers, CFOs and other executive staff to hear from HCA policy staff, state Department of Health (DOH) officials, and industry consultants on home care fiscal issues. HCA staff will discuss our ongoing advocacy efforts on the 2014-15 State Budget and our upcoming Federal Advocacy Day. HCA staff will also provide participants with a demonstration of the powerful Salient Medicaid data software tool which HCA has begun using for our own data analysis. The Salient software allows users to create sophisticated reports analyzing billions of various Medicaid transactions by diagnosis, cost, demographics and more.

DOH staff will provide updates on: the upcoming premium rate adjustments to Managed Long Term Care (MLTC) and Mainstream Medicaid Managed Care plans, Wage Parity adjustments to plans and home care providers, the CHHA Episodic Payment System (EPS) and other fee-for-service Medicaid rates, upcoming 2013 Medicaid cost reports, and the Medicaid Global Cap.

William Simione III, will provide participants with a detailed presentation on the Calendar Year (CY) 2014 Home Health Prospective Payment System (PPS) that includes numerous changes due to the rebasing of PPS. He will also summarize key changes and provide best practice tips on the 2014 PPS, as well as review the latest aggregate home health benchmarking and average cost data from state and national providers participating in the Simione Financial Monitor.

Finally, HCA has brought together a panel of financial officers from MLTC plans to discuss key system developments and proposals currently in the mix. Panelist will provide their perspectives on key MLTC fiscal issues, needs, challenges and future directions.

Please do not miss out on this robust program which delves into several important areas relevant to your agency’s fiscal health.
HCA Registration & Continental Breakfast – 9:00am – 9:30am

HCA Update – 9:30am – 10:00am
HCA staff will provide a state legislative update, which will focus on the 2014-15 proposed Executive Budget and its impact on home care along with an update on advocacy efforts in Albany and Washington. HCA staff will provide highlights of our Annual Financial Condition Report as well as discuss the latest Wage Parity mandates, possible changes in the gross receipts tax and the CY 2014 Medicare Prospective Payment System (PPS).

HCA Demonstration of the Salient Medicaid Data Software – 10:00am – 11:00am
HCA staff will also provide participants with a demonstration of the powerful Salient Medicaid data software tool which HCA has begun using for our own data analysis. The Salient software allows users to create sophisticated reports analyzing billions of various Medicaid transactions by diagnosis, cost, demographics and more. Participants will have an opportunity to recommend focus areas for HCA’s data analysis.

Department of Health Update – 11:00am – 12:00pm
Tim Casey, Bureau of Long Term Care Reimbursement
James DeMatteo, Bureau of Managed Care Reimbursement
Mr. Casey and Mr. DeMatteo will provide updates on the following: provisions in the 2014-15 State Executive Budget that impact home care, personal care and Medicaid managed care; the upcoming premium rate adjustments to Managed Long Term Care (MLTC) and Mainstream Medicaid Managed Care plans, Wage Parity adjustments to plans and home care providers, the CHHA Episodic Payment System (EPS), LTHHCP and Personal Care fee-for-service Medicaid rates, the 2013 Medicaid cost reports and other Medicaid reimbursement issues.

Lunch – 12:00pm – 12:45pm

Simione Consultants’ CY 2014 Medicare PPS Review – 12:45pm – 2:00pm
William Simione, III, Principal, Simione Consultants
During the session, Mr. Simione will provide an in-depth review of the U.S. Centers for Medicare and Medicaid Services’ (CMS) Calendar Year 2014 for the Home Health Prospective Payment System (PPS) including a detailed summary of CMS’s rebasing of the PPS methodology. Mr. Simione will examine how drastically the CY 2014 PPS has changed while offering best practice tips for adapting to those changes and forecasting in the future. The session will also provide participants with the latest aggregate benchmarking data for Medicare PPS, Medicaid EPS and managed care from clients of Simione’s Financial Monitor.

MLTC Financial Issues Panel – 2:00pm – 3:15pm
Eric Price, Chief Financial Officer, VNS Choice
June Castle, Chief Financial Officer, VNA Homecare
HCA has brought together a panel of financial officers from Managed Long Term Care (MLTC) plans to discuss key system developments and proposals currently in the mix. Panelist will each provide their perspectives on key MLTC fiscal issues, home care needs, challenges and future directions.

Adjournment