
HCA’s 2015 state Home Care Financial Condition online survey is ready for your answers now. We need your responses as soon as possible for our 2016 advocacy – and no later than January 15. To begin the survey, please take the following steps:

- Click the survey link at https://www.surveymonkey.com/r/2015HomeCareFinCondSurvey.
- Once there, please download the PDF instructions to make sure you are completing the survey correctly. (Please read these instructions carefully before starting the survey.)

HCA, DOH Meet on Immediate Need for Home Care Funding

On December 8, HCA and other provider associations met with the state Department of Health (DOH) to discuss the urgent need for financial support to meet new costs under overtime, travel, 24-hour live-in cases, wage parity, Workers Compensation and other labor-related expenses.

HCA Offers New Marketing, Sponsor & Exhibitor Opportunities for 2016

Providers, vendors, consulting firms are invited to read and share our 2016 Marketing Prospectus to support HCA education – and promote your brand!


This coming year, we are offering several brand new opportunities, and an expanded range of benefits in
MARKETING from p. 1

several sponsorship categories. You can sponsor at six bundled levels (Titanium, Platinum, Gold, Silver, Bronze and Friend) and/or pick and choose from an exciting array of new a-la-carte sponsorship options that include:

- New advertisement options on HCA's website home page and education page; in our e-mail alerts to thousands of home care contacts; and in print communications like our weekly newsletter which reach thousands of readers.

- Support for the work our Board of Directors as a sponsor during special receptions and meetings.

- Wi-Fi sponsorship at HCA's signature events, with special recognition through your own custom code link that brings Wi-Fi coverage to event attendees – and...
recognition to your organization for this highly valued service!

- Opportunities for logo placement on hotel key cards, promotional inserts in conference materials and custom signage at HCA events.

These are just a few of the a-la-carte options available to you, along with a greatly expanded package of benefits for our bundled sponsorship levels, as well as new benefits for exhibiting at HCA events.

All of these opportunities have been designed to offer you greater flexibility to select a sponsorship and exhibiting package that best supports your engagement goals.

Whether you are a technology vendor, a home care business consultant, or a provider organization, we invite you to reinforce your vital partnerships with the home care community by sponsoring and exhibiting at our Annual Conference, other HCA signature events and through vital communications links to the HCA provider membership on our website, e-mail alerts and in our newsletter.

To further explore HCA’s 2016 marketing opportunities, please contact Billi Hoen, CMP, Meetings and Events Manager at (518) 810-0666 or bhoen@hcanys.org.

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It’s Membership Renewal Time: Reserve Your ‘Admission to HCA 2016’ Today

Over the past two weeks, HCA has sent targeted membership renewal e-mails to our provider members and specific subsets of providers (such as county-based home care agencies and Home Care Council of HCA members), as well as vendor and associate members.

Your organization’s main contact should have received these messages, with simple instructions for renewing your HCA Membership in 2016 using an online form that makes renewing easy – with a few button clicks.

Our theme this year is “Admission to HCA 2016.” As a 2015 member, the admission ticket to HCA membership in 2016 awaits you; all you need to do is reserve your order for continued membership online.

We will be sending follow-up e-mails and renewal information throughout the coming weeks and we encourage you to renew as soon as possible so that you can continue having access to HCA staff, our resources, our discounted education programming, our free member informational sessions, our communications, and our advocacy on your behalf.

If you have any questions about membership, please do not hesitate to contact HCA’s Senior Membership Director Laura Constable at lconstable@hcanys.org.
Hiring

Title: Director of Patient Services
Organization: Winthrop University Hospital Home Health Agency

Winthrop seeks a Director of Patient Services for the CHHA, which services Nassau, Suffolk and Queens. The DPS is responsible for the administrative, professional and clinical operations of the agency. Minimum qualifications include: BSN, NYS RN license, two years of professional nursing experience, two years of supervisory experience in a CHHA or related program, Master’s degree preferred.

Send résumés to Anne Calvo via e-mail to acalvo@winthrop.org.

Patient Relations Manager

Americare, New York’s leader in home health care, seeks a high energy, dynamic, self-starter for an exciting career opportunity in its patient relations department. The Patient Relations Manager’s primary responsibility will be to develop relationships and educate MDs about home care and the benefits to their patients. The ideal candidate will have 2-3 years home care or pharmaceutical experience. An excellent compensation and benefits package is offered, including: 401K with company match, medical, dental and direct deposit.

E-mail résumé to hrrecruiter@americareny.com.

Title: Chief Financial Officer / Controller
Organization: Westchester Visiting Nurse Services Group/VNSW/WCAH

Westchester Visiting Nurse Services Group (VNSW/WCAH) seeks a Chief Financial Officer / Controller for its group.

The CFO/Controller will oversee all financial operations of the agency, including billing and payroll. The CFO/Controller would also coordinate the preparation of the budget and financial projections. Minimum qualifications include: At least 10 years of experience in health care finance, with at least 5 years in a financial leadership position. Knowledge of McKesson is a plus. Must have strong organizational and leadership skills. Send résumés to Kristine Giglio via e-mail to kgiglio@vns.org.

Why We Need You to Complete this Survey

This survey is a linchpin of our state advocacy efforts. It informs the resource documents, arguments, and data from providers that we will be sharing with legislators, the state Health Department and the Governor’s office as we advocate on your behalf this coming year. Last year’s survey culminated in a special report about the fiscal and regulatory pressures confronting you. Click the link below for last year’s report:


The survey asks 30 questions including several new ones related to current developments like the Delivery System Reform Incentive Payment Program, the impact of new federal overtime requirements (“companionship exemption” changes), CHHA Medicaid Episodic Payment System rebasing, and more.

This survey gives you a chance to have your voices heard on these and other pressures created by system changes in New York State. All answers will be used in the aggregate, and no agency-specific identifying information will be shared.

The survey due date is January 15, but we ask for your responses as soon as possible so that we can start reviewing the data and preparing our resource documents for HCAs February 2 State Advocacy Day (more details on this program coming soon).

If you have any questions, do not hesitate to contact HCAs Communications Director Roger Noyes at rnoyes@hcanys.org. If there are ways we can make this survey process easier for you, please let us know. Thank you for your participation.
FUNDING from p. 5

DOH discussed its recent proposal to set aside funding to meet some of these new obligations under the Fair Labor Standards Act (FLSA) final rule, with HCA and others posing questions and recommendations, and emphasizing the financial pressures endured by home care providers and managed care plans necessitating immediate relief.

DOH also reported that multiple divisions within the Department – as well as Mercer (the DOH-contracted actuary for managed care premiums) – are also closely reviewing and considering HCA’s proposal (covered in prior editions of ASAP) to create a set-aside/stop-loss pool to more accurately and fully fund these additional labor expenses for managed care plans and providers. Our proposal also calls for using this real-time, experiential data as a basis for truer premium and rate adjustments.

This proposal is an alternative to premium adjustment calculations which would be difficult to compute and possibly lead to underfunded premiums and home care provider payments.

Funds coming to managed care in January

Meanwhile, DOH confirmed that, as per its November 9 “Dear Colleague Letter” (see November 13 ASAP), the state’s goal is to make a premium adjustment to the managed care plans in January (not in December as outlined in the Letter) for the new FLSA overtime, travel and live-in costs.

DOH said it would issue guidance and instructions to managed care plans about passage of funds through to home care agencies and workers (see additional information in the “Managed Care Update” story in today’s ASAP, p. 8).

DOH emphasized that it will advance the state-share ($0.17) of the proposed $0.34 total per hour increase and will be proposing that the federal government match the state amount. It also described plans to increase the fee-for-service rates for CHHAs (episodic and non-episodic), LTHHCPs, and personal care providers as part of Recruitment and Retention funds to account for the new FLSA costs.

The total cost of funding is projected at $100 million; but DOH could not say if it would be part of the Governor’s 2016-17 proposed budget.

Once initial state funds are distributed, the state may ask its actuary, Mercer, to survey home care providers on the real-time impact of the FLSA changes. DOH solicited HCA’s assistance in developing survey questions, and HCA asked and DOH agreed to share a draft of any survey prior to posting for completion.

DOH did not indicate whether there would be any reconciliation/process, whereby agencies would have to demonstrate that they used the funds for overtime, travel and other defined services.

HCA, DOH discuss survey findings on provider-plan impact

At the meeting, HCA and fellow associations shared with DOH the initial findings of our joint survey on overtime and travel expenses. The survey found that, in addition to payroll increases, providers expect increases in costs for: training, travel, advertising for new recruitment; additional staff for new recordkeeping/monitoring; workers compensation, disability, health pension and union benefits; information technology and software; and others.

DOH said its survey of managed care plans and their home care contractors found that about 11 to 12 percent of home care cases include overtime. All parties agreed it is difficult to accurately determine the cost of FLSA changes, due to practice changes, lack of accessible data, and other complicating factors.

BIP funds for FLSA costs

In a related matter, DOH reported that Balancing Incentive Program (BIP) funds – to compensate fiscal intermediaries (FIs) for their new FLSA costs under consumer directed personal assistance services – should be going to FIs in their 12/30 Medicaid billing payment cycle.

Later today, after ASAP went to press, HCA and the other Associations were planning a follow up meeting with additional DOH finance staff to obtain further details on the distribution of funds for FLSA costs. HCA will report on any new information that comes out of that meeting in next week’s ASAP.

For more information, contact the HCA Policy staff.
Wanted: Home Care Visionary Leaders for Positions on HCA's Board of Directors

*Deadline is December 15: apply or nominate today*

The HCA Nominating and Governance Committee is seeking applications for members on HCA's main governing unit, our Board of Directors, which is an exceptional opportunity for a visionary home care leader to influence the strategic direction of our organization and serve with distinction on behalf of New York's entire home care industry.

Applicants should have demonstrated leadership potential, a strong interest in public policy and advocacy, and commitment to promoting and implementing a vision and strategic policy direction for the home care industry and the Association.

HCA's Board of Directors is comprised of members from regions throughout the state of New York who represent a variety of provider members including LHCSAs, CHHAs, MLTCs, LTHHCPs and Hospices. If you haven't considered serving on the Board in the past, please consider doing so today to be a part of this elite group.

Candidates are asked to complete and submit the PDF application at the back of this week's ASAP or visit [https://www.surveymonkey.com/r/2016BoardNomination](https://www.surveymonkey.com/r/2016BoardNomination) to submit an application online.

The deadline for submission is **December 15**. All candidates for consideration must be affiliated with an HCA member organization.

If you have questions regarding the application or nomination process, please contact Jenny Kerbein, Director of Governance, at jkerbein@hcanys.org, or at (518) 810-0659.

NGS Launches F2F 'Probe-and-Educate' Audits

This week, National Government Services (NGS), New York's Medicare Administrative Contractor (MAC), began its Medicare home health face-to-face (F2F) “Probe-and-Educate” audit process by selecting **five claims to undergo audits from each home health agency** that submits to NGS.

HCA has previously reported on this process, which is intended to ensure that agencies understand the F2F requirements by testing, auditing and educating the provider on a limited set of reviewed claims. (See our November 13 ASAP for details.) However, it should be noted that the MACs will deny each non-compliant claim while outlining the reasons for denial in a letter sent to providers at the conclusion of the probe review.

The claims are for episodes with start-of-care dates on or after August 1, 2015. Excluded from this review are claims involving third party liability, Medicare Advantage, Medicare Secondary Payor, or claims under review by other contractors.

While the U.S. Centers for Medicare and Medicaid Services (CMS) anticipates most agencies will be subject to medical review, if a provider has not submitted any claims for billing or has not been selected for medical review during the last several months, it may **still** receive generalized education on the final rule.

The “Probe-and-Educate” edit codes for providers in Jurisdiction 6 are: 5WPE1 and 5CPE1.

*Continued on next page*
A Medical Review Additional Development Request (MR ADR) will be generated for claims that meet the “Probe-and-Educate” criteria. MR ADR documentation may be submitted via NGSConnex, electronic submission of medical documentation esMD, fax, or mail.

Claims will be reviewed for valid F2F encounter documentation, medical necessity, compliance with the CMS coverage guidelines, correct billing and coding associated with F2F. Agencies can also expect the following:

- A detailed results letter will be sent to the provider upon completion of the five claims reviewed. Letters will be sent regardless of whether or not errors are found. The letter will include claim-by-claim rationales.

- Letters to providers with error findings will also include an e-mail address for providers to request one-on-one education with a clinician knowledgeable of the claim being discussed. CMS, as a third party for quality assurance purposes, may be on the call as well. For providers in J6, the NGS contact is: Verica.Basic@anthem.com.

- Timely documentation is important. Denials for “No documentation received” claims will be included in each probe result. This may cause a provider to be included in a second round of probe reviews even if it could have otherwise been placed in the “minor concern” category (0-1 denials).


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

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**HHCAHPS Announcement on ICD-10**

The U.S. Centers for Medicare and Medicaid Services (CMS) is advising Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) vendors that there are now some restrictions for submitting primary diagnosis ICD-10 codes to the HHCAHPS Data Center.

HHCAHPS vendors must ensure that their XML files comply with these restrictions before submitting their April 21, 2016 data files, which is the first time that ICD-10 codes will be submitted to the HHCAHPS Data Center.

The HHCAHPS Coordination Team has updated the relevant appendices in the Protocols and Guidelines Manual, the XML file schema, and the XML schema validation tool to reflect these new restrictions. These materials are now available on the “Transition to ICD-10-CM” dedicated webpage on the HHCAHPS website.

Vendors can access these materials at the link below, once they are logged in to the website. (Updated versions of the Protocols and Guideline Manual will be made available in January 2016, incorporating these changes.)

https://homehealthcahps.org/DataSubmission/TransitiontoICD10CM.aspx
Managed Care Update

This week’s state Department of Health (DOH) Managed Care Policy and Planning meeting provided updates on: DOH funding for recent Fair Labor Standard Act (FLSA) changes, managed care and the Fully Integrated Duals Advantage (FIDA) program, the Community First Choice Option (CFCO) and other issues.

*Fair Labor Standards Act*

DOH reviewed the $0.34 per-hour adjustment (see related p. 1 and 10 stories in today’s ASAP) and three options to adjust plan rates:

1. Add the amount to the plans’ base rate and risk-adjust (requires recertification by Mercer, the DOH-contracted actuary for managed care premiums, and the U.S. Centers for Medicare and Medicaid Services);

2. Risk-adjust the FLSA add-on and not add to the base (no recertification needed); or

3. Adjust using a region average add-on.

Some MLTC plan representatives suggested that the plans have some leeway in distributing the funds to each provider as long as they distributed the required “aggregate” amount. HCA countered that this was contrary to the state’s “Dear Colleague Letter” (in which the payment process was first announced) and DOH said it had to review this issue with program staff.

DOH said it will discuss the distribution method internally and then will issue written guidelines. HCA will be continuing to advocate strenuously for a process that adequately funds cost obligations across the spectrum of plan and provider operations and services.

DOH also reported that Mercer will be requesting information from home care providers sometime early next year to judge their experience with overtime, travel and live-in expenses that are increasing due to the FLSA changes.

*FIDA*

As a result of the Long Term Care Forum and various stakeholder engagement efforts, DOH and the U.S. Centers for Medicare and Medicaid Services (CMS) have agreed to make reforms to the Fully Integrated Duals Advantage (FIDA) program.

According to DOH, specific attention was given to improve flexibility for participants, plans, and providers.

The reforms are extensive and include changes in the Uniform Assessment System process, assurance of patient satisfaction, quality withholds, changes permitted for the interdisciplinary teams, reporting, marketing and more. HCA has presented these reforms in a separate ASAP website feature online for those interested in reading the full array of changes. To read this addendum article, please visit [http://hca-nys.org/general-news/doh-announces-several-changes-to-fida-requirements-procedures](http://hca-nys.org/general-news/doh-announces-several-changes-to-fida-requirements-procedures).

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CFCO

As reported in many past editions of ASAP, New York has been approved to participate in the Community First Choice Option (CFCO).

This program provides enhanced federal Medicaid funding to expand and enhance state plan home and community-based (HCB) attendant services. The focus is on person-centered, individually-directed services that help nursing-home-eligible individuals to remain in the community.

By participating in CFCO, New York will have to offer the following services (and others) under Medicaid fee-for-service and managed care to HCB-eligible recipients through DOH, the state Office of Mental Health (OMH) and the state Office for People with Developmental Disabilities (OPWDD):

- Home and community-support services (including supervision and/or cueing);
- Personal care/consumer directed personal assistance services;
- Assistive technology;
- Community habilitation, community transitional services, durable medical equipment, environmental modifications, home delivered/congregate meals;
- Home health care (aide), homemaker/housekeeper; and
- Moving assistance and personal emergency response.

DOH hopes to incorporate these services into the existing managed care and fee-for-service systems in the first quarter of 2016 (plan rates will also have to be adjusted). DOH stressed that individuals will not enroll into CFCO but will be offered CFCO services, based on an assessment of their needs.

Some outstanding issues include: the conflict-free assessment and service planning process; person-centered planning; transition of waiver programs to managed care; aligning DOH, OMH, and OPWDD services (rates, personnel licensure and certification, and scope of practice); and data collection/monitoring and reporting.

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

DSRIP Update

The state Department of Health (DOH) has made available its latest video, “Value Based Payments (VBP): An Introduction,” in English and Spanish.

The video gives an overview of what value based payments are, its role in the state Medicaid program, and its goals for patient outcomes. The English version can be viewed at https://www.youtube.com/watch?v=9D4M-QsaNfM while the Spanish version is at https://www.youtube.com/watch?v=Aq4sJq8XjJo.


Any questions may be directed to dsrip@health.ny.gov.

eMedNY Posts

December Training

eMedNY has posted a schedule of its December training. Information and registration are at https://www.emedny.org/training/index.aspx.

Some December programs include: Medicaid Eligibility Verification System; Electronic Remittance and Electronic Fund Transfer (EFT) Forms Completion; and Electronic Transmitter Identification Number (ETIN/TSN) Recertification Requirements.
Two New HCA Webinars on Care Transitions and Federal Star Ratings

HCA is offering two exciting new webinars that give you practical insights on care transitions as well as the federal star ratings process, which affects how consumers and partners assess the services you provide.

These convenient webinars are among the various education delivery options that HCA provides to members, whether on your computer screen or in-person.

Registration for all programs is on our Education and Events page at http://hca-nys.org/events-education/upcoming-events.

Transitions from Hospital to Home: New Evidence for Improving Health Outcomes (webinar): January 19, 2016 from 11:30 a.m. to 1 p.m.

Community Care of North Carolina (CCNC) will share findings and strategies stemming from its study on how to maximize the impact of transitional care on readmissions and total cost of care. One of the findings was that transitional care management has far greater benefits for patients with multiple chronic conditions than for patients with one or no chronic conditions. This session will describe how CCNC care managers are successfully using this information. Participants will receive an understanding of how to target their work to reach recipients with the right transitional care interventions to maximize patient benefit.

5-Star Ratings Best Practices (webinar): January 26, 2016, from 11:30 a.m. to 1 p.m.

Home health agency star ratings were made available to the public on Home Health Compare in July, and only 2.6 percent of 9,000 agencies earned a top score of 5 stars. Now, more than ever, agencies need to place greater focus on coordination of care to improve process and outcome measures used to determine star ratings. Don’t lose referrals to other, higher-ranked agencies. This session will describe what two agencies did to stand out on key process and outcome measures. Participants will gain an understanding of strategies to assist in improving quality outcomes and star ratings.

DOH Posts Materials on Fair Labor Standards Act Changes

The state Department of Health has posted materials on the recent changes to the Fair Labor Standards Act (FLSA).

The materials include a “Dear Colleague Letter,” an Informational Letter, and Frequently Asked Questions (FAQs).

They are at http://www.health.ny.gov/health_care/medicaid/redesign/fair_labor_standards_act.htm.

The Dear Colleague Letter advises agencies of the changes in overtime, travel time and live-in rules. It mentions DOH’s efforts to assess the extent of additional Medicaid funding needed under fee-for-service and managed care and its plan for an increase of $0.34 per hour across all aide hours (see the November 13 ASAP for more information).
Agencies should note the following information in the “Dear Colleague” Letter:

- For live-in workers who previously were only allowed to bill up to 13 hours of care per day, the final rule (FLSA) allows for additional billable hours in the event that the worker’s meal periods, sleep time, or other periods of free time are interrupted by a clients’ needs.

This point reinforces the practice that while agencies can exclude payment of live-in staff for 8 hours of sleep and 3 hours of meals, aides must be paid if they have to tend to their patient’s needs during such time.

The FLSA Informational Letter advises providers that “caution should be exercised while setting limits or caps on workers’ hours or travel time. Any such caps would need to account for emergency situations and situations where capping overtime hours would put an individual at risk of institutionalization or segregation.”

The FAQs cover the effect of the FLSA rule on travel time, live-in care, overnight work (less than 24 hours) and capping aides’ hours. HCA had submitted questions to the state Department of Labor and state Department of Health; those questions were not included in the FAQs, but some of the issues were covered in general terms.


Industry News: Alliance for Home Health Quality and Innovation and VNAA Announce Collaboration

The Visiting Nurse Associations of America (VNAA) and the Alliance for Home Health Quality and Innovation announced this week a new partnership.

According to a press release, the partnership “aligns the research and education initiatives of both organizations, creates opportunities for operational efficiencies through sharing of resources, provides the VNAA and the Alliance members with reciprocal benefits and elevates the scope of existing programs and initiatives.”

The new VNAA-Alliance partnership will begin immediately.

VNAA is a nonprofit, national industry organization that supports, promotes, and advances mission-driven providers of community-based health care including home health, hospice, and palliative care, and health promotion services to ensure quality care within their communities.

The Alliance is a nonprofit, national consortium of nonprofit and proprietary home health care providers and organizations. The Alliance invests in research and education about home health care and its ability to deliver quality, cost-effective, patient-centered care across the care continuum.
Revalidation Warning

HCA advises members to respond timely on information you may receive about your need to revalidate Medicaid or Medicare enrollment.

Agencies should also ensure that both programs have correct identifying information, including contacts and addresses.

HCA was recently contacted by an agency who said that it had never gotten any mail about the need to revalidate under Medicaid and then received a letter that the agency’s participation in Medicaid was being terminated.

It took a lot of frantic work by the member and assistance by HCA and the state Department of Health to get the agency reinstated to Medicaid on a timely basis.

More information on Medicaid revalidation is at https://www.emedny.org/info/ProviderEnrollment/revalidation/index.aspx.


The Affordable Care Act mandates that all Medicare and Medicaid providers be revalidated every five years.

MedPAC Recommends Zero Hospice Update for FY2017

The Medicare Payment Advisory Commission (MedPAC) held a meeting this week where recent changes to the Medicare hospice benefit as well as data on payment adequacy and benefit utilization were discussed for consideration in MedPAC’s March Report to Congress.

The MedPAC panel gave preliminary approval for a recommendation that Congress eliminate the hospice payment update for fiscal year (FY) 2017. The Commission plans to meet in January to finalize its recommendations. MedPAC also plans to monitor the redistributional impact of the payment reform changes scheduled to go into effect on January 1, 2016, as part of future payment adequacy discussions.

MedPAC staff indicated the following happened in the hospice industry between 2013 and 2014:

- The supply of hospices increased by 4 percent (driven by an increase in for-profit providers);
- The percent of Medicare decedents using hospice increased by a 0.5 percentage point;
- The number of hospice users increased by 9,000;
- Length of stay remained stable;
- The hospice live discharge rate dropped by 0.8 percentage points; and
- Access to capital appears to be adequate.

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During the meeting, MedPAC staff estimated that the financial margin for hospice providers in 2016 will be approximately 7.7 percent, as compared with an estimated margin of 8.6 percent in 2013. The projected 2016 margin takes the following factors into consideration: market basket, productivity, and other legislated payment adjustments; full elimination of the budget neutrality adjustment factor; and the sequester.

MedPAC staff noted that the financial margin calculation rate excludes the cost of bereavement and certain volunteer services, which would further reduce the financial margin by 1.7 percent at most.

Lastly, the Commission expressed an interest in future discussion of hospice care for patients in nursing facilities, including length of stay, higher profits, and resulting efficiencies for both hospice and nursing home providers.

A transcript of the meeting and a copy of the presentation slides are expected to be posted to MedPAC’s website at: http://www.medpac.gov/ next week.

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

MLTCs Warned of Security Issues with UAS

The state Department of Health (DOH) has posted guidance (MLTC Policy 15.07) to highlight potential security exposure for MLTC plans related to the assignment of Uniform Assessment System (UAS-NY) roles in the Health Commerce System (HCS), and to provide suggestions to minimize potential security exposure.


Since the UAS-NY transition began for MLTCs in October 2013, DOH says in its guidance that it has

ACF Do Not Refer List No Longer Posted on HCS

The state Department of Health (DOH) has announced that the Adult Care Facility (ACF) “Do Not Refer” list will no longer be posted on the Health Commerce System.

Instead it will be available at www.health.ny.gov/facilities/adult_care/memorandum.htm.

Home care and other providers have used these lists when making referrals to ACFs.

Questions about the list can be directed to the Division of ACF/Assisted Living Surveillance at (518) 408-1133.

CMS Updates its ICD-10 Website ‘Wheel’ for FFS Providers

The U.S. Centers for Medicare and Medicaid Services (CMS) recently released its ICD-10 Website Wheel as a guide specifically for Medicare fee-for-service (FFS) providers at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ICD-10-Website-Wheel-ICN909222.pdf. It provides access to official resources on CMS ICD-10 web pages including frequently asked questions, Medicare Learning Network (MLN) products, provider and CMS industry resources, statute and regulations.

For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.
become aware of three general business scenarios related to the conducting of assessments. These scenarios are:

- MLTCs use employees, including per diem staff, to conduct assessments;
- MLTCs subcontract with a LHCSA or CHHA to conduct assessments; or
- MLTCs subcontract with other non-licensed or non-certified agencies to conduct assessments.

Each time a staff person accesses the UAS-NY, he or she is required to select a UAS-NY role which is associated with a specific organization. Some staff have one role provisioned by one organization and other staff have multiple roles provisioned by a number of organizations. If a staff person performs any action within the UAS-NY that could be construed as fraudulent, a security breach, or a violation of HIPAA or HITECH, the organization that assigned the UAS-NY role and the organization under which the HCS user account was created may be held accountable for the security violation.

Some examples of a potential security violation are:

- User has multiple UAS-NY roles provisioned by multiple organizations, the user logs in to the UAS-NY for the purposes of conducting an assessment, chooses the incorrect organization and proceeds to conduct a statewide search, attests to a business need to access the record on behalf of the incorrect organization and adds the consumer to that organization’s case list, and conducts an assessment for the incorrect organization.

- User has an HCS User account created by a former employer.

- User has a UAS-NY role created by a former employer.

To minimize security exposure, DOH strongly encourages each MLTC to review its business operations and procedures for conducting assessments. Specifically, each MLTC should review its internal procedures for:

- Creating HCS user accounts and establishing Trust Level 3 assurance for staff and subcontractor staff;
- Managing and updating UAS-NY role assignments for staff and subcontractor staff; and
- Creating, managing and accessing the organization case list for the MLTC.

To reduce its security exposure, MLTCs should ensure that subcontractors are responsible for:

- Creating HCS user accounts and establishing Trust Level 3 assurance for its staff;
- Managing and updating UAS-NY role assignments for its staff; and
- Creating, managing and accessing the organization case list for the subcontractor. This case list will represent only those case records that the subcontractor is required to access.

Questions about this guidance can be addressed to mltcworkgroup@health.ny.gov.
Nonprofit Infrastructure Capital Investment Program Q&As to be Posted

Questions and Answers (Q&As) related to the Nonprofit Infrastructure Capital Investment Program (NICIP) request for applications are expected to be posted today.

Once posted, they can be viewed at http://www.dasny.org/RFP-BidOpportunities-Solicitations/Details.aspx?id=a24a6852-ee2f-45ab-be48-eaa6e10796d7.


The program will make targeted investments throughout the state in capital projects that will improve or maintain the quality, efficiency, accessibility, and reach of nonprofit human services organizations that provide direct services to New Yorkers through state contracts, state-authorized payments, and/or state payment rates.

Organizations are eligible to apply for a NICIP grant if they:

- Are a human services organization, as defined in the RFA, and are registered with the Grants Gateway at the time and date that the application is due.
- Provide direct services in New York State to individuals and families residing in the state as defined in the RFA and currently receive funding from New York State in the form of a state contract, state-authorized payment, or state payment rate.
- Have annual revenue of at least $100,000 and have not received (or will not be receiving) funding through the Health Care Efficiency and Affordability Law for New Yorkers (HEAL NY) or the Capital Restructuring Financing Program.
- Are not the Performing Provider System lead organization for a Delivery System Reform Incentive Payment Program network.

The NICIP grant will fund capital projects for certain technology upgrades, renovations or expansions of space used for direct program services, modifications to make spaces more sustainable and energy efficient, and accessibility renovations.

A total of $50 million is available for NICIP; of that amount, $30 million will be reserved for projects that involve construction and $10 million will be reserved for technology. The remaining $10 million will be placed in a Base Pool to fund projects from either category.

The due date, using the Grants Gateway, is by 4 p.m. on December 23, 2015.
CMS Hosts Dec. 7 Forum on Value-Based Purchasing Demo

The U.S. Centers for Medicare and Medicaid Services (CMS) will host an open door forum on Thursday, December 17 from 2 to 3 p.m. for home health agencies in the nine states selected for the upcoming Home Health Value-Based Purchasing (VBP) Demonstration project.

New York is not one of the nine states selected for the demo, but the state is separately pursuing a value-based project and it is important for home care analysts to gather as much information as possible about the two initiatives, especially if the federal demo ends up being extended to other states, like New York.

HCA staff will be listening to the forum and we wanted to share the following dial-in code for HCA provider members interested in listening as well:

- Telephone No.: (800) 837-1935
- Conference ID: 1894333

Participants can also now access CMS’s slide presentation prepared for the Forum at:

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

Hospice Item Set Record Submissions: CASPER Reports Available

The U.S. Centers for Medicare and Medicaid Services (CMS) requires all Medicare-certified hospice providers to submit Hospice Item Set (HIS) data electronically via the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

Certification And Survey Provider Enhanced Reports (CASPER) reports are available to help monitor the status of HIS records, allowing providers to connect electronically to the national reporting database.

Current CASPER reports allow providers to track HIS record status and determine when correction of errors is needed.

For questions about access to CASPER or specific provider reports, contact the QTSO Help Desk at help@qtso.com or 888-477-7886.

NHTD/TBI Managed Care Transition Update

The state Department of Health has posted minutes and Frequently Asked Questions (FAQs) from its November 30 meeting of the Nursing Home Transition Diversion (NHTD) and Traumatic Brain Injury (TBI) Waiver Transition Workgroup.

The materials, including meeting slides made available last week, are at http://www.health.ny.gov/health_care/medicaid/redesign/mrt_90.htm.
The FAQs address home visits by medical personnel; four non-state plan services that will continue to be coordinated by the Regional Resource Development Centers; service coordination caseloads; role of Conflict Free Evaluation and Enrollment Centers; frequency of reassessments; and use of the Uniform Assessment System (UAS).

For more information on the proposed continuity-of-care requirements for services and payments, see last week’s ASAP.

DOH will hold “Services and Workforce” and “UAS Subcommittees” Meetings on Monday, December 14, 2015, from 10 a.m. to 2:30 p.m. The Services and Workforce Subcommittee will meet from 10 a.m. to 12 p.m. while the UAS Subcommittee will meet from 1 to 2:30 p.m.

Those interested can attend in-person at One Commerce Plaza (99 Washington Avenue), 16th floor, Room 1613, Albany, NY 12210, but you must respond to the waiver mailbox at waivertransition@health.ny.gov to reserve a space.

You can also participate by telephone at 1-844-633-8697 or 1-866-776-3553 / Profile no. 93491143.

Publications

- “Access and Oversight Concerns for Home Health Services, Washington DC VA Medical Center,” by the Department of Veterans Affairs Office of Inspector General


For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.
2016 HCA BOARD NOMINATION APPLICATION

SHARE your expertise with other home care industry leaders.

LEARN from the most influential leaders in the state.

LEAD your agency and region into the future of home care.

The Home Care Association of New York State (HCA) is actively seeking nominations for its Governing Board.

Complete this application and submit it along with your resume, or go to the following link to submit online:

https://www.surveymonkey.com/r/2016BoardNomination
The Home Care Association of New York State (HCA) is actively seeking nominations for its Governing Board.

HCA’s Mission Statement
The Mission of HCA is to promote and enhance the quality, accessibility and availability of home and community based care by empowering our members to meet the needs of the individuals and communities they serve.

Responsibilities of HCA Board of Directors
The Board’s principal task is to promote and implement a vision and strategic policy direction for the home care industry and the Association.

Duties of the HCA Board of Directors
• Participating in scheduled Board meetings, assigned ad-hoc workgroups and Association events.
• Providing strategic policy guidance on issues that support cost-effective, efficient, high quality home and community-based care services; and promote home and community-based care as a core integral service that crosses home care settings.
• Representing the broad interests of the entire membership.

About HCA’s Board of Directors
The HCA Board is composed of 25 Directors who represent a variety of provider member organizations including CHHAs, MLTCs, LTHHCPs, Hospices, and LHCSAs. In addition, non-provider members (such as allied organizations or individuals knowledgeable in home care, etc.) may also be elected to the Board of Directors. All HCA Board Members are expected to serve the mission and goals of HCA. HCA seeks a Board that represents racial, ethnic, gender and geographical diversity.

Meetings, Terms of Office, and Committees
HCA Board of Directors’ meetings are held five times per year; however, the Chairperson may convene the Board throughout the year by conference call. A Board Member’s appointment is for a two-year term and the bylaws allow for up to four consecutive two-year appointment terms. Board Members may be invited to participate in Board Committees which include the Executive, Nominating and Governance, and Finance and Investment Committees. In addition to the regularly scheduled meetings, Board Members are asked to attend HCA signature events which include the HCA Annual Membership Meeting, held in May, and HCA’s Advocacy Day, usually held in late January or early February.
Candidate Criteria
The Nominating and Governance Committee of HCA’s Board is seeking nominations for Board candidates who have exhibited accomplishments in one or more of the following areas:

- Demonstrated commitment to HCA
- Leadership role in an HCA member organization in good standing
- Participation in HCA signature events including the HCA Annual Membership Conference and Advocacy Day

Characteristics of Candidates
In addition, the following personal characteristics are sought in Board candidates:

- Demonstrated leadership potential
- Commitment to HCA’s Engagement and Attendance policy which requires Board Members to routinely participate in scheduled meetings and signature events
- Commitment to HCA’s mission, values, and strategic plan
- Consensus builder
- Strong interest in public policy discussions and advocacy
- Active participant and contributor in meetings and discussions
- Authority to vote on items before the Board

How to Submit:
Please return
- Your completed application (on the back of this form)
- Your current bio/C.V.
- A letter of support from your Board Chair or CEO to: Jenny Kerbein, Director of Governance HCA, 388 Broadway, 4th Floor, Albany, NY 12207 or at: jkerbein@hcanys.org, or by fax to (518) 426-8788 by December 15, 2015.

Nomination Process and Timeline
Candidates should complete the nomination application on the back of this form by December 15, 2015. Candidates' applications will be reviewed by the HCA Nominating and Governance Committee. Those candidates selected for consideration will be contacted and vetted for approval by the HCA Board of Directors and the HCA Membership at the Annual Meeting in May.

All nominees must be employed by an HCA member in good-standing.
Name of Nominee: __________________________________________________________________________

Title: ___________________________________________________________________________________

Organization: ____________________________________________________________________________

Address: ________________________________________________________________________________

City:_______________________________________________________ State:__________ Zip:____________

Telephone:____________________________________________ Fax: ______________________________

email: __________________________________________________________________________________

Relevant Experience (attach resume):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Areas of expertise/contributions you feel you can make:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Why are you interested becoming a member of HCA’s Board of Directors?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Have you attended HCA’s Annual Meeting in the past? YES ________ NO ________

Have you attended HCA’s Advocacy Day in the past? YES ________ NO ________