Minimum Wage Funding Guidance Imminent

The state is soon expected to issue guidance for disbursement of funds corresponding to home care minimum wage increases.

HCA and its government relations team at Hinman Straub have been working for weeks with collaborating provider and health plan representatives to try to shape state guidance language that ensures appropriate, explicit and quantifiable distribution of these funds to health plans and to providers.

See WAGE p. 3

Write Sen. Schumer Urging Action on “Home Health Care Planning Improvement Act”

As reported in last week’s edition of The Situation Report, Congress is preparing bills for action during the post-election lame-duck session in November. At this time, HCA is focusing our grassroots advocacy on a commonsense bill that has long demanded passage: S.578/H.R.1342, also known as the “Home Health Care Planning Improvement Act.”

See SCHUMER p. 2

Note: HCA’s offices are closed on Monday, October 10, 2016, for the Columbus Day Holiday.

We will reopen for regular hours on Tuesday, October 11.
▼ SCHUMER from p. 1

We’ve extensively reported to you about this bill, which would allow nurse practitioners, physician assistants, clinical nurse specialists and other non-physician advance-practice professionals to order and certify Medicare home health services.

We need your help to advocate for this measure, with direct outreach to U.S. Senator Charles Schumer, a co-sponsor of S.578.

Please visit HCA’s Legislative Action Center, where we’ve posted a message to Senator Schumer using our Phone2Action platform that you can send in less than a minute of your time. Please encourage all of your staff to do the same. A direct link is at http://p2a.co/ibsOrc1.

We need to get this bill on the Senator’s radar for a priority push in the lame-duck session. During this upcoming period, Congress will be considering a series of other measures, especially bills like S.578/H.R.1342 that already enjoy bipartisan support.

With over 50 bipartisan Senate cosponsors and 200 bipartisan House cosponsors, this bill is especially suited for action during the lame-duck session, and we need all home care providers weighing in to make this happen. Please write Senator Schumer today!
The state has come far in accepting many HCA modifications and recommendations to the original draft guidance presented by the state Department of Health (DOH) and Division of Budget (DOB) weeks ago. However, the state would not go as far, as asked, to ensure an explicit rate supplement amount for each and every home care provider.

Moreover, the state insisted on inserting language specifically providing that managed care plans not be held to a standard supplement payment amount for every agency.

HCA and nearly all other participating associations had worked to agree that the least complicated and most appropriate course was for each health plan to use the additional wage funding to supplement each provider’s rate by the same $1.33/hour that the plan was receiving from the state.

While subject to change until formally issued, the state’s guidance, in its presumed final iteration, provides that:

- The Department will add increased funding for minimum wage compliance uniformly to the MLTC/MMC regional rate, risk adjusted. The funding, when combined with increased wage trend, will total $1.33/hour for MLTC partial capitation plans (it may differ for other managed care programs), based on the total number of hours worked by direct care employees.

- The funding assumes that reimbursement rates to providers will not be decreased to supplement base wage increases.

- Effective January 1, 2017, managed care plans will supplement their contracted reimbursement rates for providers, which will utilize the $1.33 of additional funds to pay the full increment of the minimum wage increase as well as other additional statutory wage cost obligations (e.g. wage parity, FLSA), as identified by DOH, for direct care workers.

- The aggregate additional funds paid to MCOs will be paid out entirely to providers and subsequently to workers for these obligations (including the minimum wage and wage parity amounts). In other words, the plans are expressly prohibited from keeping these additional funds. However, while the guidance does not obligate managed care plans to give every provider a $1.33/hour increase in additional reimbursement, managed care plans are required to ensure that sufficient funds are forwarded to providers to ensure compliance with statutory wage obligations.

- Managed care plan-provider contract amendments should specify that the increase in reimbursement rates is to supplement existing contract rates in order to enable the provider to fund the statutory increase to minimum wage and to enable the provider to remain compliant with wage parity. The Department of Labor will be responsible for ensuring that providers are paying workers in compliance with these statutory wage requirements.

- The Department recommends that contract amendments be sent to providers no later than November 1, 2016. If providers do not execute the contract amendment, then the MCO is not responsible for paying an increase in the contracted rate until the contract is executed and returned to the MCO. Providers or MCOs may seek the Department’s guidance if a dispute arises over whether the contracted increase for wages between the provider and the MCO is consistent with the guidelines.

In an important improvement, the guidance omits prior state language that would have added new attestation requirements for the supplement funds, which HCA had argued would add more layers for already overburdened managed care plans and providers. While
pleased with this omission, the issue remains unresolved and HCA has since learned that the state may next be attempting impose the attestations in revisions to the managed care plan/provider contacts – a move we will seek to mitigate.

Upon finalization, DOH intends to quickly seek federal approval so the payments are timely in reflecting both federal and state share funds.

HCA will keep providers and MLTCs closely apprised of all developments. Even with the progress of these first distributions, HCA must gear up for the next round’s essential inclusion in the 2017-18 state budget.

For further information, please contact a member of the HCA policy team.

2015 OMIG Report Announces $339M in Recoveries, Focus on Managed Care


Under Public Health Law, OMIG is required to publish an annual report on its activities for the prior calendar year.

According to the report, OMIG has pivoted its attention to managed care, given the state’s shift away from fee-for-service Medicaid. In 2015, OMIG completed 301 managed care audits, identifying over $48 million in overpayments, the report says.

These audit activities included “match-based” targeted reviews and data mining for overpayments, as well as retroactive disenrollment audits of managed care organizations that did not void premium payments for enrollees deemed ineligible for services.

The report also describes OMIG’s work with the special investigative units (SIUs) of Managed Care Organizations (MCOs) to identify suspicious trends across plans, coordinate responses to referrals, and provide SIUs with information to enhance program integrity.

In addition, OMIG audits MLTC plans to ensure enrollees are eligible for the program and that appropriate care management is being provided by plans.

Lastly, the report describes other work with plans, including quarterly data reports that MCOs are required to submit to OMIG which describe the value of payments made by MCOs to providers serving their enrollees.

During HCA’s Corporate Compliance Symposium on Thursday, State Medicaid Inspector General Dennis Rosen presented on OMIG’s work in home care and was asked by HCA whether OMIG would be developing audit protocols to further guide its managed care audit activities. Such audit protocols are already in effect for home care and personal care providers. Mr. Rosen said this work is underway, but he did not mention any specific timetable for implementation.

Continued on next page
Very little of the OMIG report mentions home care specifically. However, the section on third-party liability (TPL) refers to over $180 million in recoveries (for all sectors) where private insurance or Medicare should have been the payor, not Medicaid.

As providers well know, OMIG has conducted TPL audits for home care over the past several years, requiring agencies to submit demand-bill claims to Medicare for certain dual-eligible beneficiaries. The purpose of this program is to determine whether Medicare, not Medicaid, should have paid the claims. The initiative also includes preparation of extensive patient record files that agencies must compile and submit to contractors. According to a chart in OMIG’s report, the “Home Health Care Demonstration Project” (presumably the TPL audits), netted $3.148 million in recoveries for Medicaid in 2015.

HCA has worked vigorously to restore the former TPL Demonstration Project, a federal demo which employed a sampling methodology that significantly reduced the number of demand-bill claims and record reviews required for home care audit purposes. OMIG supports the demo, and HCA has gotten Congress to contact officials at the U.S. Centers for Medicare and Medicaid Services (CMS) directly, urging a return to the demo. We have also prepared legislation to this end, but CMS has thus far resisted these efforts.

OMIG’s report lists audit and recovery findings for health care providers overall, but this data is not delineated by provider type. The only other specific mention of home care is the listing of five home health agencies who were referred to the state Attorney General’s Medicaid Fraud Control Unit for investigation.

For more information, please contact a member of the HCA Policy staff.

Medicaid Inspector General Dennis Rosen speaks at HCA's Corporate Compliance Symposium last week.
NEW: HCA Quality & Technology Symposium on Nov. 16-17 Covers Hot Topics, Care Innovations

Register by October 21 for early-bird discount available to HCA members

HCA’s Quality and Technology Symposium is coming on November 16 and 17 in Saratoga.

We’re offering a special early-bird discount for HCA members who register by October 21. Another rate is offered for prospective members of HCA.

This signature conference is geared for your clinical leaders, nurse managers, health information technology strategic planners, and executives seeking to know the latest trends and hot topics in quality and technology.

In designing this program, HCA was mindful about key state and federal deliverables, target areas and new models. Each session addresses the intersection between quality, payment and technology to meet the imperatives of a new clinical delivery environment. You’ll gain insights on:

- The state’s quality performance measures and related payment initiatives;
- EHR network integration in home care;
- The role of home care in population health management, a key component of DSRIP and Value-Based Payments;
- An up-close look at a home-care-led bundled payment program aimed at targeted clinical improvement interventions;
- A unique home care and physician partnership effort that is improving care delivery, providing high quality outcomes, and saving dollars;
- The latest clinical tools and technologies during our technology showcase;
- HCA’s sepsis-prevention protocol and intervention tool; plus
- A special bonus, post-conference session on “Data-Driven QAPI”! This free workshop offers personalized, hands-on, and customized guidance to help you interpret your quality data ... and you’ll be eligible for CEUs!

Please be sure to have your clinical teams sign-up for this signature opportunity that focuses on tools, strategies and information supporting their work. A brochure and online registration are linked below.


At Compliance Program, DOH Stresses Filing of Required Statistical Reports

**LHCSA report due October 15, CHHA report to be posted October 24, plus info for LTHHCPs**

During HCA’s *Corporate Compliance Symposium* on Thursday, Rebecca Fuller Gray, Director of the state Department of Health (DOH) Division of Home and Community Based Services, reported that over 53 percent of LHCSAs and over 14 percent of CHHAs and LTHHCPs were not compliant with state requirements to file a statistical report in 2014.

As we reported in an alert to members last week, the 2015 LHCSA Statistical Report is due October 15. All providers must submit the report, and failure to do so may result in an enforcement action, as well as the suspension of any licensure applications.

Ms. Fuller Gray stressed that these reports are vital, so that the Department has sound patient census and other data to inform state policies and basic data needs.

She also said that the 2015 CHHA statistical report will be available on October 24, with a due date of December 19. In response to a question posed by HCA, she additionally stressed that providers operating an LTHHCP, even if they did not have any patients on census for the reporting period, must still file a statistical report.

**More info on LHCSA Report**


LHCSAs that exclusively serve patients in the Assisted Living Program (ALP) must complete the 2015 ALP LHCSA Statistical Report. LHCSAs that serve non-ALP patients must complete the 2015 LHCSA Statistical Report. LHCSAs that serve both ALP and non-ALP patients must complete both forms.

Providers are advised to submit their Statistical Reports as early as possible to avoid any potential system delays and wait-times for support. Only the person with an Administrator role on the Health Commerce System (HCS) is able to submit the report, and only people in the Administrator, Director of Home Care Patient Services, Data Reporter or HPN Coordinator can access the forms.

Any questions should be submitted to [HCStatRpts@health.state.ny.us](mailto:HCStatRpts@health.state.ny.us).

**LHCSA Offsite Surveillance Process to Resume in Early 2017**

The state Department of Health (DOH) plans to conduct another phase of LHCSA off-site surveillance activities, likely in early 2017.

During last week’s HCA *Corporate Compliance Symposium*, Rebecca Fuller Gray, Director of DOH’s Division of Home and Community Based Services, provided an overview of the first off-site surveillance pilot conducted in February 2016. The pilot assessed compliance with clinical records, emergency preparedness and Health Commerce System requirements, personnel records, and quality assurance and complaint processes.

*Continued on next page*
For the February 2016 project, four LHCSAs in each region of the state were selected, all of which: had a re licensure survey conducted within the past 36 months; were not a franchise; and had a “reasonable compliance history.”

For the 24 LHCSAs surveyed, 14 statements of deficiency were issued, so it is important for LHCSAs to perform a risk-assessment of the target areas and other compliance issues in the event your agency is selected for the next phase of this pilot early next year.

Ms. Gray said DOH will be modifying the process in 2017 by forgoing clinical record reviews, due to the enormous volume of paperwork involved, and DOH will modify the transmission process to use the Health Commerce System (HCS), rather than the onerous transmission of audit records by fax.

DOH will “continue with established selection criteria to identify providers appropriate for the offsite survey.”

For more information, please contact the HCA Policy staff.

**On CMS Webinar, HCA Raises Funding Need for Emergency Prep. Final Rule**

This week, HCA participated in a national webinar, held by the U.S. Centers for Medicare and Medicaid Services (CMS), on the new final rule that establishes emergency preparedness requirements for home care, hospice and other health care providers participating in Medicare and Medicaid.

As highlighted in the September 26 edition of *The Situation Report*, this rule mandates that agencies develop and implement: an emergency plan; emergency preparedness policies and procedures; a communication plan; and training and testing.

CMS reviewed each of these requirements and provided the following new information on the rule:

- While the rule is effective November 15, 2016, agencies are required to comply by **November 15, 2017**.

- CMS’s Survey & Certification Group (SCG) is in the process of developing the Interpretive Guidelines (IGs) which will assist in implementation of the new regulation; the guidance is expected to be completed in early 2017.

- The IGs will be formatted into one appendix as opposed to updating all 17 provider/supplier type IGs.

- Facilities are expected to be in compliance with the rule by November 16, 2017; in the event facilities are non-compliant, the same general process will occur as for any other conditions of participation, including possible termination of the provider agreement.

- CMS anticipates the development of checklists for surveyors and state agencies, as well as for providers/suppliers.
SCG is working with a contractor to develop a web-based (self-paced) training for surveyors, as well as providers/suppliers. Part one of the training will be on the four core elements as a general module; part two will be broken down by provider type.


Technical assistance and resources are available at https://asprtracie.hhs.gov/cmsrule.

On the call, HCA raised the issue of funding needed for home care agencies to comply with the new rule. CMS’s response was that it does not provide funding for requirements that are part of the Conditions of Participation and that there are lots of free resources to help agencies. HCA does not agree and will continue to urge for assistance.


HCA has already been in discussions with the state Department of Health (DOH) to discuss the rule’s implications for home care providers. We have made recommendations to mitigate any duplicative or unreasonable aspects of the rule, including a request for a state-developed crosswalk between existing state regulatory and procedural requirements and those provisions in the federal rule that providers don’t already meet under state requirements.

HCA has also appealed for provider and managed care reimbursement for the increased provider cost of the rule. In addition, we have stressed the need for support with provider education and assistance in implementing the rule.

**OIG Posts Advisory on Medicaid Fraud and Patient Harm in Personal Care Services**

The federal Office of Inspector General (OIG) has posted an “Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services.” It is at http://po.usa.gov/xKzQq.

The advisory highlights several of the most significant program vulnerabilities related to personal care services that OIG continues to encounter during the course of federal investigations.

These include payments for personal care services that were unnecessary or not provided; false documentation of activities; aggressive tactics when recruiting Medicaid beneficiaries to participate in fraud schemes; Medicaid beneficiaries voluntarily participating in fraud; and incidents of patient harm. Many examples of these cases were recently reported by the national news, including CBS Evening News and the Washington Post, and shared with members in our biweekly news clips.

The advisory states that most fraud cases involving personal care services presently come to the attention of law enforcement only through referrals from individuals who know the people committing the acts. However, if the availability and quality of personal care data were improved, OIG asserts that states, the U.S. Centers for Medicare and Medicaid Services (CMS), and OIG could analyze the data to identify and follow up on aberrancies and questionable billing patterns.
OIG and CMS have been discussing administrative actions that CMS can take to address vulnerabilities in the personal care services program, including issuance of an informational bulletin to states that outlines steps they can take to improve internal controls.

OIG continues to recommend CMS’s action to prevent fraud, patient harm and neglect in Medicaid personal care services by implementing the following recommendations from a 2012 OIG report:

- Establish minimum federal qualifications and screening standards for personal care workers, including background checks.
- Require states to enroll or register all PCS attendants and assign them unique numbers.
- Require that personal care claims identify the dates of service and the attendant who provided the service.
- Consider whether additional controls are needed to ensure that personal care services are allowed under program rules and are provided.

In the future, OIG intends to complete a survey of State Medicaid Fraud Control Units (MFCUs) about fraud trends in the personal care services program, the results of which OIG will summarize in a data brief expected to be released in the spring of 2017.

OIG will also continue to partner with state MFCUs to combat Medicaid fraud, including personal care services fraud.

Home care providers should expect more scrutiny of personal care services and ensure that they have procedures in place to prevent fraud and abuse.

HCA’s Corporate Compliance Symposium last week featured a presentation by Nancy Brown, Senior Counsel, Office of Counsel to the Inspector General, who described her office’s functions and procedures, risk areas for home care, and data on OIG findings and investigations. She reported on some of the fiscal year 2015 false claims act settlements, exclusions and civil monetary penalty actions in home care. She also described OIG’s self-disclosure protocol and referred providers to some new resources on the OIG website at: https://oig.hhs.gov/reports-and-publications/portfolio/home-health/reports.asp#mainBody.

For more information, please contact a member of HCA’s Policy staff.
HIRING: Hospice & Palliative Care Association of NYS (HPCANYS) President/CEO

Reporting to the Board of Directors, the President/CEO has overall strategic and operational responsibility for the HPCANYS nonprofit’s staff, programs, expansion and mission. This individual will initially develop deep knowledge of core programs, operations, financials and business plans.

The President/CEO leads association activities, as authorized by the Board of Directors, HPCANYS’ strategic plan, and budget. He or she serves as liaison between member providers, the NYS Department of Health and the community, including building, developing and fostering communications with political, economic and affiliated organizations in the state and national realm.

Responsibilities Include:

- Ensure programmatic excellence and evaluation, as well as consistent quality of finance and administration, fundraising, communications, and systems.
- Design and implement short-term and long-range plans to fulfill membership goals and organizational mission within a sustainable budget framework.
- Policy, legislative, and regulatory advocacy supporting the Association’s mission.
- Revenue expansion and fundraising for existing and future program operations, including grants and non-dues revenue.
- Serving as external local and national presence communicating program results with an emphasis on successes and shared partnerships.


October Means More ‘Bring The Vote Home’ Activity

Now that a full week of October has passed, we remind providers of some signal dates for outreach to your patients as part of HCA’s Bring The Vote Home-New York campaign, which is delivering voter material to home care patients so they can register and vote from home.

Important dates

October 13: This is the day prior to the deadline for mailing a voter registration form, and the form must be postmarked by October 14, so this date is really the last call for

See VOTE p. 19
Legal Challenges Strike at FLSA Changes to “White-Collar” OT Exemptions

Twenty-one states (not including New York) have banded together against revisions to the “white-collar” overtime exemption under the Fair Labor Standards Act (FLSA), set to take effect December 1, 2016.

The revisions call for an increase in the minimum salary threshold by which employees would remain exempt from overtime – from a salary minimum of $455 per week ($23,660 annually) to $913 per week ($47,476 annually).

The states’ legal action seeks to declare these new rules invalid, and, at a minimum, postpone the rule change, pending further consideration by the court.

The complaint asserts that these new FLSA changes unconstitutionally violate the 10th amendment by dictating the payment of wages to state employees and, thus, infringing upon state sovereignty. The plaintiffs also say the FLSA changes: exceed congressionally authorized power; are “arbitrary and capricious”; and constitute an unlawful delegation of congressional power. Also, plaintiffs say the automatic updates to the salary thresholds violate the statutory requirement to “define and delimit” the thresholds “from time to time,” and these automatic changes also fail to allow for notice and comment on rulemaking.

Several business groups are separately seeking relief, claiming violations of the Administrative Procedure Act. Like the states, these business groups claim that the revised rule is in excess of granted authority, violates the notice and comment provisions, and is arbitrary and capricious.

Both lawsuits are pending in the U.S. District Court of the Eastern Division of Texas, Sherman Division. The main source of contention is that the revised white-collar exemptions effectively eliminate any analysis of whether an employee is performing the job duties of an executive, administrative or professional because the new minimum salary level is set too high. (In addition to the salary thresholds, the overtime revisions include a “duties test” for determining whether overtime applies, meaning that the employee’s work function is also a consideration in overtime applicability.)

The business groups are also unpersuaded by the U.S. Department of Labor’s allowance to count certain non-discretionary bonuses, incentives and commissions toward the minimum salary level (up to ten percent), calling it meaningless in operation, given the arbitrary exclusion of other types of commissions that are paid less than quarterly.

Both lawsuits highlight the increased administrative burdens and cost of compliance with this revised exemption, which will result in cuts to staff, programs and services, the complaints assert. They also express concern that the minimum salary levels for overtime will increase without notice or the opportunity to comment.

While both actions seek to postpone enforcement of these new rules, the question remains whether the court will agree and how quickly the court will act to issue decisions.

As of now, the revised exemption rules are effective. Home care and other employers need to plan for compliance by December 1, 2016, which means that many employers will face choices such as reclassifying employees or increasing wages to retain exempt status.

Continued on next page
HCA has extensively covered this issue in prior newsletters and has provided educational programs explaining this rule change and other labor law issues.

More information on the final rule is at https://www.dol.gov/whd/overtime/final2016/.

**Important Revalidation Notice**

*Claims won’t be paid if Revalidation not done*

The Affordable Care Act requires revalidation of all Medicaid and Medicare providers every five years. This process involves the submission of information on the provider’s ownership, managing employees, agents, persons with a control interest, as well as current business addresses, specialties, etc.

eMedNY warns of adverse consequences for providers who have already received individual written reminders to revalidate but have not done so by the September 25, 2016 deadline.

Effective October 27, 2016, **all claims from non-revalidating billing providers will be pended** until the provider’s revalidation package is received. To avoid interruption of claims payment, providers must revalidate immediately.

To revalidate:

- Visit the Provider Enrollment page at [www.emedny.org/revalidation](http://www.emedny.org/revalidation), locate your enrollment form and additional required documentation, and determine whether an enrollment fee is required. The page offers a slide presentation, step-by-step processes, and an FAQ section.

- Complete and mail the appropriate form(s) with all required documentation to the address provided. Keep a copy of the forms and documentation.

- Allow 2 to 3 weeks for processing by eMedNY. Once your completed revalidation is received and processed, all claims that have been held (due to missing or late revalidation) will be released for processing during that cycle.

- If more than three weeks have passed since sending the revalidation to eMedNY, please contact providerenrollment@health.ny.gov with the subject “FINAL REVALIDATION NOTICE” and provide all pertinent information regarding your submission, such as the date you sent it, and the address you sent it to, so that it can be researched.

- The remittance message for these pended claims is “Health Claim Status Code: 46 INTERNAL REVIEW/AUDIT.”

In the past year, HCA was contacted by a member who never revalidated and was terminated from Medicaid participation. It took a lot of work by the member and assistance by HCA and DOH to get the agency reinstated to Medicaid.
If you have additional questions about revalidation, including whether your agency is responsible to revalidate now, contact providerenrollment@health.ny.gov with the subject “FINAL REVALIDATION NOTICE” or call the eMedNY Call Center at 800-343-9000 Option 2.

Information on revalidation, including the required form, questions and answers and more, is at https://www.emedny.org/info/ProviderEnrollment/revalidation/index.aspx.

NY Senior Action Council, HCA Engage on Home Care Support

The New York Statewide Senior Action Council is aiming to create a major grassroots advocacy effort to urge support for home care.

Senior Action – a longstanding, prominent organization of consumers and professionals – featured what it called a “home care crisis” at its annual statewide meeting and conference last week. Senior Action invited HCA for a panel outlining the urgency of home care advocacy, supporting the home care system’s capacity to meet the burgeoning needs of patients and communities for its services.

Senior Action Executive Maria Alverez called for major strategic outreach leading into the 2017 state legislative session and budget to support home care staffing and services across the state, especially targeting areas of severe shortage. Senior Action set in motion an outreach campaign by its statewide membership to press elected officials about the urgent need for home care support.

HCA Executive Vice President Al Cardillo addressed the conference, outlining core areas for accessible quality services, and he urged Senior Action’s specific support of:

- Adequate agency infrastructure to enable quality operation, adequate service area presence and reach;
- Adequate reimbursement and requisite governmental and commercial coverage of home care services and operations truly geared to meeting patients’ needs and reflective of home care’s diverse roles in the current health care system;
- Staffing that is both sufficient and skilled to meet population and community health needs, with support for agency workforce recruitment, as well as flexibility and regulatory relief for agencies and personnel;
- Engagement of critical partners (including physicians and hospitals) in the referral and delivery of home care services throughout the service area; and
- Resource capacity of the community (e.g. housing, transportation, allied services) for supporting care at home.

HCA and Senior Action will be meeting further in the coming weeks to discuss collaboration for supporting home care in the upcoming state legislative and budget preparatory period.

For further information, please contact acardillo@hcanys.org.
First Home Care Sepsis Tool Webinar Now Available as an Archive Link

The September 30 webinar launching HCA’s home care sepsis screening tool and protocol is now available at http://atlanticquality.org/initiatives/sepsis-initiative/.

The link will take HCA members to the IPRO webpage for the webinar. IPRO has been a partner to HCA in the development of this first-of-a-kind tool. Under a U.S. Centers for Medicare and Medicaid Services (CMS) project, IPRO has led sepsis pilot projects in New York incorporating the HCA tool and training home care nurses in its use and application.

The webinar provides critical background on sepsis, along with a detailed walkthrough of the HCA sepsis tool.

HCA is urging all home care agencies to adopt and incorporate the tool as a “best practice” for sepsis early recognition, treatment, mitigation, prevention, patient education and increased public awareness.

In New York, sepsis is the number-one cause of Medicare 30-day hospital readmissions. Providers who adopt the tool stand to make a significant health contribution, equipping themselves to partner with hospitals, physicians and health plans in reducing the $24 billion annual cost tied to sepsis.

At least two additional webinars are planned, and participants are urged to participate:

- Part II: Thursday, October 20, 2016 – 10:30 a.m. to noon. This session focuses on agency adoption of the sepsis tool and integration into your electronic health records.
- Part III: Wednesday, November 9, 2016 – 10:30 a.m. to noon. This session is a train-the-trainer program.

This webinar series is being offered free of charge to your organization but you must register to attend each session.

To register, visit https://qualitynet.webex.com/mw3100/mywebex/default.do?siteurl=qualitynet. Locate each of the sessions by date (listed chronologically) and click on “Register” to the right of the session name. Once you submit your information, you will receive a confirmation e-mail with the log-in information.

HCA extends thanks to Sara Butterfield and Eve Bankert of IPRO for hosting, recording and archiving the webinar.

After viewing our webinar, quality staff from the Visiting Nurse Associations of America (VNAA) contacted HCA to recommend a series of ways in which VNAA could partner to support this effort nationally.

HCA will keep the membership apprised of these broader efforts, including our partnership with the U.S. Centers for Disease Control and Prevention (CDC) on this high-priority clinical intervention.

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

The state Department of Health has announced changes to the timeline for the Mid-Point Assessment of provider networks under the Delivery System Reform Incentive Payment (DSRIP) program. The purpose of this change is to complete on-site reviews of all 25 Performing Provider Systems (PPSs) by the Independent Assessor.

This change delays the release of the initial Mid-Point recommendations for PPSs and public comment. The table below outlines major events scheduled for the Mid-Point Assessment, with the original dates and the revised dates for each event.

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<th>Task</th>
<th>Original Schedule</th>
<th>Revised Schedule</th>
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<tr>
<td>Release Initial Mid-Point Assessment Report to PPS</td>
<td>November 3, 2016</td>
<td>November 10, 2016</td>
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<tr>
<td>Release Initial Mid-Point Assessment Report for Public Comment</td>
<td>November 10, 2016</td>
<td>November 17, 2016</td>
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<tr>
<td>PPS/Public Comment Period Ends</td>
<td>December 3, 2016</td>
<td>December 10, 2016</td>
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<tr>
<td>Release Final Mid-Point Assessment Report for Public Comment</td>
<td>December 23, 2016</td>
<td>December 23, 2016</td>
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<td>2nd Public Comment Period Ends</td>
<td>January 23, 2017</td>
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Questions about the Mid-Point Assessment should be directed to DSRIP_midpoint@pcgus.com.

In other news, the Independent Assessor has completed its reviews of the DSRIP Year 2 First Quarterly Reports, covering PPS activity from April 1, 2016 to June 30, 2016.

The reports for each PPS can be accessed through the PPS section of the DSRIP website at http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/index.htm.
CMS Releases New Medicare Hospice Payment and Utilization Data  
*Data serves as comprehensive resource on payments and utilization*

The U.S. Centers for Medicare and Medicaid Services (CMS) released this week a privacy-protected public data set, entitled the Hospice Utilization and Payment Public Use File (Hospice PUF), which provides information on services provided to Medicare beneficiaries by hospice providers.

CMS also released an update to the Market Saturation and Utilization Data Tool, formerly called the Moratoria Provider Services and Utilization Data Tool. For the first time, this tool includes information on hospice services.

The Hospice PUF contains information on utilization, payments, submitted charges, diagnoses, and hospice beneficiary demographics organized by provider and state. The Hospice PUF covers calendar year (CY) 2014 and includes information on 4,025 hospice providers, over 1.3 million hospice beneficiaries, and over $15 billion in Medicare payments.

With this data, it is now possible to analyze geographic variation in the delivery of hospice care, as well as variation across individual hospice providers. The Hospice PUF also includes a number of metrics on hospice beneficiary demographics and diagnoses to facilitate analyses of differences in the patient population across providers.

The third release of the Market Saturation and Utilization Data Tool includes interactive maps and supporting data sets that show national, state, and county-level provider services and utilization data for three reference periods and the following service areas: home health, ambulance, independent diagnostic testing facilities (Part A and Part B), skilled nursing facilities, and hospice.

The data is made public to assist health care providers in making informed decisions about their service locations and the beneficiary populations they serve. CMS can also use the tool to monitor market saturation as a means to prevent fraud, waste, and abuse. The data additionally reveals the relationship between service capacity and the number of providers in a geographic region.


The Market Saturation and Utilization Data Tool can be found at: [https://data.cms.gov/market-saturation](https://data.cms.gov/market-saturation).

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

HHCAHPS Coordination Team Quarterly Review Posted

The next issue of the Home Health Care CAHPS Coordination Team Quarterly Review (CTQR) has been posted. It provides information about Home Health Care CAHPS (Consumer Assessment of Healthcare Providers and Systems) to home health agencies and survey vendors.

CTQR newsletters are posted on the HHCAHPS website and updated quarterly every calendar year. The October 2016 newsletter is at: [https://homehealthcahps.org/Portals/0/Newsletter/CTQR_Newsletter_Oct_2016.pdf](https://homehealthcahps.org/Portals/0/Newsletter/CTQR_Newsletter_Oct_2016.pdf). The CTQR will **not** replace any source of information currently on the
HHCAHPS website; instead, it will highlight important information for readers each quarter. Agencies are encouraged to visit the HHCAHPS website (https://homehealthcahps.org/Home.aspx) for more information on the items mentioned in the newsletter.

**Equal Employment Opportunity Commission Revises Reporting Form**

The U.S. Equal Employment Opportunity Commission (EEOC) has announced that, beginning with the 2017 Employer Information Report (EEO-1), private employers and federal contractors with **100 or more employees** also will report summary pay data on the EEO-1.

For many years, certain employers have reported data about their number of employees by EEO-1 job category, and then by sex and ethnicity or race, on the EEO-1. The EEO-1 report for 2017 will be due for the first time with pay data on **March 31, 2018**, and the EEO-1 will be due every March 31 after that.

Employers will have 18 months between the 2016 and 2017 EEO-1 deadlines – from September 30, 2016, until March 31, 2018 – to prepare for this change. Employers with 1 to 99 employees that are not federal contractors or subcontractors will **not** file EEO-1 reports. This is a continuation of current practice.

The revised EEO-1 report has two new elements:

- **Summary pay data**: Employers report the total number of full and part-time employees they had during that year in each of 12 pay bands listed for each EEO-1 job category; employers do not report individual pay or salaries.

- **Aggregate hours worked data**: Employers tally and report the number of hours worked that year by all the employees accounted for in each pay band.

The affected EEO-1 job categories are at [https://www.eeoc.gov/employers/eeo1survey/jobclassguide.cfm](https://www.eeoc.gov/employers/eeo1survey/jobclassguide.cfm).

The EEOC is offering webinars on October 20 and October 26 and technical assistance for employers. More information is at [https://www1.eeoc.gov/employers/eeo1survey/2017survey.cfm?renderforprint=1](https://www1.eeoc.gov/employers/eeo1survey/2017survey.cfm?renderforprint=1).

If your business needs assistance filing the EEO-1, please contact the Joint Reporting Committee at 1-877-392-4647 or e1.techassistance@eeoc.gov.

**NGS Updates**

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), has recently posted the following information to its website.

- **New Video on Credit Balance Reporting** – NGS has recently posted a new Credit Balance Reporting video in its Navigating NGSConnex Video Playlist.

- **NGS Encourages Website Users to Complete Survey** – The ForeSee Results (pop-up) survey is an easy mechanism for providers to comment on NGS services and NGS has asked HCA to encourage users to complete the survey.

*For further information, contact Patrick Conole at (518) 810-0661 or pconole@hcanys.org.*
patients to send in their registration forms. It is also a good date to remind patients to mail in their absentee ballot request form as well, if they haven’t done so yet. For those patients who have already registered, already submitted an absentee ballot request, and already received their ballot, please encourage them to mail in their final ballot.

October 24: This is a good day to remind patients to mail their absentee ballot requests or the actual ballot itself, if they’ve received the ballot already. Remember: the earlier the better!

October 31: This is the day before the absolute last day for mailing an absentee ballot application; this is a good time to give patients a last reminder to mail their actual ballot, if they’ve already received it, and they should definitely have sent in their absentee ballot application by this date.

November 7: This is the day prior to election day and it is the absolute last day for people to postmark their absentee ballots.

For questions about this initiative or next steps, feel free to contact HCA’s Communications Director Roger Noyes at rnoyes@hcanys.org or (518) 810-0665.

Resources

- “Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program,” by the Kaiser Family Foundation
  http://files.kff.org/attachment/Issue-Brief-Fewer-Hospital-U-turns-The-Medicare-Hospital-Readmission-Reduction-Program

- “Implementation of New Influenza Virus Vaccine Code,” by the U.S. Centers for Medicare and Medicaid Services

- “2015 Quality Incentive for Medicaid Managed Care Plans,” by the state Department of Health

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.
Quality and Technology Solutions for Value Driven Home Care

HCA Quality & Technology Symposium

November 16-17, 2016
Embassy Suites by Hilton Saratoga Springs
86 Congress St
Saratoga Springs, New York, 12866
The path of success in a value-based payment environment begins at the intersection of quality and technology. HCA’s Quality & Technology Symposium brings you to this intersection by demonstrating ways that emerging technologies build bridges of connectivity, increase accuracy and efficiencies in care and operations, and drive quality and value in home care.

To thrive in an environment of integrated payments and services, home care providers must also prioritize their demonstration of quality, for the sake of accountability, to enter new marketplaces, and to offer concrete value-propositions for system partners. This conference will present some of the unique technological and programmatic approaches being innovated by providers and policymakers for driving positive clinical outcomes, and focusing your clinical intervention strategies on core areas of need.

As a special bonus, we’re also holding a post-conference session on “Data-Driven QAPI,” offering personalized, hands-on, and customized guidance to help you interpret your quality data – plus, you’ll be eligible for CEUs!

Don’t miss this exceptional opportunity to get your agency ready to meet the imperatives of quality enhancement and technological integration!
Wednesday, November 16

8:30AM
Registration and Light Breakfast

9:00AM
HCA Welcome

9:00 – 10:30AM
State Perspectives on Quality Performance Measures & Payment Innovation
Patrick Roohan, Director, Office of Quality and Safety, New York State Department of Health

Raina Josberger, Bureau of Quality Management & Improvement, New York State Department of Health (Invited)

New York State Health Department officials will share insights about the state’s priorities and planning to improve quality in the home care environment through performance measures, policy advancement, innovations in payment models and other initiatives.

10:30AM – 10:45AM
Break

10:45 – Noon
EHR Network Integration in Home Care
Christina Galanis, President and CEO, HealthLinkNY

Elizabeth Amato, Director of Statewide Services, NY eHealth Collaborative

Hear from two of the state’s most influential health information technology experts about technology policies that are influencing and shaping the landscape for the state’s home care provider community.

12:00 – 12:45PM
Lunch

12:45 – 1:45PM
Technology Innovation Spotlight (TBA)

1:45 - 3:15PM
New Developments in Sepsis Identification and Detection in the Home Care Setting
Sara Butterfield, RN, BSN, CPHQ, CCM, Director, Health Care Quality Improvement Program, IPRO

Amy Bowerman, RN, Director of Quality Improvement/Privacy Officer at Mohawk Valley Health Systems-Home Care Services and Director of Patient Services, Senior Network Health

Sepsis is the number-one driver of hospital readmissions in New York. More than 1.6 million people are diagnosed with sepsis nationally, and it is the highest cost factor for hospitalizations in the U.S., at approximately $20 billion per year. There are few other concrete areas of intervention that can have a more pronounced effect on outcomes, and home care is especially equipped to help, given that the vast majority of sepsis cases occur in the community setting.

HCA’s Adult Sepsis Screening Tool for Home Care is a cutting-edge clinical resource that is garnering national attention for its ability to support the early detection and intervention of sepsis in the home care setting. This session will provide an overview of the tool’s components, design, development and strategies for adoption and implementation.

3:00 – 3:30PM
Extended Break and Vendor Networking

3:30 – 4:30PM
Role of Home Care in Population Health Management
Noreen Nelson, PhD, Clinical Assistant Professor, NYU Rory Meyers College of Nursing

Population health management is getting some heavy focus from federal and state policymakers aiming to improve health outcomes in a value-based payment environment. Learn from a national population health clinical expert how home care providers can play a pivotal role in delivering positive population health outcomes.

4:30PM
Wrap Up and Adjourn
Tentative Agenda

Thursday, November 17

8:00AM
Registration and Light Breakfast

8:30-9:30AM
An Up Close Look at a Home Care Led Bundled Payment Program
Amy Weiss, Vice President, Solution Development, Visiting Nurse Service of New York

Whether its value-based payments, your current MLTC contract arrangements, or a range of federal program initiatives, bundled payment models are a core feature of many new clinical models to share risk, target interventions for specific populations, and reduce costs. Visiting Nurse Service of New York, the largest not-for-profit home and community based health care organization in the U.S., is actively participating in CMS’s Bundled Payments for Care Improvement (BPCI) program as a risk-bearing episode initiator. In this session, VNSNY will share insights on the following topics related to its work on BPCI:

- Redesigning care to meet the needs of the target population
- Innovating through technology and data management
- Challenges and lessons learned
- Future opportunities for home care agencies in the bundled payments space

9:30-10:45AM
The Value Proposition for Physician-Home Care Partnerships
Cyndi Nassivera-Reynolds, VP, Transformation & Clinical Quality, Hudson Headwaters Health Network

The home care-physician partnership has long been a staple of quality, care transitions and oversight. Physician buy-in and understanding of home care’s role are vital for authorization of services, but also, increasingly, for unique new partnerships in care delivery. Hear from one of the state’s most innovative providers about ground-breaking partnerships being forged between physicians and home care that are improving care delivery, providing high quality outcomes, and saving dollars.

10:45AM
Break

11:00 – Noon
General Session - TBA

Noon
Wrap Up and Adjourn

Be sure to check out the Post- Conference HHQI Workshop – Bonus Session!
Post-Conference HHQI Workshop – Bonus Session!

Thursday, November 17
1:00 – 5:00PM

Building & Sustaining Data-Driven QAPI
Misty Kevech, RN, BS Ed, MS, COS-C, CCP, CPTM
Cindy Sun, MSN, FNP, COS-C
Crystal Welch, RN

During this interactive workshop, RN Project Coordinators from the Home Health Quality Improvement (HHQI) National Campaign team will provide personalized, hands-on guidance on data interpretation and the next steps toward developing and sustaining a strong Quality Assurance & Performance Improvement (QAPI) plan.

Bring Your HHQI Data Reports for Personalized Assistance

HHQI uses OASIS data to generate custom data reports on high-priority topics such as Acute Care Hospitalizations (ACH) for all CMS-reporting home health agencies. You are encouraged to bring these reports with you to this session for personalized guidance on interpretation as well as suggested next steps.

To access your agency’s custom reports, register or login to the HHQI Data Access System. Sample reports will be provided for those who do not bring their agency’s custom reports.

Learning Objectives:

• Interpret your agency's HHQI ACH Data Reports and identify gaps in patient care

• Distinguish a minimum of three free evidence-based tools/resources to address gaps in patient care

• List three additional support resources to assist with development and sustainment of a Quality Assurance and Performance Improvement (QAPI) plan

* 3.75 Nursing CEs for this activity will be provided.
Thanks to our Program Sponsors!
Hotel Information
A small block of rooms has been secured at the Embassy Suites, 86 Congress Street, Saratoga Springs, NY 12866 for the evenings of November 15 and November 16 at a discounted rate of $149. To make your overnight accommodations, call the hotel directly at 518-290-9090 before October 21 and ask for the Home Care Association of New York State rate.

REGISTRATION FORM
Registration Deadline is November 7.
Name: _____________________________________________________________
Title: _____________________________________________________________
Agency: _______________________________________________________________________
Address: _______________________________________________________________________
City/State/Zip: ___________________________________________________________
Phone: ____________________________ Ext. ________________
Email: ____________________________________________ (Required)

FEESCHEDULE FOR FULL SYMPOSIUM
Rates are Per Person (Nov 16 & 17)
HCA Member Early Bird Rate (Register by 10/21) $269 □ ☐ $0 Yes, I will attend (Free the post-conference session
HCA Member Rate (Register after 10/21) $299 □ ☐ $0 Yes, I will attend (Free) the post-conference session
Prospective Member Rate $399 □ ☐ $0 Yes, I will attend (Free) the post-conference session

PAYMENT
Please check method of payment: (Checks must be received by date of program).
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*Make checks payable to: HCA Education and Research and mail to:
388 Broadway, 4th Floor, Albany, NY 12207

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Billing Address of card (including City, State and Zip Code)
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Authorized Signature
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Cancellations received in writing via email to info@hcanys.org by November 7, are refundable less a 25% administrative fee. No refunds are permitted after this date or for no shows. Substitutions are permitted.

Please fax to: (518) 426-8788