Rep. Faso to Introduce HCA-Requested CoP Delay Bill in Congress

At HCA’s request, U.S. Rep. John Faso (R-Kinderhook) has drafted and will introduce legislation to delay the implementation of the new federal Conditions of Participation (CoPs) from the current implementation date of July 13, 2017 to no earlier than July 13, 2018.


Assembly Hearings Focus on Home Care Workforce Issues

HCA presenting testimony today during Albany hearing

A state Assembly hearing on home care workforce issues in New York City last week featured testimony from HCA members, providers and Managed Long Term Care Plans, associations, consumers and others.
While in Washington, Ms. Cunningham advocated on HCA’s regulatory relief agenda in meetings with the New York Congressional Delegation, encouraging Congressional action on a number of regulatory measures, including the CoP delay. In January, the U.S. Centers for Medicare and Medicaid Services (CMS) finalized the CoP changes, which represent the most significant revisions for home health providers in more than two decades, giving providers only six months to understand and incorporate these changes.

The CoP revisions affect all levels of an agency’s operations from the delivery of services, to staff management, recordkeeping, emergency preparedness and patient care.

Rep. Faso’s office is seeking original cosponsors of this delay legislation and HCA has reached out to its network of state home care associations across the nation to encourage bipartisan support. In addition, HCA has encouraged support for this bill by all of New York’s Congressional Delegation Members.

Simultaneous with this effort, HCA continues to prepare members for the impending new CoP changes with two educational programs. The first, a webinar, was held earlier this month, followed by an upcoming full-day program on the new CoPs, which will be held on April 5. Please register for this program today at http://hca-nys.org/wp-content/uploads/2017/02/Unpacking-the-New-Home-Health-CoPs-Registration-Form.pdf.

HCA will continue to advance efforts like the Faso delay legislation to ensure that providers have adequate time to prepare for the new regulations. We will also continue to advance legislation to highlight the need for federal relief on other regulations including the full repeal of the Medicare face-to-face regulation.

We appreciate Rep. Faso’s strong leadership on this issue. HCA will be activating its online advocacy platform in the coming weeks to secure strong New York grassroots support for this important legislation.
FLSA Update

On February 24, HCA and other associations, along with health plan members, participated in a call with the state Department of Health (DOH) on the status of funding to meet costs to plans and home care providers under the final Fair Labor Standards Act (FLSA) rule.

DOH confirmed its intention to include funds in the plan premiums for FLSA, similar to DOH’s prior infusion of funds, targeting approximately $0.34/hour in plan premiums for FLSA. DOH is drafting a memo that will explain the funding and provide guidance on plan/provider responsibilities. This is also expected to include the amount of FLSA funding that each plan will receive from the state.

DOH will request that plans and providers sign attestations related to the use of funds.

DOH had provided funding to managed long term care plans for the period of October 15, 2015 to March 31, 2016 and those monies were passed on to their home care contractors. However, there were problems faced by plans and providers in the distribution of those funds due to unclear DOH guidance that led to differences in the ways that the funding amounts were calculated and distributed. HCA raised with DOH the concerns that were communicated by MLTCs and home care providers during that period and urged the Department to consider those concerns in creating a more workable process for this coming round of FLSA funding.

For the period of April 1, 2016 and afterwards, DOH stated that it had included FLSA funding in plans’ premiums, with plans and home care providers to determine FLSA cost and payments, and to return to DOH funds over and above the FLSA cost impact.

HCA appreciates the opportunity to discuss this issue with DOH and fellow associations, and will keep members informed of the developments. HCA anticipates having further information in the coming week which we will relay to home care providers and plans.

HCA will discuss this issue at Thursday’s HCA MLTC member Forum meeting in New York City on March 2 and in other and provider-MLTC venues upcoming.

HCA and Coalition of Health Care Organizations Oppose Cuts to Medicaid

This week, HCA joined eight New York organizations to communicate strong opposition to proposals in Congress that would end the Medicaid entitlement and place caps on Medicaid funding to states (see related p. 8 story.)

The letter, sent to New York’s Congressional Delegation, was signed by HCA President Joanne Cunningham and leaders of LeadingAge NY, 1199SEIU United Healthcare Workers East, the Continuing Care Leadership Coalition, the New York State Association of Health Care Providers, the New York State Health Facilities Association, the Adult Day Health Care Council, the Greater New York Health Care Facilities Association, and the Southern New York Association.

“The results of a decline in federal support for New York’s Medicaid program would be dramatic: severe reductions in reimbursement for providers, limits on needed services for beneficiaries or denying

Continued on next page
beneficiaries coverage all together,” the letter states. “Rural parts of the state are particularly vulnerable, with a limited number of providers.”


The letter reflects HCA’s federal advocacy on this issue, which has aimed to ensure that the New York Congressional Delegation is educated on the importance and value of New York’s Medicaid program which provides vital home care services to New York’s elderly and disabled residents. HCA will be launching a grassroots advocacy message to assist HCA’s member organizations in communicating directly to their Congressional Representatives regarding the importance of preserving and protecting New York’s Medicaid program.

FORUM from p. 1

home health Conditions of Participation (CoPs), minimum wage funding and other state-budget-related Medicaid reimbursement matters, the Home Health Prospective Payment System (HHPPS), MLTC rates, and much more.

We have all payor sources and issues covered to make this session as comprehensive as possible.

If you are a CEO, COO, CFO, finance manager or other senior-level staff member with responsibility over your agency’s or plan’s budget and finances, you will not want to miss this critical forum focused squarely on home care and MLTC finance issues. Please consider having several members of your team attend: for shared learning that keeps you all updated on critical reimbursement and finance trends.

At this program, HCA and state Department of Health reimbursement officials will detail everything you need to know about minimum wage and Fair Labor Standards Act funding procedures and amounts, the CHHA Episodic Payment System (EPS), MLTC premium payments and issues, the Medicaid Global Cap, the Delivery System Reform Incentive Payment (DSRIP) program and Value Based Payments, home care utilization data, Cost Report updates, HHPPS, and more.

We are also pleased to have Joy Cameron of the Visiting Nurse Associations of America (VNAA) who will specifically address the financial implications and watch-areas in the new home health CoPs, as well as the effect of Congressional moves to repeal and/or replace the Affordable Care Act and overhaul the Medicare and Medicaid programs. (See related p. 8 story.)

HCA members routinely ask for benchmarking data, and Simione Healthcare Consultants will provide a refresh of the latest CHHA EPS and Medicare HHPPS benchmarks on utilization, outlier episodes, service discipline mixes and more, both nationally and in New York State.

As a bonus, we’ve added a new session to the Forum on the finance implications of OASIS C2, which will give your team some important considerations to make in their oversight of cost factors related to clinician activities.

Please register today by faxing or e-mailing the registration form below.

A second hearing is occurring today in Albany, at which HCA and HCA members are testifying. HCA greatly appreciates the state Assembly’s focus on home care workforce issues. We especially thank HCA members – the Visiting Nurse Service of New York (VNSNY) and JASA – for sharing their insights with the panel last Wednesday on workforce pressures and needs faced by their organizations and patients during the New York City hearing.

In addition to VNSNY, JASA and several others, the New York Statewide Senior Action Council also testified. HCA has been working with the Council on advocacy coalescing around our shared concern over issues related to home care and Managed Long Term Care workforce capacity, recruitment and retention throughout the state.

Well before these hearings, HCA has engaged an action plan on this issue. As previously reported to the membership, we’ve already presented the Legislature with draft budget legislation that would set in timely motion a comprehensive, short-and-long-term plan to ensure statewide and regional home care capacity to meet the system’s and consumers’ needs. We hope the Assembly’s hearings today and last week elevate the need for such a comprehensive strategy that includes adequate reimbursement for wages, training and infrastructure investments, and other mechanisms to ensure workforce stability for the hundreds of thousands of New Yorkers who rely on home care.

During today’s testimony in Albany (after deadline for *The Situation Report*), HCA will be urging legislative support for our workforce proposals in the state budget and sharing aggregate findings supporting a comprehensive, holistic approach to workforce support.

According to our recent survey of the membership, home care agencies across New York State report a 24 percent turnover rate for home care aides and a 21 percent turnover rate for nurses and other professional staff. This same survey found that approximately 14 percent of home health aide, 17 percent of personal care aide, 13.5 percent of registered nurse, and 10.6 percent of therapist positions are unfilled due to shortages. Providers also report they are unable to accept an average of 37.3 cases due to staff shortages statewide.

We note that these shortages affect regions of the state in different ways, with variations even on a county-by-county level when it comes to the types of nursing, therapy, aide-level or social work staff needed to meet local demands and service patterns. HCA’s findings on workforce shortages and turnover rates also reflect the current field-level experiences of existing referral to home care, not the capacity growth and potential that are necessary for home care providers and Managed Long Term Care plans to achieve ambitious state reform goals, like a 25% reduction in unnecessary hospital use.

See next week’s edition of *The Situation Report* for updates on today’s Albany hearing as well as any other developments culminating from our advocacy in this critical area.

HCA thanks the Assembly Committees on Health, Aging and Labor, as well as the Assembly Task Force on People with Disabilities, for convening this important hearing.
Minimum Wage Survey Reminder

*March 3 deadline fast approaching*

HCA reminds members that the minimum wage survey developed by the state Department of Health (DOH) is due **March 3**.

The survey is being disseminated to help DOH determine the financial impact of the minimum wage increase legislation for state fiscal year 2017-18 (and later) and to assist DOH “in developing a reimbursement methodology that will respond to the benchmarks of the Minimum Wage statute.”

The survey is at [http://www.surveygizmo.com/s3/3300538/Minimum-Wage-Survey-Home-Care-Final](http://www.surveygizmo.com/s3/3300538/Minimum-Wage-Survey-Home-Care-Final). Those agencies that provide fiscal intermediary services are asked to complete a separate survey for personal assistants.

The survey asks agencies to report the number of hours that employed staff were paid at various wage levels and the percentage of wages currently spent on payroll taxes and other benefits which are provided and paid as a percentage of wages or required to increase if wages go up, for **2016**. The information is requested to be divided by: 1) New York City; 2) Long Island; 3) Westchester; and 4) the rest of the state.

DOH advises agencies that if they do not respond to the survey, this may impact the minimum wage rate adjustment on behalf of their agency/facility/program.

HCA has obtained PDF copies of the survey ([http://hca-nys.org/wp-content/uploads/2017/02/Minimum-Wage-Survey_DOH_Final_021417.pdf](http://hca-nys.org/wp-content/uploads/2017/02/Minimum-Wage-Survey_DOH_Final_021417.pdf)) and its accompanying attestation form ([http://hca-nys.org/wp-content/uploads/2017/02/Minimum-Wage-Survey-Attestation_DOH_Final_021417.pdf](http://hca-nys.org/wp-content/uploads/2017/02/Minimum-Wage-Survey-Attestation_DOH_Final_021417.pdf)). We suggest that you first print out the PDF survey form and complete the hard copy before filling out the online format. This will assist in the process, as the online version of the survey does not allow you to complete parts of the survey, nor save those sections and then return to complete the rest at a later time.

We also want to inform members that the attestation, once signed by your CEO or CFO, needs to be uploaded to your computer and sent along with the completed survey.

HCA has received many questions on the survey and has directed members to send those questions that need direct DOH response to mltcrsmw@health.ny.gov (please copy Andrew Koski at akoski@hcany.org).

DOH has also told us that it will be working toward a formal cost report system to capture necessary data not obtained from the survey, and we have asked DOH to be involved in development of this cost report.

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

Statewide call Frames LTHHCP Opportunities

*More to come in DOH follow-up on Q&A, LTHHCP for Pediatrics cases, and other areas*

Long Term Home Health Care Providers (LTHHCPs) and partners convened for a statewide call Thursday with state Department of Health (DOH) officials discussing new developments and opportunities applicable to the program.

The call, hosted by HCA, reviewed DOH’s policy that now allows LTHHCPs to directly admit and bill for services following the same standard guidelines as for certified home health agencies.
For billing purposes specifically, DOH has worked over the past several months to upload Episodic Payment System (EPS) reimbursement rates for LTHHCPs onto the state system, in line with the EPS billing process now utilized for CHHA cases outside of mandatory managed care enrollment. The admission process and rates are live for LTHHCP use as soon as the LTHHCPs are ready. DOH verified on the call than no further state action is needed in order for LTHHCPs to admit and bill.

The policy essentially enables LTHHCP providers, under their LTHHCP operating certificate, to function in a home health agency capacity, since LTHHCPs inherently also meet the federal and state conditions of participation to do so, akin to CHHAs. The state’s managed care enrollment requirements, unchanged by this development, continue to apply as they do for CHHAs and other providers. However, under the policy and new reimbursement system, LTHHCPs can function in the system both directly and in strategic partnership with managed long term care plans, managed care organizations, hospitals, physicians, and other partners while also billing directly to Medicaid for EPS cases that fall outside of mandatory managed care enrollment.

HCA and providers raised a series of questions on the call, including reimbursement clarifications for existing LTHHCPs to provide personal care services or personal care service assessments for local social service districts. HCA also sought clarification of LTHHCP provision and billing of waivered services under the new Community First Choice Option (CFCO) being implemented by the state in managed care – specifically how LTHHCPs may function as CFCO waiver service providers/billers for MLTCs and MCOs.

HCA also asked about LTHHCP billing rates and procedures for pediatric cases, including whether the rate and billing system for such cases would be the same as is currently in place for CHHAs. HCA noted that the state’s value based payment initiative includes targeted areas for pediatric services such as maternal and child health, high-risk prenatal and perinatal care, pediatric asthma, and others that LTHHCPs can now provide.

Q&A document preparation underway – provider inquiries sought

HCA will be preparing a summary of the Q&As discussed on the call, and will submit this compilation for DOH’s review, finalization and determination of how best to disseminate it. HCA member providers and MLTCs can submit further questions directly to HCA Vice President Andrew Koski at akoski@hcany.org for inclusion with HCA’s submission to DOH.

In your inquiries, providers may wish to consider the potential strategic application of LTHHCP in a new environment including: DOH’s granting of LTHHCP safety-net status under DSRIP; the potential LTHHCP role in value based payment arrangements; and partner opportunities under MLTC and mainstream managed care.

We invite member providers and MLTCs to share with us directions you choose to take. HCA will keep members apprised of developments.

HCA thanks DOH officials participating in this effort and in last week’s call, particularly Mark Kissinger, Rebecca Fuller Gray, Steven Simmons, Diane Jones and Margaret Willard, and their teams.
Technical Issues Prompt DOH Delay of Universal Billing Codes

The state Department of Health (DOH) is postponing the May 1 implementation of universal billing codes for home and community-based long term care services under managed care.

The delay stems from technical issues with the codes and their compliance with Health Insurance Portability and Accountability Act (HIPAA) standards by the U.S. Centers for Medicare and Medicaid Services (CMS).

HCA has been in contact with our MLTC plan members, providers and DOH about this issue, and a potential course for a solution.

In an e-mail exchange with HCA, the Department has indicated it will be “revamping the modifiers and the presentation so that we are HIPAA compliant” and sharing these changes with the home care and MLTC community soon. “Any proposed changes to the billing codes will be distributed to both plans and providers for comment prior to being finalized,” the Department explains. “Upon completion of the review, new guidance regarding both the codes and the revised implementation deadline will be issued.”

DOH is scheduling a meeting for HCA and other representatives in the very near future to discuss a proposed solution to billing code revisions that will ensure HIPAA compliance and avoid any other complications.

The uniform billing codes were developed pursuant to language in the final 2015-16 state budget.

HCA will be discussing this issue and concerns further with providers and MLTC members. HCA has also scheduled this discussion for our upcoming meeting with HCA MLTC Forum plans (on Thursday, March 2 in New York City). HCA will be providing further updates and communications to all members as the next steps proceed and we will be discussing these issues at our upcoming March 15 Senior Financial Managers Forum, in our newsletter, or e-mail alerts in the interim.


The Department is asking that any questions about this matter be sent to nfrates@health.ny.gov.

HCA will immediately inform the membership of any further updates as we gain additional information from our discussions with the Department.

House Unveils ACA Repeal-and-Replacement Measure

Just before last week’s Congressional recess, U.S. House Republicans previewed their long-vowed plan to repeal and replace the Affordable Care Act (ACA). A draft bill was later leaked to the press, providing further details on the plan under consideration. (See http://www.politico.com/story/2017/02/house-republicans-obamacare-repeal-package-235343.)

At the heart of ACA is an “individual mandate” requiring Americans to obtain insurance – with income-based government subsidies in certain cases – or else face a financial penalty. The House Republican Majority’s plan, as announced publicly, would eliminate the penalties as well as taxes and fees that fund ACA’s coverage provisions. In place of the individual mandate, the G.O.P. proposes tax credits for individual insurance
purchases, along with the establishment of incentives for health savings accounts. The leaked version of a draft bill calls for limits on tax-breaks for higher-cost employer-sponsored health insurance premiums.

House Republicans are also proposing to claw back the expanded Medicaid payments that many states, including New York, have opted for as a way of extending insurance coverage to lower-income Americans alongside private insurance coverage choices in ACA’s health exchanges.

Medicaid would, instead, be administered as a block-grant program, with states receiving a lump-sum payment for Medicaid services rather than a federal match structured under the current open-ended entitlement. (See related p. 3 story about the actions of HCA and allies to opposed Medicaid caps and changes.)

The G.O.P.'s Medicaid proposal, in particular, could mean a significant loss of federal money to New York – and some ripple effects are already being felt. According to the Times Union newspaper last week, New York State health officials have notified the vendor for the state’s proposed billing system upgrade that the state may need to cancel the $550 million project that is otherwise funded at 90 percent from the federal government under the current Medicaid levels.

Meanwhile, at a rally last week in the Bronx, Governor Cuomo implored Democrats in Congress to “stand up and fight” against the ACA repeal measure, citing the risk that 2.7 million New Yorkers – who obtained health insurance through the Medicaid expansion and insurance exchanges – would lose coverage. The Governor also estimated that New York stands to lose $3.7 billion in federal funding under ACA’s repeal, blowing a major gap in the state budget which could put pressure on other health or non-health care priorities, including implications for home care.

House Speaker Paul Ryan indicated that a bill on the ACA repeal and replacement is forthcoming after the President’s Week recess, which ended on Friday. President Trump has indicated that a White House health care plan would additionally be released, sometime in March, though it is unclear how this plan coordinates with the efforts underway in Congress.

Regulatory Freeze Halts Bundled Payment Initiatives

In other federal health policy news, the President’s executive order freezing business regulations has led to a 60-day delay for new and expanded bundled payment models to take effect.

Blueprint for OASIS Accuracy: OASIS C-2

April 19-20 Workshop, 8 a.m. to 4 p.m.
April 21 COS-C Exam, 9 to 11:30 a.m.
Doubletree by Hilton
100 Nott Terrace Schenectady, NY 12308

This two-day OASIS-C2 data collection workshop provides effective, up-to-the-minute education targeted for field data collectors, their supervisors and those preparing for the COS-C Exam.

Experience the comprehensive and nationally acclaimed two-day Blueprint for OASIS Accuracy workshop and learn to confidently teach, audit and collect OASIS items accurately. Through guided, expert instruction, and participation in problem-solving discussions and application scenarios, participants will achieve mastery of the OASIS items, conventions, and the latest data collection rules. Rather than provide opinions, assumptions, or unfounded interpretations, the “Blueprint” presenters will model reliance on U.S. Centers for Medicare and Medicaid Services (CMS) guidance documents and provide and demonstrate strategies for how to find defendable answers to your OASIS questions.

Individuals may register for the workshop, the exam or both. Please note the exam fee is in addition to the two-day workshop fee.

Registration is at http://hca-nys.org/events-education/upcoming-events.

Continued on next page
The models, finalized by the U.S. Centers for Medicare and Medicaid Services (CMS) in December, were initially set to take effect on July 1. Under the models, hospitals are responsible for cost controls related to cardiac, joint replacement and other procedures through risk and reward incentives that promote coordination with post-acute providers, including home care. HCA will report back on the status of these initiatives as more details become known.

Within this environment, HCA has redoubled our efforts seeking regulatory relief in several areas, such as the Medicare face-to-face requirement, pre-claim review demonstration, limitations on practitioners authorized to order and refer home care services, and the implementation schedule of the new Home Health Conditions of Participation (CoPs).

In a related development this week, New York Rep. John Faso is introducing a CoP-delay bill sought by HCA. (See related p. 1 story.) We will continue to press vigorously for these and other critical regulatory changes, while opposing dangerous cuts to home health services, as members of Congress reconvene.

**State Officials Engage with HCA Quality Committee**

Key state Department of Health (DOH) officials met on Thursday with members of the HCA Quality Committee to discuss innovations in home care and managed long term care quality.

Participants included DOH Office of Health Insurance Programs Medical Director Douglas Fish, MD; new DOH Division of Long Term Care Medical Director, Khalil Alshaer, MD, MPH; and Office of Quality and Patient Safety principal Raina Josberger – a great and productive opportunity for HCA and the committee to engage with some of the most significant DOH representatives on quality.

The officials presented the latest quality metrics, recommendations and directions of the Department

“Unpack the Home Health CoPs” with HCA on April 5

HCA provider and MLTC members: Join HCA for an in-person, comprehensive session that will be “Unpack the New Home Health CoPs” in Albany on April 5.

This program is the second installment of HCA education to assist providers on the most significant federal regulatory changes in 30 years: the newly finalized revisions to the Home Health Conditions of Participation (CoPs).

We recently offered a webinar on this topic. Our April 5 session will take you deeper into the CoPs, offering implementation action items, operational and clinical practice refinements, and insights from peer agencies that have already begun moving quickly with their compliance and readiness activities for the July 13 effective date.

Barring an implementation delay, providers only have a few months to get ready for this sprawling new set of regulations affecting all aspects of your agency. (See related p. 1 story on HCA’s efforts for an implementation delay to give providers and state surveyors more preparation time.) Don’t miss this opportunity for further insights and tools to set your agency on a path to success in CoP readiness, especially if you are a CEO, COO, Administrator, Clinical Supervisor, Director, Educator, Performance Improvement Manager or are responsible for the oversight and delivery of care and services.

This program is presented by Trish Tulloch, a seasoned clinician and home care operational management consultant who works with multiple health care organizations to meet regulatory and accrediting standards.

**Unpacking the New Home Health CoPs**
April 5, 2017
Albany Marriott (189 Wolf Road)
and its advisory committees for the value based payment model, the Delivery System Reform Incentive Payment (DSRIP) program and managed long term care. HCA also serves on all of these advisory committees.

Meanwhile, HCA, in turn, presented our Quality Measurement, Risk and Compliance Tool that we are seeking to automate with potential technology companies for use by the entire HCA membership. HCA and DOH officials discussed ways of synchronizing the Department’s and HCA’s metrics.

HCA also discussed the status and imminent launch of the HCA home care sepsis screen and intervention tool, presenting DOH with the latest compelling data. We noted that sepsis intervention holds enormous promise for quality and cost-containment – including avoidance or reductions in hospitalization, rehospitalization, or longer lengths of stay – in ways that have generally been overshadowed by interventions for other leading conditions, such as acute myocardial infarction or COPD, which are actually eclipsed by the risks posed by sepsis.

The Committee also discussed the MLTC Quality Incentive payment methodology and 2017 plans for incentive payments, and the quality measurement and performance implications of the new federal Home Health Conditions of Participation (CoPs). (See related p. 1 story on HCA’s legislative efforts aimed at a delay in the CoP implementation date to allow more time for preparation by providers and state surveyors.)

HCA will be following up on multiple areas identified during the committee discussion.

For further information, please contact acardillo@hcanys.org.

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<th>Important Upcoming Deadlines</th>
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<tr>
<td><strong>Requirement</strong></td>
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<td>Home Care Worker Wage Parity certification forms for CHHAs, LTHHCPs and Managed Care Organizations (MCOs) that serve New York City, Long Island and Westchester</td>
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<tr>
<td>Home Care Worker Wage Parity certification forms for LHCSAs that contract with CHHAs, LTHHCPs, or MCOs serving New York City, Long Island and Westchester</td>
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OMIG Issues Revised LTHHCP Audit Protocols

The state Office of the Medicaid Inspector General (OMIG) has shared with HCA revised audit protocols that apply to LTHHCP service dates prior to December 31, 2013.

The current protocols apply to service dates prior to December 31, 2012. The revised protocols are expected to be posted soon at https://www.omig.ny.gov/index.php/audit/audit-protocols.

While much of the protocol language is the same or slightly revised, there were some changes that HCA will be examining more closely, including revisions to protocol numbers 4 (Failed to Obtain Authorized Practitioner’s Signature Within Required Time Frame), 12 (Initial Assessment Not Documented/Late) and 22 (Patient Excess Income Not Applied Prior to Billing Medicaid).

For more information, contact the HCA Policy staff.

HCA-State Medical Society Task Force Meets on Key Areas of Concern

The HCA-State Medical Society Task Force on Physician-Homecare issues met on Friday, progressing in key areas of concern.

The Task Force combines physician members from the Medical Society of the State of New York (MSSNY), MSSNY executive staff, HCA home care agency and MLTC directors, and HCA executive staff. The Task Force has been meeting regularly since last September, working to mitigate obstacles to physician-homecare engagement, and to promote and strengthen physician-homecare-MLTC partnerships.

Issues discussed at Friday’s meeting included: a dominant focus on joint efforts and potential new avenues for HCA and MSSNY to mitigate federal and state “face-to-face” encounter mandate burdens; outreach to hospitals to embed home care eligibility criteria within the hospital’s electronic health record and discharge summary; implications of state budget proposals and opportunities for physician-homecare collaboration; new areas of research or initiative, including new physician-homecare health information exchange technology; new research on encouraging patients to overcome hesitancy in accepting home care when home care is necessary and referred by the physician; and a webinar being planned for physician orientation to HCA’s new home care sepsis screening tool.

Between meetings, HCA and MSSNY collaborated on and exchanged joint advisories to our mutual homecare-physician memberships about the 2017 phase of the “Probe and Educate” activity. As previously reported, this effort by the U.S. Centers for Medicare and Medicaid Services’ fiscal intermediaries involves audits, potential claim denials, and follow-up education concerning Medicare documentation requirements like the face-to-face requirement. HCA and MSSNY are seeking to disseminate parallel messages about the importance of “Probe and Educate” sessions and documentation compliance.

HCA will keep the membership informed of our progress with these items. The Task Force continues to be an excellent forum for physician-homecare-MLTC discussions.

For further information, please contact acardillo@hcans.org or pconole@hcans.org.
MMCARP Meeting News

HCA participated in this week’s Medicaid Managed Care Advisory Review Panel (MMCARP) meeting. The following information was provided.

DOH held a brainstorming session with Fully Integrated Duals Advantage (FIDA) plans on February 17 to discuss the future of FIDA. DOH will be requesting public comment about integrated care in New York; this will consist of meetings to start in the next couple of months.

Suffolk and Westchester counties will be opening for voluntary FIDA enrollment (including HCA-member-sponsored FIDAs) in March, and plans will be approved on a rolling basis as their Medicare and Medicaid provider networks pass certain requirements.

DOH reported that the Programs of All-inclusive Care for the Elderly (PACE) Model Expansion Request for Information (RFI) received responses from a variety of stakeholders, offering the following key recommendations:

- Expanding the eligibility criteria for covered populations;
- Integrating PACE with housing supports;
- Innovative models that provide alternatives to Center-based services;
- Expansion of rural-based PACE;
- A larger role for telehealth and emerging technologies;
- Community outreach and increasing the awareness of PACE;
- Expanding partnerships with other providers and community organizations; and
- Streamlining and greater flexibility in the Interdisciplinary Team process.

Early last year, DOH had issued a Request for Information (RFI) to solicit suggestions about the PACE model of services and supports, specifically to explore strategies and concepts to enhance and expand this approach for providing long term services and supports (LTSS). DOH indicated that responses to this RFI will help it to develop a comprehensive analysis of the impact PACE has on LTSS in the state and develop possible strategies to expand the current PACE model.


The RFI followed enactment of federal legislation in 2015 – the PACE Innovation Act – authorizing the U.S. Secretary of Health and Human Services (HHS) to design and test new models. As a result, CMS allows providers and other entities which are not currently PACE providers to consider adapting the model to serve new populations in innovative ways. The Act creates opportunity for these new populations previously not
qualified for PACE programs to be served by this model. In addition, in June of 2015, CMS used its waiver authority to allow for-profit entities to operate PACE demonstration programs.

**NGS Provides Updates on Two Hospice Claim Issues**

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), has recently provided the following information regarding two hospice claims-processing issues.

**Routine Home Care Rates for Part A Hospice Claims Corrected**

NGS has informed hospice providers of a correction to a prior error in Routine Home Care (RHC) rates for Part A hospice claims. For claims with dates of service on or after January 1, 2016, there are two hospice routine RHC rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. In 2016, hospice claims were paying at the incorrect RHC rate.

An RHC payment correction was installed on January 3, 2017. Hospice providers are advised that they can now adjust claims impacted by this issue. Hospices should continue to check the Production Alerts section of NGS’s website and NGS’s list serv updates for additional information regarding this issue.

**Part A Hospice Claim Adjustment Issue on EOL SIA Payments**

NGS has informed hospice providers of a Part A issue relative to the End of Life (EOL) Service Intensity Add-on (SIA) payments that did not occur via an unsolicited adjustment process defined in Change Request (CR) 9201.

For impacted claims, the unsolicited adjustment did not auto create when the subsequent claim was billed with the discharge equal to deceased (patient status 40, 41, 42) and the date of death (DOD) occurred within the first days of the subsequent month. Also, retractions of the EOL SIA payment occurred on hospice unsolicited adjustment records during a period of a few weeks in September 2016.

According to NGS, a correction to both issues was made on January 3, 2017. However, NGS is awaiting direction from the U.S. Centers for Medicare and Medicaid Services (CMS) on resumption of mass adjustment for these claims. Hospices should continue to check the

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**Bootcamp: Maintaining an Effective Compliance Program**

March 23, 2017
New York City
9:30 to 10 a.m. (registration and continental breakfast)
10 a.m. to noon (program)

HCA is holding a bootcamp session on March 23 in New York City (from 9:30 a.m. to noon) to help providers establish and maintain an effective compliance program — a topic that is all the more important during a time of heightened compliance scrutiny and multiple audits by state and federal agencies.

This program, presented by compliance expert Rachel Hold-Weiss of the Arent Fox Health Care Group, will convey why a compliance program is needed, state and federal requirements for compliance programs, the eight required elements of a compliance program, staff training, state and federal audit protocols, the disclosure process, compliance program testing, and more.

Registration is at [http://hca-nys.org/events-education/upcoming-events](http://hca-nys.org/events-education/upcoming-events).
Production Alerts section of NGS’s website and NGS’s list serv updates for additional information regarding this issue.

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

CMS Releases Market Saturation and Utilization Data Tool

The U.S. Centers for Medicare and Medicaid Services (CMS) has developed a Market Saturation and Utilization Data Tool, formerly called the Moratoria Provider Services and Utilization Data Tool. It includes interactive maps and a dataset that show national, state, and county-level provider services and utilization data for selected health service areas, including home health.

Market saturation refers to the density of providers of a particular service within a defined geographic area relative to the number of the beneficiaries receiving that service in the area.

The analysis is based on paid Medicare claims data from the CMS Integrated Data Repository (IDR). The IDR contains Medicare and Medicaid claims, beneficiary data, provider data, and plan data. Claims data are analyzed for a 12-month reference period, and results are updated quarterly to reflect a more recent 12-month reference period.

CMS uses the tool to monitor and manage market saturation as a means to prevent fraud, waste, and abuse. The data can also reveal whether use of a service is related to the number of providers servicing a geographic region. The data, now made public, can also assist health care providers in decisions about their service locations and the beneficiary population they serve.

CMS’s tool is available at https://data.cms.gov/market-saturation.

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

OSHA Reminds Employers to Post Certain Information

The federal Occupational Safety and Health Administration (OSHA) has reminded employers they must post a copy of the agency’s “Summary of Work-Related Injuries and Illnesses, Form 300A” (https://www.osha.gov/recordkeeping/RKforms.html) summarizing job-related injuries and illnesses logged during 2016.

Each year, between February 1 and April 30, employers must display the Summary in a common area where notices to employees are usually posted. Employers must fill out and post the Summary annually, even if no recordable work-related injuries or illnesses occurred during the year.

Under its recordkeeping regulation, OSHA requires certain covered employers to prepare and maintain records of serious occupational injuries and illnesses using the “Log of Work-Related Injuries and Illnesses, form OSHA 300” (https://www.osha.gov/recordkeeping/RKforms.html).

At the end of 2016, OSHA also updated its recordkeeping rule to clarify that employers are required to maintain OSHA 300 logs for a period of five years. Moreover, starting on January 1, 2017, certain employers
are required to electronically submit information from their OSHA 300 logs and OSHA will then make that information publicly available on its website.

Currently, employers, including home health and hospice, are required to record information about certain injuries and illnesses occurring in their workplaces, and to make that information available to employees, OSHA, and the Bureau of Labor Statistics.


This story is based on information provided by Jackson Lewis, our counsel’s firm.

**Resources**

- “Episode Payment Model Operations,” by the U.S. Centers for Medicare and Medicaid Services  

- “Preventing Hospice Notices of Election with Future Dates,” by the U.S. Centers for Medicare and Medicaid Services  

- “Block Grants and Per Capita Caps Pose Risks for Medicaid Beneficiaries and for States,” by AARP Public Policy Institute  
  [http://www.aarp.org/content/dam/aarp/ppi/2017-01/Block%20Grants.pdf](http://www.aarp.org/content/dam/aarp/ppi/2017-01/Block%20Grants.pdf)

- “Medicaid’s Role for Medicare Beneficiaries,” by the Kaiser Family Foundation  
  [http://files.kff.org/attachment/Issue-Brief-Medicaids-Role-for-Medicare-Beneficiaries](http://files.kff.org/attachment/Issue-Brief-Medicaids-Role-for-Medicare-Beneficiaries)

- “Emergency Department Visits for Injury and Illness Among Adults Aged 65 and Over: United States, 2012–2013,” by the U.S. Centers for Disease Control and Prevention  
  [https://www.cdc.gov/nchs/data/databriefs/db272.pdf](https://www.cdc.gov/nchs/data/databriefs/db272.pdf)

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