HCA Advocates on Draft Minimum Wage Funding Guidelines

HCA has been working vigorously with association partners and stakeholders in response to draft guideline language from the state Department of Health to define and dictate the financing and disbursement of minimum-wage-related cost coverage for managed care plans and providers under Medicaid, addressing the upcoming December 31, 2016 minimum wage increase.

See WAGE p. 3

Time Is Running Out for This Week’s Women’s Summit – Last Call to Register

HCA’s Women in Healthcare Leadership Summit later this week is not to be missed. Will I see you there? Time is running out!

We’ve already told you about the incredible learning sessions at the summit, on September 28-29 in

See WOMEN p. 2
WOMEN from p. 1

Saratoga. But the conference also offers several great amenities to help you unwind, be your best ... and indulge a little bit.

After a morning and early afternoon of speakers on September 28, HCA is offering an “Executive Headshot Station,” where you’ll get to pose for a free headshot photo to use on your professional or social-media networks.

Our afternoon “Women’s Mino-Expo” features over a dozen vendors. There, you can treat yourself to the corporate spa space, or check out some fun and trendy vendors offering accessories and other shopping that we picked out just for you.

Evening festivities on September 28 include an Appetizer Cooking Demo, a networking reception, and a wine tasting hosted by a seasoned wine connoisseur teaching you about selections and pairings.

This segment of the program offers an opportunity to network, unwind, relax and recharge after a full program of top-tier leadership training. It will prepare you for another day of sessions on September 29, where the learning continues during this two-day summit.

There is still time to register for this inaugural conference in beautiful Saratoga Springs – a perfect early fall setting for leadership training.

Download the brochure or register online at the links below. We can’t wait to see you in Saratoga.


Online registration: https://www.eventville.com/Catalog/EventRegistration1.asp?EventId=1011975
WAGE from p. 1

As we’ve reported to you in recent communications, including an alert last week, HCA has made several recommendations and language suggestions for this guideline document, now under fervent discussion.

Our core position is that the guidelines must ultimately assure full coverage of minimum-wage-related cost increases, including a direct pass-through of rate increases from managed care plans to home care providers, fully covering the costs borne by providers for the minimum wage increases effective December 31, 2016. The state has pushed back against any language that clearly delineates such a pass-through and HCA has suggested language that leads to the same result without such wording.

In meetings last week in New York City and Utica, and a conference call with a subgroup of LHCSA providers, home care members have stressed to HCA the necessity of receiving such funds if they are to afford paying the minimum wage increase to their aides. Many of our MLTC members have indicated that they favor clear guidance from the state on how to distribute the funds in order to avoid the same kinds of problems faced in distributions of the separate wage-related Fair Labor Standards Act (FLSA) funding.

We stress that this is an incredibly dynamic process, with proposed language changes and fine-tuning by stakeholders across the continuum, including provider and plan association representatives. We expect that a final version of the guidelines will be shared with the associations and stakeholders imminently, and developments on this discussion are moving at a very fast pace.

HCA will keep you closely apprised of any material developments, via e-mail alert and/or in our newsletter as changes occur. Please stay tuned.

HCA Offers Oct. 20 Bootcamp: Federal, State Wage & Hour Rules

If you attended our recent Senior and Financial Manager’s Retreat or Annual Conference, you know that the attorneys from Hodgson Russ are in-demand experts on all areas of home care labor law. Their sessions have garnered rave reviews, and now HCA has invited them to provide an even deeper look at labor law issues during an October 20 Bootcamp in New York City entitled “Understanding the Federal and State Wage & Hour Rules for Home Care Providers and Rising Above the Challenges.”

Hodgson Russ Attorneys Peter Godfrey, John Godwin and Emina Poricanin specialize in wage and hour laws for the home care industry. They’ll discuss the key federal and state compensation requirements for home care providers, also covering topics such as: accurate computation of the regular rate of pay; properly paying overtime; accurately tracking work time, including travel time; spread of hours and split-shift pay; call-in pay regulations; the Domestic Workers’ Bill of Rights; and the Wage Parity Law.

The session will additionally provide an overview of some of the most pressing challenges to the home care industry, including litigation of live-in cases, complications created by the elimination of the companionship exemption, and the rise in private plaintiff class-action litigation. Attendees will develop a greater understanding of their legal obligations and learn about tips to overcome some of the most difficult issues plaguing the home care industry today.

If you missed the Hodgson Russ team at our Annual Conference and Senior and Financial Managers Retreat, or feel you could use a refresh or deeper dive into these issues, you will not want to miss this session, which is expected to draw a big turnout. A registration form is at the back of this week’s Situation Report or on our website at www.hca-nys.org.
Update on 24-Hour Sleep-In Care and MLTC Payments

HCA has communicated to the new Director of the Division of Long Term Care at the state Department of Health (DOH) in our continued effort to address the practice of some MLTC plans to not pay at least 13 hours for 24-hour sleep-in cases.

DOH posted guidance in the fall of 2014 stating: “Previous guidance on how to pay individuals working on live-in cases indicated that the rate of payment was based on 12 hours of care. Effective immediately, MLTCPs and their network providers are required to provide a rate of payment that is based on at least 13 hours of care.”

While most MLTC plans complied with this policy, there have been a few plans that have not. They have contended that they pay a per-diem rate (not hourly) for such cases and, thus, their rate does not have to equal 13 hours of the contracted hourly rate to home care providers.

Based on outreach from HCA members to address these payment questions, HCA contacted DOH numerous times, but the issue has not been resolved. Last week, HCA brought this matter to Andrew Segal, Director of Long Term Care. Our communication stated:

The action of these plans is not fair to the other MLTC plans that are in compliance with Policy 14.08, and are exacerbating the financial pressures on our home care agencies which already face new wage, benefits and other related and new costs.

We have exhausted all means to rectify this situation and would greatly appreciate any assistance you can provide.

HCA will keep members updated on any new developments with this issue.

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

HCA Bootcamp: Addressing Factors that Increase Workers’ Compensation Costs and Developing Ways that Home Care Providers Can Reduce Their Expenses

September 28, 2016
130 East 59th Street (near Lexington Ave.)
7th Floor
New York, NY 10022
9 to 9:30 a.m. Registration and continental breakfast
9:30 a.m. to noon program

HCA is holding a program on Wednesday to assist agencies with Workers’ Compensation costs.

This program will address fixed and variable costs affecting Workers’ Compensation insurance for home care agencies, and ways in which those agencies can affect the variable costs to significantly improve their bottom lines.

The financial burden of Workers’ Compensation has been increasing for home care providers due to numerous factors. Agencies face the potential for additional increases due to the recently enacted $15 minimum wage and a shrinking Workers’ Compensation insurance market.

This program will help agencies develop a cohesive Workers’ Compensation risk management strategy and play an active role in reducing their costs.

CMS Delays Home Health Pre-Claim Review Demo Opposed by HCA, Partners

The U.S. Centers for Medicare and Medicaid Services (CMS) has announced a delay in the expansion of the Home Health Pre-Claim Review Demonstration, which drew opposition from HCA and other associations nationally for its onerous intrusion into claims authorization for duly administered home health services.

Based on early reports of difficulty from home health agencies in Illinois, CMS has stated that more education is needed, especially in the areas of how to submit pre-claim review requests, documentation requirements, and common reasons for non-affirmation.

CMS intends to take additional time prior to expanding this demo to other states, including Florida, Texas, Michigan and Massachusetts (New York is not included in the current demo); the beginning dates for these states have not been announced. CMS said it will provide at least 30 days’ notice on its website prior to beginning in any of the other demo states. CMS continues to expect a staggered start, beginning with Florida.

Under this demo, the home health agency (HHA) must submit a request for pre-claim review to the Medicare Administrative Contractor (MAC) for each episode of care. The HHA will have to submit documentation from the medical record that supports medical necessity, and demonstrates that the Medicare home health coverage requirements are met (including the face-to-face/F2F encounter).

The pre-claim review request may be submitted at any time before the final claim is submitted, and the review process must occur before the final claim is submitted for payment.

Though not currently affecting New York State providers, HCA has firmly opposed the demonstration. We submitted comments voicing extensive concerns about pre-claim review and we similarly commented on a prior iteration of the demo that required prior authorization. This earlier prior-authorization demo was distinct from its successor pre-claim review demo. Prior-authorization would have required a MAC decision before services commenced, whereas pre-claim review puts the authorization process at the claims-submission stage, after services have commenced.

HCA also obtained signatures from New York Congressional Representatives as part of a Congressional letter in opposition to the prior-authorization demonstration and worked with the New York Delegation on a separate letter to CMS. Engaging members on grassroots advocacy, HCA employed our Phone2Action Legislative Action Center where members sent over 500 messages to Congress opposing this program.

CMS says the demo is in response to previous government reports that show “evidence of fraud and abuse in Medicare’s home health benefit” and a 59 percent improper payment rate for home health claims that is attributed largely to insufficient documentation. Furthermore, the demonstration states were targeted as “high-risk states” under the temporary moratoria on home health provider enrollment authorized under the Affordable Care Act.

HCA has argued that the physician face-to-face (F2F) encounter requirement is responsible for the large number of documentation issues targeted by this demo, due to the onerous and unworkable way the requirement has been administered by CMS/MACs. HCA has worked and will continue to advocate for reforming and simplifying the F2F mandate so that it can be met by home health agencies and ordering physicians.

HCA’s comments on pre-claim review and prior-authorization are posted to our website in the “Letters and Comments” section at http://hca-nys.org/category/letters-and-comments.
Historic OIG Fines in Home Care Offer Cautionary Tales: Get Your Compliance Plan in Shape at October 6 Symposium

Recent news reports have offered some major cautionary tales in the compliance arena for home care. Just last week, the Office of the Inspector General (OIG) imposed the “largest-ever penalty of its kind” – at $3 million – on one home health organization in the south related to billing practices. Similar audits and enforcement actions, amounting to several millions of dollars, have been reported in recent weeks by the Boston Globe and other media outlets.

Again, these headlines and others about payment, operational and record-keeping compliance present dramatic numbers and implications; compliance activities, great or small, must be a top concern at all levels and functions in your agency. Compliance oversights not only risk your quality of care and your bottom line, but may also harm your reputation.

HCA’s Corporate Compliance Symposium, on October 6, is one of our signature annual events. In fact, it’s our most comprehensive and biggest compliance program of the year, drawing top officials from the state Office of the Medicaid Inspector General (OMIG), the federal Office of the Inspector General (OIG), the state Department of Health’s surveillance and regulatory compliance offices, and legal experts, all offering you updates, tips, and compliance answers.

This conference is little more than a week away. Please read the conference agenda at the link below and we are certain you will find that this is one conference you cannot afford to miss. A link to online registration is below as well.


Online registration: https://www.eventville.com/catalog/eventregistration1.asp?eventid=1012021

CAHPS Preview Reports Available

Preview Reports with results from the Home Health Care CAHPS (HHCAHPS) survey from April 2015 through March 2016 are now available on https://homehealthcahps.org. This period accounts for quarter 2 of 2015 through quarter 1 of 2016. These same data will be updated on Home Health Compare (HHC), at www.medicare.gov, in October.

The Preview Reports present the publicly reported results with Star Ratings for those agencies with a sufficient number of completed interviews to receive Star Ratings. Agencies must have data for 40 or more patient surveys in the reporting period in order to have Star Ratings.

To access your agency’s Preview Report, log into the HHCAHPS website using your username and password. Select the “Preview Reports” link under the “For HHAs” tab. If you have forgotten your password, click the login link, type in your username, click “Forgot Password,” and follow the directions to have your password sent to you via e-mail.

Continued on next page
If you have comments about your HHCAHPS Star Ratings on the Preview Report, send an e-mail (by September 30, 2016) to hhcahps@rti.org and include the following information:

- Your name, your facility name, CMS Certification Number (CCN), and contact information.
- Your comments about your preview report.
- Evidence showing why the Star Ratings are incorrect. Note that your history of receiving higher ratings is not considered viable evidence. You must provide information showing that the data submitted by your vendor for the most recent quarter are incorrect and therefore may have impacted the assigned HHCAHPS Star Ratings for your agency.

For more information about the Preview Reports, refer to this document on the HHCAHPS website, accessible once you are logged in: https://homehealthcahps.org/LinkClick.aspx?fileticket=rEmqINcxYK8%3d&tabid=277.

For more information about HHCAHPS Star Ratings, including Frequently Asked Questions, go to https://homehealthcahps.org/GeneralInformation/StarRatingsInformation.aspx.

If you have any questions about the HHCAHPS Star Ratings or your HHCAHPS Preview Report, contact the HHCAHPS Survey Coordination Team at hhcahps@rti.org or (866) 354-0985.

**eMedNY Manual Update Covers HCA-Sought Physician Order Change**

eMedNY has posted an updated General Billing Manual and Frequently Asked Questions (FAQs) on “Delayed Claim Submission” addressing HCA-sought changes in the physician order timeline for purposes of billing.

The documents are at https://www.emedny.org/new/index.aspx.

The first question in the FAQs refers to the recent HCA-recommended change that allows home care providers up to 12 months to obtain signed physician orders and advises providers who submit claims for payment after the usual 90-day required timeframe that they don’t have to submit a delay reason code, but must still submit the claim within 30 days of obtaining the signed order.

This is a change in Medicaid fee-for-service that HCA long advocated for – the subject of several recent member communications.

Please note that managed care plans which contract with home care providers for services have different rules for claims submission, and HCA’s provider members should review their contracts for those provisions.

**CMS Cancels Oct. 5 Home Health, Hospice Open Door Forum**

The U.S. Centers for Medicare and Medicaid Services (CMS) has cancelled its next Home Health, Hospice and DME Open Door Forum scheduled for Wednesday, October 5, due to a national call on the new Emergency Preparedness Requirements the same day. (See p. 9 story.) The next Open Door Forum call is scheduled for November 16, from 2 to 3 p.m.
HIRING: Director of Patient Services (DPS) Sought at Three Organizations

Director of Patient Services, Home Care/Hospice Program—Brookhaven Memorial Hospital Medical Center (Patchogue, Long Island, NY) is changing every day. With a brand new cardiac care center about to open and constant care advances throughout the hospital, there’s an air of change and excitement about all of the possibilities of the future. Our stellar 306-bed acute-care community hospital is part of a multidisciplinary, multi-campus, healthcare complex, serving 28 communities in Suffolk County.

Duties and requirements of home care DPS:

- Plan, direct, coordinate and evaluate the delivery of home health/hospice services
- Ensure high quality and effective patient care
- Ensure that Home Care/Hospice departmental activities are in compliance with all regulatory guidelines
- Assign middle managers to implement the planning, direction and controlling of service delivery management
- Education: Knowledge of nursing theory/practice acquired through completion of at least 2 years of training at an accredited school of nursing a must. BSN required. Master’s preferred.
- Experience: 2-3 years’ experience as a supervisory community health nurse/home care manager.
- Knowledge: Community healthcare, governmental licensure regulations and Medicare criteria.
- Licenses/Cert: Current NYS RN & BLS required.
- Strong interpersonal skills to effectively interact with patients/people in their support system as well as analytical ability to assess/develop clinical solutions.

Email a résumé: careers@bmhmc.org.
EOE/M/F/Vet/Disabled

Living Resources Certified Home Health Agency in Albany is growing and we are seeking a dynamic leader to fill this pivotal DPS position.

This position is responsible for overall strategic, clinical, operational and financial leadership to the CHHA and ensures high quality, cost effective care. This individual will work in collaboration with the Living Resources Corporation’s CEO and Associate Executive Director to ensure the integrity of the agency in accordance with the goals and objectives of the agency as set forth by the Board of Directors.

Qualifications: Current RN license, required Bachelor’s degree, Master’s degree preferred; minimum of three years of management experience in home health care or related field.

For immediate consideration, please forward résumé/cover letter and salary requirements in confidence to Lisa Razanousky at lrazanousky@livingresources.org.

Additional opportunities available: Clinical Manager, RNs, Physical Therapists, Occupational Therapists, Home Health Aides and PCAs.

Essex County Nursing Services, Elizabethtown, New York, located in the heart of the Adirondacks is seeking an experienced individual who has the will and determination to successfully lead the agency in today’s home health care environment.

This DPS position involves planning, organizing, directing, coordinating and evaluating patient care services provided by the certified home health agency. The Director of Patient Services is responsible for the professional and financial operations of the agency; and provides and ensures that quality improvement is the main focus of the agency.

MINIMUM QUALIFICATIONS: A Masters or Baccalaureate Degree in Nursing from an approved program, or from a non-approved program supplemented by content which can be equated to an approved program, and either: A) Two years of experience in a management level position in a certified home health agency; or B) A combination of education and experience which is deemed equivalent to the experience requirement as specified above and by the State Office of Health Systems Management.

BENEFITS: Excellent county/government benefits including New York State Retirement System. Great team of professionals to work with.

Candidates must possess a limited permit to practice or licensure and current registration to practice as a Registered Professional Nurse in New York State at the time of appointment.

Qualified candidates will be subject to a civil service examination to be announced at a later date. Applications will be accepted until the announced closing date for the examination.

Please go to www.co.essex.ny.us/job.asp to complete an application and to view a complete job description.
CMS to Host October 13 Conference Call on IMPACT Act

The U.S. Centers for Medicare and Medicaid Services (CMS) is hosting an October 13 conference call (1:30 to 3 p.m.) to discuss how data elements are used in measure development.

Participants will learn how information from assessment instruments is used to calculate quality measures. The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals.

The following will be covered:

- Overview of National Quality Strategy and CMS Quality Strategy
- Why do we have quality measures?
- How do data elements fit within measure development?
- How is provider data used in the development process?
- An example using the pressure ulcer measure
- Question and answer/discussion session

Registration is at: https://blh.ier.intercal.com/details/b745cb4472bb40018189a1da9077eeee.

More Details on Fed Emergency Preparedness Rule for Home Health

CMS to hold conference call on October 5

As described in the September 12 edition of The Situation Report, the U.S. Centers for Medicare and Medicaid Services (CMS) issued a final rule that establishes emergency preparedness requirements for health care providers participating in Medicare and Medicaid.

The rule is at https://www.gpo.gov/fdsys/pkg/FR-2016-09-16/pdf/2016-21404.pdf. It provides for an implementation timeline of one year, requiring impacted providers to meet the requirements contained in the final rule by November 16, 2017.

CMS will hold a nationwide conference call on the rule on October 5 at 1:30 p.m. Registration is at https://blh.ier.intercal.com/details/d4e7a2cd3a1245f5b20fa6e053e215fe. Members are encouraged to register promptly, as the session will fill up quickly.

HCA participated in a special conference call with the state Department of Health (DOH) this past Monday to discuss the rule and implications for New York providers. We made a number of recommendations. These aim to mitigate any duplicative or unreasonable aspects of the rule, including our request for DOH to create a crosswalk between existing state regulatory and procedural requirements and those “newly” contained in the federal rule when it comes to emergency preparedness.

HCA asked that the crosswalk highlight those areas where existing provider planning and compliance under state rule already suffice for compliance with the federal rule. We also asked that the crosswalk clarify the most effective, efficient, and least burdensome way of complying with any additional duties created by the federal rule in cases where the federal requirements are not currently in practice in the state.
HCA also appealed for provider and managed care reimbursement consideration for the increased cost associated with the rule’s implementation. We additionally stressed the need for support with provider education and assistance in discerning and implementing the new rule, including a DOH and health care association collaboration for planning, outreach and participation in the needed training.

Broadly, the rule requires home health agencies (HHAs) and hospices to develop, maintain, and update **annually** an emergency preparedness plan; policies and procedures; communication plan; and training and testing.

More specifically, the HHA requirements include the following.

**Emergency Plan**

The emergency plan must include: 1) a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach; 2) strategies for addressing emergency events identified by the risk assessment; 3) a method of addressing patient population risks and needs, including, but not limited to, the type of services the HHA has the ability to provide in an emergency; 4) continuity of operations, including delegation of authority and succession plans; and 5) a process for and collaboration with local, tribal, regional, state, and federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency situation.

**Emergency Preparedness Policies and Procedures**

Policies and procedures must be developed and implemented, based on the emergency plan, the agency’s risk assessment and its communication plan. These policies and procedures must address the following:

- The plans for HHA patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the currently required comprehensive patient assessment.

- Procedures to inform state and local emergency preparedness officials about HHA patients in need of evacuation from their residences due to an emergency situation, based on the patient’s medical and psychiatric condition and home environment.

**Come to HCA’s Downstate LHCSA Forum: Oct. 28**

As recently reported in HCA alerts and communications, a set of draft state guidelines on the minimum wage funding mechanism for home care is fast taking shape. This development is among the top issues that HCA’s policy and executive team will bring to you during our **October 28 Downstate LHCSA Forum** in New York City.

HCA recently held an upstate session of the LHCSA Forum, with an agenda of items unique to LHCSAs in this region. Our Downstate LHCSA Forum on **October 28** will similarly address issues of concern for LHCSAs in the downstate region, including minimum wage, Fair Labor Standards Act (FLSA) and Quality Incentive/Vital Access Provider Pool (QIVAPP) monies, regulatory changes affecting your operation, the status of uniform billing codes, DSRIP and Value Based Payments, and any additional issues or concerns you want to raise.

These Forums are for HCA members-only and offer a chance for your team to get LHCSA-focused updates. If your agency is a LHCSA or has a LHCSA in your organization, please be sure to register, so we can plan for your attendance, or share with your downstate LHCSA colleagues. Simply complete the PDF form at the link below.

Procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that an emergency causes an interruption in services. The HHA must inform state and local officials of any on-duty staff or patients that they are unable to contact.

A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

Use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or federally designated health care professionals to address surge needs.

**Communication Plan**

The HHA must develop and maintain an emergency preparedness communication plan that complies with federal, state, and local laws. The communication plan must include all of the following:

- Names and contact information for staff; entities providing services under arrangement; patients’ physicians; and volunteers.

- Contact information for federal, state, tribal, regional or local emergency preparedness staff, and other sources of assistance.

- Primary and alternate means for communicating with the HHA’s staff, federal, state, tribal, regional, and local emergency management agencies.

- A method for sharing information and medical documentation for patients under the HHA’s care, as necessary, with other providers to maintain continuity of care.

- A means of providing information about the general condition and location of patients under the facility’s care as permitted under 45 CFR 164.510(b)(4).

- A means of providing information about the HHA’s needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

**Training and Testing**

The HHA must maintain an emergency preparedness training and testing program that is based on its established emergency plan, risk assessment, policies and procedures, and communication plan. It must be reviewed and updated at least annually.

**Training**

The HHA must do **all** of the following:

- Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

- Provide emergency preparedness training at least annually.

- Maintain documentation of the training.

- Demonstrate staff knowledge of emergency procedures.

*Continued on next page*
The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:

- Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based exercise. If the HHA experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the HHA is exempt from engaging in a full-scale exercise for one year following the onset of the actual event.

- Conduct an additional exercise that may include, but is not limited to the following: 1) a second full-scale exercise that is community-based or individual, facility-based; or 2) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

- Analyze the HHA’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA’s emergency plan, as needed.

Integrated Healthcare Systems

If an HHA is part of a health care system consisting of multiple separately certified health care facilities that elects to have a unified and integrated emergency preparedness program, the HHA may choose to participate in the health care system’s coordinated emergency preparedness program. Such unified and integrated emergency preparedness programs must:

- Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

- Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.

- Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

- Include a unified and integrated emergency plan that meets the rule’s emergency plan requirements. The unified and integrated emergency plan must also be based on and include all of the following: 1) a documented community-based risk assessment, utilizing an all-hazards approach; and 2) a documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

- Include integrated policies and procedures, a coordinated communication plan and training and testing programs that meet the rule’s previously outlined requirements.

The provisions affecting hospices are very similar to those for home care, but include additional requirements for making arrangements with other hospices and providers to receive patients in the event of limitations or cessation of operations, and the rule establishes an additional set of requirements for hospice inpatient care facilities.

Resources

In order to assist providers with compliance, CMS has established a webpage (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html) containing information and tools for developing effective and robust emergency

Further guidance, resources and information will be regularly posted to the website.

**Reminder: Free Sept. 30 Webinar to Launch Home Care Sepsis Screening Tool**

HCA reminds all home care providers to participate in an important **September 30** webinar (from 10:30 a.m. to noon) launching HCA’s home care screening tool and protocol for sepsis recognition and intervention. This session is the first in a series throughout the fall. The September 30 webinar is being hosted by IPRO, HCA and other key organizations.

We reported on the webinar series in last week’s edition of *The Situation Report* newsletter, but HCA just wanted to draw your attention to this important program, given recent alarms by the U.S. Centers for Disease Control and Prevention (CDC) about sepsis, a top cause of health care morbidity and cost. The HCA Quality Committee and its subgroup on sepsis have worked for the past two years on this first-in-the-nation home care sepsis screening tool, well before the recent CDC alarms about the sepsis crisis. The U.S. Centers for Medicare and Medicaid Services (CMS) has approved use of the HCA tool as part of a CMS-sponsored sepsis project currently being implemented by IPRO in two major regions of the state.

In the latest development, the *Utica Observer-Dispatch* newspaper reported on the HCA-IPRO effort in a September 24 article “Local home care providers help create screening tool for deadly disease,” quoting **Amy Bowerman**, director of quality improvement and privacy officer for the Mohawk Valley Health System’s home care services and director of patient services for Senior Network Health. Ms. Bowerman has led the Quality Committee’s efforts to develop the screening tool. “Having worked with sepsis in the hospital in the past, Bowerman wondered what was being done about it in home care when she changed jobs a few years ago,” the article states. “Nobody seemed to have any real answers for me,” she recalled, prompting efforts within HCA to address this gap. You can read the article online at [http://www.uticaod.com/news/20160924/local-home-care-providers-help-create-screening-tool-for-deadly-disease](http://www.uticaod.com/news/20160924/local-home-care-providers-help-create-screening-tool-for-deadly-disease).

The webinars dates are:

- **Part I:** Sept. 30 (10:30 a.m. to noon.) This session will provide background on the sepsis emergency and the HCA Home Care Sepsis Screening Tool and Protocol.
- **Part II:** Oct. 20 (10:30 a.m. to noon). This session focuses on agency adoption of the tool and integration into your electronic health records.
- **Part III:** Nov. 9 (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.** Please follow the instructions below for registration.

**Registration Instructions**

Click the registration link ([https://qualitynet.webex.com/mw3100/mywebex/default.do?siteurl=qualitynet](https://qualitynet.webex.com/mw3100/mywebex/default.do?siteurl=qualitynet)) or copy and paste the address into your web browser. This will bring you to the QualityNet e-University webpage. Locate each of the sessions by date (listed chronologically) and click on “Register” to the right of the session name. Enter the information
requested and click “submit.” You will receive a confirmation e-mail with the meeting information and the registration ID for each session that will be used to log into the WebEx portion of the meeting. Please note: this e-mail may go to your spam folder or filter. It will come from the e-mail address messenger@webex.com.

Q&As Posted on HCBS Statewide Transition Plan

In response to the questions received from a webinar on the Home and Community-Based Services (HCBS) Statewide Transition Plan, New York State has recently posted a Q & A document. It is at http://health.ny.gov/health_care/medicaid/redesign/hcbs/2016-08-18_hcbs_qanda.htm.

As explained in many HCA communications, the HCBS federal rule establishes criteria for what is considered a home and community setting under many Medicaid waiver programs, including long term care and mainstream Medicaid managed care.

The HCBS webinar provided an overview of New York State’s plan to comply with the HCBS final rule, deliverables and priority concepts.


HCA PAC Shout Out!

Thanks to Russell Lusak, Senior Vice President Selfhelp Community Services, for his PAC leadership in encouraging Stuart Kaplan, CEO, Selfhelp Community Services, to donate to HCA’s PAC.

If you donate to HCA’s PAC at the $100 level or more, and get others to do the same, we’ll publish a special “Shout Out” to both of you in our weekly newsletter, The Situation Report. All you have to do is donate and complete the “Shout Out” instructions at:

http://hca-nys.org/advocacy-pac/pac
NY Sees 10.6% Drop In Readmissions, CMS Says

The U.S. Centers for Medicare and Medicaid Services (CMS) has reported new data showing that 49 of the 50 states, including New York, have reduced their Medicare hospital readmission rates – an area of improvement where home care providers are especially equipped to intervene.

CMS says that between 2010 and 2015, hospital readmission rates fell by 8 percent nationally. Meanwhile, new data shows that all states but one (Vermont) have seen Medicare 30-day readmission rates fall. In 43 states, readmission rates fell by more than 5 percent. In 11 states, readmission rates fell by more than 10 percent, including New York. Across states, “Medicare beneficiaries avoided approximately 100,000 readmissions in 2015 alone, compared to if readmission rates had stayed constant at 2010 levels,” CMS reports.

New York, specifically, saw a reduction of 8,407 hospital readmissions between 2010 and 2015 – a 10.6 percent drop from the 491,897 hospital readmissions in 2010 and the 402,439 readmissions in 2015. The readmission rate fell from 19.9 percent to 17.8 percent.

According to CMS, potentially avoidable hospital readmissions that occur within 30 days of a patient’s initial discharge are estimated to account for more than $17 billion in Medicare expenditures annually. High-cost readmissions are also seen as an indicator of fragmented care, and readmission rates are used as a benchmark for quality-of-care in many settings, including for home care providers, which are evaluated on these measures.

Under the Affordable Care Act (ACA), hospitals have faced stiff penalties as part of a federal readmissions-reduction program targeting facilities with rates that are too high. This year alone the program has targeted more than half of the nation’s hospitals (2,597) for penalties. More than $500 million in penalties are set to go into effect in October as part of the fiscal year 2017 hospital payment rates.

Both federal and state policy efforts have used a blend of incentives, penalties, risk-sharing models and payment bundles to address the issue of readmissions. These efforts create an opportunity area for post-acute home care to partner with hospitals and community health networks to assure the medical stability of patients at home so their conditions don’t worsen and require a return to the hospital.

As CMS officials state in a recent blog post announcing the data, “many readmissions can be avoided through improvements in care, such as making sure that patients leave the hospital with appropriate medications, instructions for follow-up care, and follow-up appointments scheduled to make sure their recovery stays on track.”


2017 Medicare Appeal Amounts Posted

The U.S. Centers for Medicare and Medicaid Services (CMS) has posted the “amount in controversy” thresholds for Medicare appeals in 2017.


The levels are $160 (up from $150 in 2016) for administrative law judge hearings and $1,560 (up from $1,500 in 2016) for judicial review.

Changes Made to NY Connects RFA

The New York State Office for the Aging (NYSOFA) has released Addendum No. 1 to the Request For Applications (RFA) on the Partnership to Expand and Enhance NY Connects: A Balancing Incentive Program Funding Opportunity for Independent Living Centers and/or Community-Based Organizations. The RFA was originally issued on August 25, 2016.

Addendum No. 1 extends the application deadline to 9 p.m. on October 1, 2016 and includes an attachment with additional space for responses, which can be downloaded from NYSOFA’s website. In addition, a reference to Letters of Support was moved from Section D to Section C and a reference to specific NY Connects Standards was added to Section D.

A Q&A document for this funding opportunity has also been posted at: http://www.aging.ny.gov/ContractsandGrants/RFA/OFA01_ILC_2016_RFA_Applicant_Questions_Answers_final2.pdf.


NY Connects is designed to help individuals and their family caregivers gain access to the “right long term services and supports, at the right time, in the right setting.” NYSOFA’s RFA process will select and contract with up to six Independent Living Centers and/or not-for-profit Community Based Organizations to perform NY Connects functions in a specified region. (See the August 26 edition of our previous ASAP newsletter for more information).

Bundled Payment Report Issued

Last week, the U.S. Centers for Medicare and Medicaid Services (CMS) released the second annual evaluation report for Models 2-4 of the Bundled Payments for Care Improvement (BPCI) initiative.

This report describes the characteristics of participants and includes quantitative results from the first year of the initiative. According to CMS, future evaluation reports will have greater ability to detect changes in payment and quality due to larger sample sizes and the recent growth in participation.

Key highlights include:

- 11 out of 15 clinical episode groups analyzed showed potential savings to Medicare. Future evaluation reports will have more data to analyze individual clinical episodes within these and additional groups;

- Orthopedic surgery under Model 2 hospitals showed statistically significant savings of $864 per episode and improved quality, as indicated by beneficiary surveys. Beneficiaries at participating hospitals indicated that they had greater improvement after 90 days post-discharge in two mobility measures than beneficiaries treated at comparison hospitals;

- For home health users, the report shows a statistically significant increase (1.5 visits) in the number of home health visits in BPCI episodes relative to those in comparison episodes.

- For Model 2 orthopedic and cardiovascular surgery episodes, participants’ efforts to reduce episode spending “are achieving expected results.” For these episodes, which account for a large share of
Model 2 episodes, CMS saw a statistically significant shift from more expensive institutional post-acute care (PAC) to less expensive home health care among beneficiaries discharged to any PAC setting.

- Cardiovascular surgery episodes under Model 2 hospitals did not show any savings yet but quality of care was maintained, the report says. Over the next year, CMS will have significantly more data available, enabling it to better estimate effects on costs and quality.

The three BPCI Models evaluated in this report vary as to the bundle definition and payment approach. The bundle is defined as the services provided during the episodes that are linked for payment purposes.

Model 2 has the most comprehensive bundle, which includes the triggering hospital stay (i.e., the anchor hospitalization), all concurrent professional services, and post-discharge services, including hospital readmissions, delivered within the chosen episode length of 30, 60 or 90 days (with certain extensions). Individual providers are paid on a fee-for-service basis and total episode payments are reconciled retrospectively against the established target price.

To view the evaluation report, which includes descriptions of the other models, go to: https://innovation.cms.gov/Data-and-Reports/index.html.

**NGS Update on Mass Adjustments to Claims with Certain G Codes**

National Government Services (NGS), New York’s Medicare Administrative Contractor (MAC), provided an update this week on incorrectly returned claims with reason codes 31814 and 31947.

The U.S. Centers for Medicare and Medicaid Services (CMS) issued instructions to all MACs on August 8 to process mass adjustments to claims processed after August 5, 2013, per the following conditions:

- Outpatient claims, TOBs: 12X, 13X, 22X, 23X, 32X, 33X, 34X, 74X, 75X, 82X, 85X or 77X;
- Claims processed from August 5, 2013 and up to July 25, 2016;
- HCPCS codes G8978-G8999 or G9158-G9186 (with RC 31947 present on line); and
- VA claims/providers are excluded from this logic.

NGS began releasing claims on August 29, 2016 with claims being suspended for reason code U6000 (claim purged from the Common Working File). NGS has also discovered numerous claims rejected because these adjustments are being applied to the beneficiary’s therapy cap, placing them over the legislative limit and rejecting in error, and affecting provider payment.

NGS stopped releasing claims as of September 1, 2016. NGS is requesting further direction from CMS. Impacted claims will have the following information in the Remarks page in the Fiscal Intermediary Standard System (FISS) Direct Data Entry (DDE): “Remarks: CQ116253 Adjusting Reimbursement.”

Effected providers should not attempt to correct or appeal the claims in question. NGS will issue an update via the Production Alerts section of its website along with email updates when additional information is available.
Late September, October Milestones for Bring The Vote Home Initiative

HCA last week mailed out a new shipment of Bring The Vote Home-NY packets to agencies that requested them. If you placed an order with HCA, be on the lookout for this mailing.

These packets include: 1) voter registration and absentee ballot application forms, as well as 2) instructions for patients and their caregivers on registering to vote and voting from home.

As a reminder, the process has several parts. The first step is informing patients of their option to register to vote. The second step is for the patient to complete an application to receive an absentee ballot so they can vote from home. The third step is for patients to receive the actual absentee ballot in the mail (after applying to do so), completing the ballot, and sending it in before the election.

If you are participating in this campaign, please mark the following key dates.

- **As soon as possible**: Though the voter registration form deadline is in October, your staff should be encouraging patients, if they are interested, to mail in their voter registrations as soon as possible, and now is a prime time to remind patients to do so.

- **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 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.

Got questions, need help?

Contact HCA’s Communications Director Roger Noyes at rnoyes@hcany.org.
MFP Policy Issued for MLTC Plans

This week, the state Department of Health (DOH) posted a policy guidance to inform all MLTC plans about the availability of additional supports through the Money Follows the Person (MFP) Demonstration, and the required role of a plan in that collaboration.


MFP is a federal initiative to rebalance the delivery of long term care services and increase the use of home and community-based services. To facilitate MFP services, MLTC plans are required to include the following “MFP Attestation for Enrollment Agreement” in the plan’s existing Enrollment Agreement: “If I am or become a resident in a nursing facility, I agree to a referral to New York State’s contractor for Money Follows the Person/Open Doors, a program that can work with my MLTC plan to help me return to community living.”

Plans must also include, in their handbooks, several lines of prescribed language explaining the MFP/Open Doors program. (Please see the policy document for the precise language.)

Plans must also review “NYS Money Follows the Person Guidance for Managed Care Organizations” and share it with all appropriate plan staff, including Care Managers, to encourage recommended practices. This document is at [http://www.health.ny.gov/health_care/medicaid/redesign/2016/docs/mfp_guidance_for_mcos.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/2016/docs/mfp_guidance_for_mcos.pdf).

DOH recommends MLTC plans review relationships with network nursing home providers and consider amending subcontracts to encourage collaboration to access MFP.

More information about MFP is at [https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm](https://www.health.ny.gov/health_care/medicaid/redesign/nys_money_follows_person_demonstration.htm).
October 20, 2016
10:00am – 12:30pm

Employment attorneys from Hodgson Russ, LLP, specializing in wage and hour laws for the home care industry, will discuss the key federal and state compensation requirements for home care providers. This session will cover topics such as accurate computation of the regular rate of pay, properly paying overtime, accurately tracking work time, including travel time, spread of hours and split-shift pay, call-in pay regulations, the Domestic Workers’ Bill of Rights, and Wage Parity Law.

The session will also provide an overview of some of the most pressing challenges to the home care industry, including litigation of live-in cases, complications created by the elimination of the companionship exemption, and the rise in private plaintiff class action litigation. Through an interactive and question-and-answer session, attendees will develop a greater understanding of their legal obligations and learn about tips to overcome some of the most difficult issues plaguing the home care industry today.

Presenters from Hodgson Russ, LLP:
Peter Godfrey, Partner
John Godwin, Partner
Emina Poricanin, Senior Associate

REGISTRATION – (Deadline October 14th)

Name: __________________________________________
Title: __________________________________________
Agency: _________________________________________
Address: ________________________________________
City/State/Zip: ___________________________________
Phone: ___________________________ Ext. __________
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Billing Address of card (including City, State and Zip Code)

Authorized Signature

Cancellations received by October 14th are refundable less a 25% administrative fee. Cancellations must be received in writing via e-mail to info@hcanys.org. No refunds after that time or for no shows. Substitutions are permitted.