Register NOW for HCA Advocacy Day in 10 Days

This is a must-attend event for all HCA member organizations

HCA’s 2014 State Advocacy Day is fast approaching in Albany on January 27, just ten days away. Please take a moment now to register you and your staff for this important event if you haven’t done so already, and be sure to make your legislative appointments as soon as possible.

During this year’s Advocacy Day, our message to state legislators and the Governor is simple. Amid payment cuts and a transitioning home care system, providers and plans need: regulatory streamlining, appropriate funding for services and regulatory mandates like Wage Parity, and new avenues for service delivery collaboration.

HCA is preparing several resources to assist you on Advocacy Day, including message points, a one-page legislative “asks” list, the findings of our most recent provider survey and financial analysis, and more. These documents are now being finalized and will be sent to the membership next week.

Most of HCA’s current advocacy materials reflect major ongoing issues and needs in the system; these issues will be an important focus of your appointments with legislators. However, the timing of Governor Cuomo’s state budget release this coming week, on January 21 (just six days before our Advocacy Day) will also require an additional set of resources and message points that allow us to get the word out early regarding home care’s position on the budget. You can expect all of these materials in your inbox sometime next week.

See ADVOCACY p. 2
Conference Call on Thursday

To learn more about the plan for Advocacy Day, HCA has scheduled a special pre-Advocacy Day conference call this coming Thursday, January 23 from 3 to 4 p.m.

This call is an opportunity for HCA to answer your questions, discuss Advocacy Day message points, brief you on the expectations for January 27, and outline key provisions of the Governor’s imminent budget proposal so that you can be as informed as possible in preparation for your legislative appointments.

To register for this members-only conference call, please go to the online form at https://www.surveymonkey.com/s/2014LobbyDay and enter your contact information. A dial-in code will be later sent to you.

Important Note about Scheduling Your Legislative Appointments

You can schedule legislative appointments at any time during the day on January 27 and before 4:30 p.m. HCA will be scheduling special leadership appointments for members of our Board of Directors to meet with Health Committee Chairs, Legislative Leaders and key Executive staff. Therefore, HCA Board Members do not need to schedule their own appointments. Where requested, and as scheduling allows, HCA staff will be available to accompany members on visits.

However, to avoid conflicts or redundancies in the scheduling process, especially for leadership meetings, HCA requests all members to inform HCA of any appointments you have made so that we can work to consolidate as many of these meetings as possible, where necessary, especially for Legislative Leaders.

Continued on next page
continued from p. 2

Please e-mail information about your legislative appointments to Jenny Kerbein at jkerbein@hcanys.org.

Change of Date for State Budget Conference Call

Please also note that HCA has rescheduled our State Budget Conference Call, which was announced in last week’s ASAP, due to an unforeseen conflict.

The new date is Thursday, February 6 from 3 to 4 p.m. The purpose of this call will be to give members a briefing on the soon-to-be-released state budget. Members can register for this call by completing the online form at https://www.surveymonkey.com/s/ExecutiveBudget.

We look forward to seeing you on January 27. Please do not hesitate to contact any of the HCA staff if you have a question about Advocacy Day.

CMS Issues a Temporary Hold of Home Health LUPA Claims

The U.S. Centers for Medicare and Medicaid Services (CMS) announced in its weekly provider eNews publication this week that Medicare contractors have identified an incorrect payment calculation affecting home health claims for low utilization payment adjustments (LUPAs).

To prevent incorrect payments, Medicare contractors will hold all home health LUPA claims with “Through” dates on or after January 1, 2014 until systems are corrected. CMS says the correction is scheduled for February 10, 2014.

Home health agencies do not need to take any action. Medicare contractors will release the claims as soon as the correction is complete.

HCA will update the membership if the scheduled February 10 correction date is changed, or upon any other developments.

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

Advocacy Day To-Do List

- Send HCA your Advocacy Day registration form so that we know you are coming and can prepare materials for you.

- Schedule appointments with your Assembly and Senate representatives now and let HCA know what appointments you have made by sending an e-mail to Jenny Kerbein at jkerbein@hcanys.org. Remember: Board Members do not need to schedule their own appointments.

- Register for HCA’s Pre-Advocacy Day conference call (January 23 at 3 p.m.) at https://www.surveymonkey.com/s/ExecutiveBudget.

- Be on the lookout for an e-mail next week with dial-in information for the conference call as well as links to Advocacy Day resources.

- Make hotel accommodations for HCA’s Advocacy Day, if needed. HCA has a special room block at the Hampton Inn and Suites on Chapel Street in Albany.

- Get ready to meet HCA staff at the Advocacy Day check-in, beginning at 8 a.m. on January 27 in Meeting Room 6 of the Empire State Plaza. HCA’s Advocacy Day operations will be stationed here throughout the day to provide you with any assistance necessary, important updates and meeting materials. Light refreshments and snacks will be provided throughout the day.
FIDA Roll-Out Delayed

The state Department of Health (DOH) announced this week that the enrollment timeline for the Fully Integrated Duals Advantage (FIDA) program has been delayed.

The voluntary period for both the community based and nursing home populations will start October 1, 2014 and the passive enrollment period for both populations will start January 1, 2015. Originally, the FIDA plans were scheduled to accept enrollments on July 1, 2014 for those who required community-based long term services and supports for more than 120 days, with passive enrollment starting September 1, 2014; plans were scheduled to accept enrollments for those who required nursing home stays starting October 1, 2014, with passive enrollment starting January 1, 2015.

DOH plans on releasing a new timeline by January 31, 2014 for all the deliverables and will host a webinar or conference call in early February to go over the new schedule. DOH is not delaying the site visit schedule for FIDA plan readiness review.

FIDA update posted

Meanwhile, DOH has posted materials used during its webinar last week covering FIDA.


Last week’s ASAP summarized the webinar, which was cut short due to technical difficulties.

The materials provide the following additional information not presented during the webinar:

- The FIDA plan shall allow participants who are receiving behavioral health services to maintain their current behavioral health services providers for the current episode of care. This requirement will be in place for the first 24 months of the contract and applies only to episodes of care that were ongoing during the transition period from fee-for-service to FIDA.

- DOH and the U.S. Centers for Medicare and Medicaid Services (CMS) released a draft rate document and are working on responses to the questions received as a result of the release.

- DOH and Mercer, a consulting firm, are working to incorporate any potential changes into the premium. A time will be set up to meet with plans and representatives to review any changes to the Medicaid and Medicare rates.

- Twenty-three plans are currently going through the readiness review process; desk reviews began in October and are ongoing; in-person reviews start this week and continue through the end of January; and systems testing will be conducted in February.

- FIDA plans submitted their networks for review on December 27 and Americans with Disabilities Act (ADA) attestations are due on January 31, 2014.

- Development of a three-way contract between a plan, DOH and CMS has begun and final contracts are expected in March 2014.

- Next steps include: finalizing the enrollment process; developing materials for participant outreach, education campaigns, provider and plan education and training; establishing quality assurance instructions and parameters; and developing policies, draft notices, and uniform written materials on consolidated appeals and grievances processes.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.
HCA, DOH Meet on Pressing Home Care-Managed Care Reimbursement Issues

HCA and state Department of Health (DOH) officials met this week to take up an agenda of critical home care-managed care reimbursement issues. Several of these issues will form a major core of our State Advocacy Day agenda on January 27, including:

- **Managed Long Term Care (MLTC) premiums and home care agency reimbursement rates for 2014, with a priority focus on Wage Parity Law support and other new cost components.** DOH reaffirmed that premiums and rates are being prepared with adjustments for wage parity and other factors. However, given the timing of next week’s Executive Budget release, specifics were not disclosed.

  While we are certainly supportive of efforts to add funds, HCA shared concerns that DOH’s current proposal, shared with HCA, is underfunded. HCA also rebutted DOH’s last shared version of a proposal which sought to benchmark home care agency administrative and general (A&G) costs to MLTC plan A&G, and to use the A&G difference as reasoning for a proposal that would fund a significant portion of new wage parity costs by cuts to home care agency A&G.

HCA continued to urge support for full funding of wage parity costs to providers and plans. HCA also continued to stress the need to ensure that the intended and needed level of funds reach the agencies and home care aides providing the direct care.

- **Adjustment of MLTC premiums and home care agency reimbursement rates to reflect 2014 service regulations.** HCA stressed the financial impact of regulations, specifically a draft DOH directive that has surfaced regarding possible applicability of federal Conditions of Participation (CoPs) to home care-managed care services. HCA, together with other health and health plan associations, have sought streamlining (and reduced cost) of the current managed care-home care regulatory base. Any actions that would elevate the base (and, therefore, the cost) of regulations must be funded. HCA urged DOH engagement with all stakeholders to work toward a workable solution.

- **Reimbursement for Uniform Assessment System (UAS) expenses.** HCA explained the significant added time, resource and cost associated with completion of the UAS, and the fact that these cost increases are not reflected in the current health plan or provider premium/rate base. DOH asked about the nature and scope of the cost increases, including whether such increases would be netted or otherwise mitigated over time. HCA cited further examples of how the requirement is adding unrecoverable cost.

- **Need for a 90-day billing exception code related to timing of physician signatures on orders.** This has been an ongoing priority item in HCA’s meetings with DOH. While DOH reimbursement staff have made efforts to facilitate solutions, a remedy has not yet occurred. DOH is next trying to coordinate a solution across the various jurisdictions in the Department.

- **Proposed revision to guidance on Episodic Payment System (EPS) claims for Medicare-Medicaid patients.** DOH has shared with HCA a proposed revision to its 2012 guidance on Medicare maximization assumptions for Medicare/Medicaid-eligible recipients under the state’s Certified Home Health Agency EPS. The draft language was in response to HCA concerns about inaccurate assumptions in the current DOH FAQ guidance. HCA and DOH discussed this language again and HCA is now vetting the most recent iteration with provider finance officers for feedback. HCA will compile and share agency feedback with DOH.

- **Managed care and home care reimbursement options during continuity-of-care period.** Some providers and health plans asked HCA whether it might be possible for plans and providers to develop and mutually consent to an alternate payment arrangement during
the continuity-of-care transition period if a more favorable arrangement could be developed for all parties. Currently DOH policy requires payment of the DOH-established fee-for-service rates and in accordance with any pre-established contractual arrangements. HCA has placed this question before the Department; however the jurisdictional staff were not present at this week's meeting to further discuss this item.

HCA will continue to engage with DOH on these core issues, and, as necessary, with the Governor’s office and the Legislature as budget negotiations commence next week.

Members should also specifically mark your calendars for HCA's March 13 Financial Managers Forum. HCA has invited DOH home care and managed care reimbursement officials to participate and discuss key developments in reimbursement as part of this important meeting.

For further information, please contact Al Cardillo or Patrick Conole at acardillo@hcanys.org or pconole@hcanys.org.

DOH Says GRT Applies to MLTC Payments

The state Department of Health (DOH) sent out a notice this week informing providers that “all cash receipts for patient care services continue to be assessable for New York’s Health Facility Cash Assessment Program (HFCAP), including patient care cash receipts from Managed Long Term Care (MLTC) providers.”

Previous to the transition to managed care, many Licensed Home Care Service Agencies (LHCSAs) provided services through contracts with Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). The monies that LHCSAs received from such contracts were not subject to HFCAP, also known as the Gross Receipts Tax or GRT, because the CHHAs and LTHHCPs were assessed on these monies.

HCA will be holding a conference call with DOH to discuss this notice and will report any new developments to members.


Get Your Staff Up to Speed for Coding Changes with Art of ICD-10 Coding Workshop

HCA is offering a special workshop on The Art of ICD-10 Coding to help get your coders up to speed in time for the October 1 implementation of the updated code sets, ensuring accurate billing for your agency.

Please register today for this comprehensive, two-day program at the Albany Marriott on February 6 and 7 using our convenient online registration process at https://www.eventville.com/Catalog/EventRegistration1.asp?EventId=1010798 or by downloading the registration form on our events page at http://www.hca-nys.org/events.cfm.

HCA has extended the registration deadline until January 27 or until the classroom is full. The registration fee includes two days of expert instruction, valuable reference materials, breaks and two lunches.

Your agency cannot afford to miss out on vital ICD-10 education for your staff who will also benefit from 13 continuing education contact hours. Appropriate for coders at all levels, this program offers an essential drill-down to prepare your agency’s billing staff for major coding changes on the horizon that directly affect home care reimbursement and compliance.

With the transition to ICD-10 looming in October, do not delay in your preparation and staff education. Register today.
Managed Care Update

This week, the state Department of Health (DOH) issued instructions outlining the circumstances in which Medicaid-only recipients can transfer from mainstream Medicaid managed care (MMC) to a Managed Long Term Care (MLTC) plan.

In other managed care updates, DOH this week also gave a timetable for MLTC mandatory enrollment upstate and posted materials on: the transition of Long Term Home Health Care Program (LTHHCP) patients into MMC plans; and the provision of hospice services by MMC plans.

MLTC Policy 14.01

According to the state’s MLTC Policy 14.01, individuals enrolled in an MMC plan may disenroll and enroll into an MLTC plan only if the member is in need of a service that cannot be provided in the MMC or if the member has become eligible for Medicare and, therefore, meets the MLTC enrollment criteria.

The following three services are not currently available in MMC but are available in an MLTC: home-delivered or congregate meals; social day care services; and social and environmental supports. An MMC plan member (Medicaid-only) who needs one of these services must also meet the MLTC eligibility criteria, including requiring a nursing-home-level of care.

For continuity-of-care purposes, if the MMC member becomes eligible for Medicare and is receiving community based long term care services (CBLTCS), the MMC plan must make “diligent efforts” to transition the member to the MMC plan’s MLTC product or else have the member consult New York Medicaid Choice, the state’s enrollment broker, for an alternative MLTC plan.

In mandatory MLTC districts, MMC members who become eligible for Medicare and are receiving CBLTCS must access those Medicaid services from an MLTC. In non-mandatory districts, MMC members receiving CBLTCS have the option of fee-for-service (FFS) or an MLTC, if available, processed through the local district of social services (LDSS).

If the Medicaid-only member requires a benefit not included in the MMC benefit package, the practitioner must provide a letter or referral for the requested service. If no evidence of need can be provided, the LDSS or New York Medicaid Choice will refer the member to an MLTC plan of his or her choice for a clinical assessment to determine if the MMC member meets the criteria for MLTC enrollment for Medicaid services prior to actual enrollment into a plan.

For members who provide evidence of Medicare eligibility and are now in receipt of Medicare, the LDSS or New York Medicaid Choice will refer the member to an MLTC of their choice for a clinical assessment to determine if the member meets the criteria for MLTC enrollment prior to actual enrollment into an MLTC; in non-mandatory districts, individuals will be advised of their FFS options.

This policy does not affect a Medicaid-only recipient’s right to initially choose an MLTC instead of an MMC if the recipient qualifies for MLTC enrollment. To enroll into an MLTC, a person must:

- Meet the age requirement based on MLTC plan type
- Be a resident of the MLTC’s service area

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- Be Medicaid eligible
- Be clinically eligible for MLTC based on assessment
- Can be maintained in the community without jeopardy to health and safety
- Require or expect to require more than 120 days of CBLTCS (personal care, consumer directed personal care, adult day health care; home health care services, or private duty nursing).

HCA commends DOH for issuing this clarification, as many members have inquired about the rules for Medicaid-only individuals being able to enroll into an MLTC after they have enrolled into an MMC plan. Still, there have been issues around Medicaid-only recipients being enrolled into MMCs without the option offered to enroll into an MLTC. HCA has urged DOH to ensure that New York Medicaid Choice includes such information in any mailings to Medicaid-only recipients.


Transition Update

HCA has obtained a list of the upstate counties that will undergo the transition to MLTC enrollment in 2014. The proposed timetable is:

April 1     Columbia, Putnam, Sullivan, Ulster
May 1       Rensselaer, Cayuga, Herkimer, Oneida
June 1      Greene, Schenectady, Washington, Saratoga
July 1      Dutchess, Montgomery, Broome, Fulton, Madison, Schoharie, Oswego
Aug. 1      Warren, Delaware, Niagara, Otsego, Chenango
Sept. 1     Essex, Clinton, Franklin, Hamilton
Oct. 1      Jefferson, Lewis, St. Lawrence, Steuben, Chautauqua, Cattaraugus, Alleghany
Nov. 1      Yates, Seneca, Schuyler, Tioga, Cortland, Chemung
Dec. 1      Genesee, Ontario, Livingston, Orleans, Tompkins, Wayne, Wyoming

LTHHCP and Hospice Transition to Mainstream MMC

This week, DOH posted guidelines for the transition of LTHHCP and Hospice patients into MMC plans.

Though the LTHHCP transition started in April 2013 – and DOH had provided earlier instructions in March – these new guidelines, dated April 2013, were just recently posted at http://www.health.ny.gov/health_care/medicaid/redesign/docs/lthhc_transition_policy.pdf.

The document includes information on the transition process, transitional care policy, and access to waiver services. The only new information not otherwise provided elsewhere in other DOH instructions or documentation is as follows:

- In cases where the Medicaid-only LTHHCP participant receives waiver services that are not included in the mainstream Medicaid managed care plan, the individual has the option to remain in the LTHHCP or apply for enrollment in another home and community based Medicaid waiver program, such as Care at
Home, Nursing Home Transition and Diversion, or the Traumatic Brain Injury, if eligible, or Managed Long Term Care if available.

- If an individual’s needs cannot be met by the managed care plan, and the consumer does not qualify for enrollment in another waiver to access the required services, LTHHCP enrollment may continue. The LTHHCP waiver will remain an option at least until the current LTHHCP waiver expires in 2015.


**MLTC FAQs**

Lastly, members should be aware of an MLTC Frequently Asked Questions (FAQs) document posted to the Medicaid Redesign Team website. It includes information on eligibility, the Program of All-Inclusive Care for the Elderly (PACE), plans of care, continuity of care, and Management Contract Guidelines. It is at [http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_faq2_final.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/docs/mltc_faq2_final.pdf).

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

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**Selfhelp Testifies at Senate Hearing on Needs of Aging Holocaust Survivors**

Leaders from HCA Member **Selfhelp Community Services**, the nation’s largest provider of services to Holocaust survivors, testified this week before the Senate Special Committee on Aging, spotlighting the critical and escalating needs of the nation’s 120,000 Holocaust survivors.

The hearing, “Aging in Comfort: Assessing the Special Needs of America’s Holocaust Survivors,” comes at a time of increased attention to survivors. Vice President Biden recently announced a four-point White House initiative to aid survivors, which will include the appointment of a special envoy to enhance and expedite efforts to help survivors living in poverty. In addition, many elected officials and advocates are supporting an amendment to the Older Americans Act (provision S.999) to provide care and services to aid Holocaust survivors who are dealing with the cumulative physical and emotional trauma that began decades ago.

“Holocaust survivors are growing older and frailer,” Elihu Kover, VP Nazi Victim Services of Selfhelp Community Services, told the committee. “Prolonged periods of starvation, exposure to severe weather conditions and experiencing and witnessing unspeakable atrocities take a severe toll on body and mind. Many of these problems only surface in old age, having been hidden during their working years when the survivors struggled and made a new life for themselves.”

Almost half the survivors in the New York City area live near the poverty level. Although organizations like the Claims Conference and UJA-Federation of New York help immensely by providing generous support for home health care and social services, Mr. Kover pointed out that the needs far exceed the financial resources earmarked for such support.

Selfhelp was formally invited by Senator Bill Nelson, Chairman of the Senate Special Committee on Aging, and Senator Susan M. Collins, Ranking Member, to present testimony at the hearing. Selfhelp has more than 75 years of experience in serving the needs of Holocaust survivors.

Video of the hearing and supplemental written materials are available at [http://www.aging.senate.gov/hearings](http://www.aging.senate.gov/hearings).
CMS Provides Documentation Guidance on F2F

The U.S. Centers for Medicare and Medicaid Services (CMS) recently issued a special edition Medlearn Matters article for home health agencies, non-physician practitioners (NPPs) and physicians regarding the home health face-to-face (F2F) documentation requirements.


Prior to certifying a beneficiary’s eligibility for the Medicare home health benefit, the certifying physician must document that he or she (or an allowed non-physician practitioner) has had a face-to-face (F2F) encounter with the beneficiary.

The regulation governing F2F requires, as a condition for payment, that the encounter occurs within 90 days prior to the start of care or up to 30 days after the start of care. Documentation of the encounter must explain “why the clinical findings of such encounter support that the patient is homebound and in need of either intermittent skilled nursing services or therapy services.”

Also, the homebound status of the patient and his/her need for skilled services must be written in a brief narrative, signed by the physician, titled “Home Health Face to Face Encounter,” and dated.

According to CMS, the majority of improper home health Medicare payments are due to “insufficient documentation” errors. Insufficient documentation errors occur when the medical documentation is inadequate to support payment for the services billed or when a specific required documentation element is missing. Most of these result from claims where the narrative portion of the F2F encounter document does not sufficiently describe how the clinical findings from the encounter support the beneficiary’s homebound status and the need for skilled services.

CMS’s Medlearn Matters article includes examples of incorrect and correct F2F encounter documentation to assist home health agencies in recognizing acceptable written documentation by the certifying physician or non-physician practitioner.

Relief from the F2F regulation remains a top-tier HCA advocacy issue. At HCA’s urging, New York Congressional Representatives Tom Reed and Paul Tonko recently led a bipartisan letter to CMS recommending a streamlined approach to F2F. Meanwhile, HCA President Joanne Cunningham, through her work as Chair of the Forum of State Home Care and Hospice Associations, has worked with colleagues throughout the country to further bolster Congressional support on F2F mitigation. As part of this advocacy effort, the Forum conducted a nationwide survey drawing 3,000 comments from over 900 home care providers about their experiences with F2F-related claim denials; cost impacts; and physician engagement issues. Those results are summarized in a briefing paper at http://www.hca-nys.org/documents/ForumFacetoFaceSurveyResultsOnePager.pdf.

Members should use this most recent Medlearn Matters article for internal staff training as well as for continuing education of your referring physician community.

For further information, contact Patrick Conole at (518) 810-0661 or at pconole@hcany.org.
MedPAC Finalizing Home Care and Hospice Recommendations

The Medicare Payment Advisory Commission (MedPAC) met this week to finalize its recommendations that will be included in the March 2014 Report to Congress.

As reported in the December 20 ASAP, one of the proposals includes a recommendation to reduce payments to home health agencies with relatively high risk-adjusted rates of readmission. Under the recommended approach, providers would be compared to a peer group that serves a similar share of low-income beneficiaries. The period for review would include all of the home health stay and a 30-day “follow-on period.” Reports indicate that the policy could save the Medicare program anywhere between $50 million and $250 million in 2015 and just under $1 billion by 2020.

HCA will be reviewing this proposal carefully, especially if it is ultimately included in the March Report to Congress to ensure that it includes appropriate safeguards, clinical measures and peer groupings that do not further imperil home health agencies.

HCA has also received word from the National Association for Home Care and Hospice (NAHC) that MedPAC is reportedly seeking to accelerate the incorporation of hospice under Medicare Advantage. The Commission will now recommend that hospice be brought under Medicare Advantage effective in 2016, as opposed to 2017 as it was previously considering.

The hospice benefit in its entirety would be covered under Medicare Advantage as is required by law (plans could not pick and choose which services were provided). Staff commented that Medicare Advantage plans could be monitored through Medicare Advantage encounter data to see if plans are limiting services. (Relative to home health, most Medicare Advantage plans require preauthorization and pay by the visit, despite the fact that home health is an episode-based care package and is paid on an episodic basis.)

HCA is in communication with NAHC regarding advocacy in the face of these recommendations and will apprise the HCA membership of next steps, including provider-level efforts that would assist the advocacy process.

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

HIRING

Director of Health Information Management and Information Technology
Montefiore Medical Center – Home Health Agency

Montefiore Medical Center is currently seeking a Director of HIM and IT for our home health agency. In this position, you will manage, direct and administer computerized and patient medical records information services for the agency. To qualify, you must have a bachelor’s degree and at least 3 years of experience as an information systems project manager with staff (or experience in computer systems management).

To apply, please e-mail your résumé and cover letter (including salary requirements) to wmcfarla@montefiore.org or fax them to (718) 920-2242. EOE
HCA, Members, DOH Progress on Emergency Preparedness

*HCA, Office of Health Emergency Preparedness collaborate*

HCA, the state Department of Health’s Office of Emergency Preparedness (OHEP) and the New York State Association of Health Care Providers (HCP) met this week to review progress and plan next steps on emergency preparedness.

Mutual goals include: connecting and working with the state’s four regional Health Emergency Preparedness Coalitions; development of a template identifying regulatory flexibility needed by providers during emergency conditions; geographic mapping and a process for identifying special emergency needs in coastal areas, flood zones and other regions; and sorting the respective roles and jurisdiction of managed care plans and home care agencies.

HCA works with OHEP under a Federal Emergency Management Agency (FEMA) project to address and advance emergency preparedness and response issues in the home and community based care system in the state. As part of this effort, and our emergency preparedness agenda generally, HCA plans to:

- Meet with each of the regional emergency preparedness coalitions and establish mutual resources.
- Convene with other health sector associations next week to plan additional steps and the timetable for development of the regulatory waiver template, and then vet the template with members.
- Conduct regional provider meetings as well as conduct a separate set of statewide education sessions that are in collaboration with the Department of Health.
- Advocate for enactment of HCA’s legislation providing “essential personnel” status for home care and hospice personnel in emergencies (S.4719 Lanza / A.6530 Cusick).
- Work with OHEP and the Office of Health Systems Management to streamline the reporting and survey demands placed on providers during emergencies.

Stay tuned for announcements of our regional meeting schedule and agenda. HCA welcomes your advance input on emergency preparedness and response topics you would like to see covered during these sessions. Please e-mail your ideas and requests to Al Cardillo at acardillo@hcanys.org.

**DOH debrief on test survey & next steps**

DOH also held a debrief this week with HCA, a study sample of providers and others who had participated in a DOH test of a potentially new survey/data reporting process for conveying information to the state during public emergencies.

State data and survey requests, while necessary, were especially problematic during Hurricane Sandy. Providers struggled with incompatible data formats, excessive information requests and immediate turnaround expectations on state survey and data demands while they were consumed with emergency patient care and service management priorities. HCA and the provider community have communicated strong concerns regarding the process, not the intent, of these reporting demands, urging a reformed process better aligned to provider resource deployment and patient care prioritization during emergencies. To address these concerns, the Office of Health Systems Management
developed and conducted a test run of an alternate survey process with a study sample of providers, along with HCA, HCP and Hospice and Palliative Care Association of New York State. In this week’s debrief, DOH and the study participants reviewed their experiences, outlined components of the process that worked or posed serious challenges, and recommended changes. As a next step, DOH will review the feedback and reconvene the group for another debrief.

HCA appreciates the participation, time and expertise devoted by our study-group providers and the efforts of DOH officials to improve the reporting system. We will keep the membership closely apprised of the further developments.

For additional information, please contact Al Cardillo at acardillo@hcany.org.

**HCBS Final Rule Explained**

As mentioned in last week’s ASAP, the U.S. Centers for Medicare and Medicaid Services (CMS) released a final rule covering many provisions of the Medicaid law for state funding of home and community-based services (HCBS) under sections 1915(c), 1915(i) and 1915(k) of the Social Security Act.

Because most of New York’s long term care services are being delivered through Managed Long Term Care (MLTC) plans, the rule would affect coverage of HCBS under managed care as well as existing HCBS waiver programs that are not part of managed care, programs receiving enhanced funding under the Balancing Incentive Program (see last week’s ASAP), and the proposed Community First Choice Option (see the January 3 ASAP).

The final rule and some fact sheets are at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html).

The rule establishes requirements for home and community-based settings in Medicaid HCBS programs, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, defines person-centered planning requirements, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs.

The final rule requires that all home and community-based settings meet certain qualifications. The settings must:

- Be integrated in and support full access to the greater community;
- Be selected by the individual from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices; and
The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements state that the individual must be afforded:

- A lease or other legally enforceable agreement providing similar protections;
- Privacy in the unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- Control over his or her own schedule including access to food at any time;
- The right to have visitors at any time; and
- A setting that is physically accessible.

Any modification of these requirements must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule also excludes certain settings as permissible for the provision of Medicaid HCBS, such as: nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals.

Also included is a transitional process for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and work with CMS to develop a plan to bring their program into compliance where necessary.

States will have up to one year to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual states’ circumstances.

Other provisions

The final rule permits, but does not require, states to combine target groups within one HCBS waiver. Prior to that change, a single section 1915(c) HCBS waiver could only serve one of the following three target groups: older adults, individuals with disabilities, or both; individuals with intellectual disabilities, developmental disabilities, or both; or individuals with mental illness. If a state chooses the option of more than one target group under a single waiver, the state must assure CMS that it is able to meet the unique service needs of individuals in each target group, according to the rule, and that each individual waiver has equal access to all needed services.

The final rule also specifies that service planning for participants in Medicaid HCBS programs under sections 1915(c) and 1915(i) must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules...
require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process.

Lastly, the final rule also provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits.

In 2012, HCA provided comments on a proposed rule that defined state plan and HCBS and provided guidance on what arrangements are considered “home and community-based settings.” We had expressed concerns about provisions related to independent evaluation, independent assessment, and provider qualifications; types of living arrangements that are considered a home and community-based setting; and the exclusion of housing assistance from HCBS. We will be reviewing the final rule to determine if our concerns were addressed.

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

**Gold STAMP Pressure Ulcer Coordinating Committee Plans 2014 Activities**

The state coordinating committee for the Gold STAMP (Success Through Assessment Management and Prevention) program to reduce pressure ulcers met this week to discuss updates, priority activities and goals for 2014.

The committee includes HCA, the State Department of Health, the State University of New York at Albany School of Public Health, the Healthcare Association of New York State, the New York State Health Facilities Association, the Foundation for Quality Care, IPRO, LeadingAge New York, the Continuing Care Leadership Coalition and others.

The Gold STAMP program:

- Provides information and education across the continuum of care about recommended practices and supporting evidence for pressure ulcer assessment, management, and prevention.

- Promotes collaboration and communication within and throughout the continuum of care related to pressure ulcer assessment, management, and prevention.

- Provides strategic direction and support for pressure ulcer performance measurement.

The committee received a report and demonstration from the School of Public Health on the evolving and comprehensive Gold STAMP website. The site (http://www.albany.edu/sph/cphce/goldstamp.shtml) contains resources, program tools, online education and other information devoted to pressure ulcer prevention. The site also includes background on the current Gold STAMP provider collaboratives and the process for establishing new collaboratives.

There are currently 18 collaboratives in the state participating in Gold STAMP, from Long Island to Niagara Falls. Each has a minimum of one hospital, one nursing home and one home care program within a community.

Preliminary information shows the collaboratives have succeeded in pressure ulcer prevention (e.g., showing reductions in pressure ulcer prevalence rates in nursing homes), saving millions in the Medicaid program. Mindful
of these outcomes, the State's Medicaid Redesign Team (MRT) focused on both quality improvement and Medicaid savings through Gold STAMP.

Committee representatives also discussed the use of Gold STAMP techniques for other quality areas/conditions. The committee is expected to meet in February again to continue these planning discussions.

The Gold STAMP program is a source of leadership, education and effective practice for providers. HCA will be ramping up efforts to encourage home care provider participation, promote the program’s education and help providers toward the program’s quality care and cost-savings goals.

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

**HCA Visits Home Care Council Members**

As part of the partnership between HCA and our Home Care Council (HCC) members, HCA staff have been visiting personal care providers who were part of the HCC to introduce HCA’s services, programs, priorities and staff as well as to learn the needs of former Human Resources Administration (HRA) vendors, and determine the types of assistance HCA can provide.

So far, **Andrew Koski**, HCA's Vice President for Program Policy and Services, and **Joseph Campanella**, former HCC Executive Director, have jointly visited:

- Home Care Services for Independent Living
- RAIN Home Attendant Services
- Home Attendant Vendor Agency
- FEGS Home Attendant Services
- Sunnyside Citywide Homecare Services; and
- Chinese-American Planning Council Home Attendant Program

HCA held a member Forum for HCC agencies in October and is planning another one in February. The October Forum involved a productive discussion on the issues faced by former HRA home attendant agencies, including regulatory issues in contracting with managed care plans, HRAs request for proposals for home care services, payment delays, the adverse impact of the state Wage Parity Law, training for personal care aides and home health aides, and Central Insurance Program (CIP) replacement insurance.

As a follow up to the meeting, HCA worked to obtain more time for providers to repay HRA advances used to purchase the managed care portion of the CIP replacement insurance. We have also participated in a state Department of Health (DOH) workgroup that is addressing outstanding claims for personal care services provided to managed care patients. We continue to advocate for adequate payments to plans and providers so they can comply with wage parity requirements. And we have continually urged streamlining of the regulatory requirements between Licensed Home Care Services Agencies (LHCSAs) and managed care plans.

If you would like to schedule a visit from HCA, please contact Andrew Koski at (518) 810-0662 or akoski@hcanys.org.

For membership offerings, contact Laura Constable, Senior Director of Membership, at (518) 810-0660 or lconstable@hcanys.org.
CMS Sets ICD-10 Testing Week for March 3 to 7

The U.S. Centers for Medicare and Medicaid Services (CMS) announced this week a national ICD-10 testing week for providers and clearinghouses from March 3 through March 7, 2014 to assist direct submitters in preparing for this transition.

On October 1, 2014, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.

CMS’s testing week will give trading partners access to the Medicare Administrative Contractors (MACs) for testing with real-time help desk support. The event will be conducted virtually and registration will be required. CMS plans to open its registration process in the coming weeks and HCA will update the membership when this becomes available.

Providers can expect the following during testing:

- Test claims with ICD-10 codes must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014), since testing does not support future dated claims.
- Test claims will receive the 277CA or 999 acknowledgement as appropriate, to confirm that the claim was accepted or rejected in the system.
- Testing will not confirm claim payment or produce remittance advice.
- MACs will be staffed to handle increased call volume during this week.

Additional information on CMS’s ICD-10 testing week can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8465.pdf.

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

BIP Webinar Materials Posted

The state Department of Health (DOH) has posted materials from the webinar on the Balancing Incentive Program (BIP) that was presented and covered in ASAP last week.


Under BIP, New York was approved by the U.S. Centers for Medicare and Medicaid Services (CMS) to receive about $600 million to provide increased offerings of, or access to, non-institutional long term services and supports (LTSS) to Medicaid recipients.

In order to participate in BIP, New York must implement: 1) “conflict-free” case management (CFCM); 2) a no-wrong-door single-entry-point system (NWD/SEP); and 3) a core standardized assessment instrument.

According to the webinar materials, CFCM can be addressed by separating case management from direct services provision and separating clinical eligibility determination and care planning assessment from direct services
provision. When overlaps occur, an effective CFCM system mitigates these conflicts through: 1) the establishment of firewalls and appropriate safeguards to assure consumer choice; and 2) an independent evaluation by a person who is not related to the individual or paid caregiver.

The state’s goals are to:

- Identify areas of possible conflict and existing mitigation strategies in case management;
- Establish protocols to remove or mitigate conflict in community LTSS eligibility determination/enrollment, case management and service delivery; and
- Develop an independent process to assure that person-centered plans meet the needs of individuals served in community-based settings.

The state has submitted to CMS a description of potential conflicts that may exist across programs and agencies as well as strategies currently in place to mitigate risks. As next steps, the state has to address CFCM within a managed care environment, decide how to remove or mitigate conflict, and clarify the scope of the CFCM requirements across all programs.

The $600 million has been allocated to address gaps in community-based LTSS: insufficient capacity, needed financial incentives for community placement, inefficient infrastructure and inadequate administrative resources.

Some of the state’s goals for BIP are to:

- Enhance the Program of All-Inclusive Care for the Elderly (PACE) in non-urban areas (pending CMS approval).
- Develop a request for applications for an Innovations Demonstration “to think differently and create new solutions” (pending CMS approval).
- Expand availability of community-based residential, support and day service options for populations transitioning from institutional settings (i.e., developmental disability individuals impacted by the closure of developmental centers).
- Create 24/7 direct Crisis Stabilization Teams for the mental health population transitioning to supportive housing.
- Provide additional housing supports and services for those transitioning out of skilled nursing facilities, psychiatric centers or adult homes.
- Implement a Community First Choice Option (see last week’s ASAP) to streamline services and increase access to home and community based services.
- Incentivize providers to consolidate and reduce administrative functions.

Under BIP, New York has to report certain service data, quality data and outcome measures. So far, the state has created an Interagency Work Group that is developing a catalog of quality tools and surveys, and a data collection protocol has been identified for semi-annual reporting to CMS.

Additional information on BIP, including a work plan, is at http://www.health.ny.gov/health_care/medicaid/redesign/balancing_incentive_program.htm.

For more information, contact Andrew Koski at (518) 810-0662 or akoski@hcany.org.
Next CMS Open Door Forum to Focus on Hospice: January 22

On January 22, the U.S. Centers for Medicare and Medicaid Services (CMS) will conduct a special Home Health and Hospice Open Door Forum from 2 to 3 p.m. that will focus entirely on hospice – in particular, the upcoming fiscal year 2015 and 2016 quality reporting requirements.

To participate, use the dial-in and conference ID below:

- Dial-In number: 1-800-837-1935
- Conference ID: 71106560

The following are some of the agenda items and resources that will be discussed during the call.

*FY 2015 Hospice Reporting Cycle*

- Data entry and submission site now available at: [https://hospice.qtso.com/](https://hospice.qtso.com/)

*FY 2016 Reporting Cycle*


*FY 2016 HIS Data Collection Training*


*For further information, contact the HCA Policy Staff.*

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**Health Homes Manual Updated**

eMedNY has updated its Health Homes manual.

It is at [https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx](https://www.emedny.org/ProviderManuals/HealthHomes/index.aspx).
NGS Updates

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

NGS Closed on Martin Luther King Day

NGS offices will be closed on Monday, January 20, 2014. This includes the EDI Help Desk, Provider Contact Center, Provider Enrollment Line, and Telephone Reopening Unit.

Electronic claim files transmitted after 5 p.m. on Friday, January 17, 2014 will have a receipt date of Tuesday, January 21, 2014 and produce electronic front-end edit reports. The FISS/DDE Provider Online System will be available on Monday, January 20, 2014, during regular hours. While DDE will be available, there will be no support available to respond to any issues.

On January 20, providers will be able to use NGS’s Interactive Voice Response (IVR) system at (866) 275-3033. NGS’s office will reopen on Tuesday, January 21, 2014 for normal business hours.

Requesting a Bypass of Timely Filing Requirements on Processed Claims

Providers requesting to have timely filing requirements bypassed on a claim processed as untimely with a valid exception should first adjust the original claim (type of bill XX7). Secondly, they should use a D9 claim change reason code (condition code). Lastly, the provider should enter remarks using the following script: “Please bypass timely filing because [insert reason here].” A claims processor will make a decision based on the justification. If the request is approved, the adjustment will be processed; if the request is not approved, the claim will remain untimely. Claims rejected due to untimely filing cannot be appealed.

Providers should not send redetermination/reopening or written requests to the Provider Written General Inquiries Unit to have timely filing requirements bypassed.

Medicare regulations define the timely filing period for Medicare fee-for-service claims such that claims must be on file with the appropriate Medicare claims processing contractor within 12 months of the service date. Allowable exceptions to the one calendar year time limit include:

- Administrative error if failure to meet the filing deadline was caused by error or misrepresentation of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.

- Retroactive Medicare entitlement where a beneficiary receives notification of Medicare entitlement retroactive to or before the date the service was furnished.

- Retroactive Medicare entitlement involving state Medicaid agencies where a state Medicaid agency recoups payment from a provider or supplier six months or more after the date the service was furnished to a dually eligible beneficiary.

- Retroactive disenrollment from a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) provider organization.

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

The Office of the National Coordinator for Health Information Technology (ONC) at the U.S. Department of Health and Human Services (HHS) has released the Safety Assurance Factors for Electronic Health Records Resilience (SAFER) Guides.

These guides are a suite of tools that include checklists and recommended practices designed to help health care providers and the organizations that support them assess and optimize the safety and safe use of electronic health records.

The SAFER Guides complement existing health IT safety tools and research developed by the Agency for Healthcare Research and Quality (AHRQ) and ONC. AHRQ’s Patient Safety Organizations (PSO) have explicitly identified health IT as a high priority area because of the enormous impact electronic health records have on patient safety. PSOs are charged to help their members improve patient safety, and the SAFER Guides give them an evidence-based tool to do so.

Each SAFER Guide addresses a critical area associated with the safe use of EHRs through a series of self-assessment checklists, practice worksheets, and recommended practices. Areas addressed include:

- High Priority Practices
- Organizational Responsibilities
- Patient Identification
- Computerized Physician Order Entry (CPOE) with Decision Support
- Test Results Review and Follow-up
- Clinician Communication
- Contingency Planning
- System Interfaces
- System Configuration

As home and community based providers continue to face unprecedented change and financial challenge, we need to marshal our forces in Albany on January 27 to push hard for vital home care priorities during HCA’s State Advocacy Day.

The window for legislative advocacy in 2014 is expected to be very narrow. For one, statewide elections and campaign activities will be gearing up in the latter half of 2014, putting enormous pressure on the legislative calendar. As a result, many important legislative proposals, needs, and priorities will be competing for attention within a very small space.

Between the Governor’s budget release (around January 21) and a tight post-budget legislative timetable, HCA’s January 27 State Advocacy program is well timed; but it will only be effective with strong participation – and a strong voice – from the HCA membership.

HCA’s Policy and Advocacy teams continue to set the groundwork for home care regulatory relief, Medicaid Global Cap and federal shared-savings reinvestment in home care, funding support for wage parity, emergency preparedness legislation, and more. These initiatives will only succeed if legislators and policymakers hear directly from you – their constituents – in face-to-face meetings on Advocacy Day and throughout the coming weeks.

HCA will be preparing materials and message points ahead of time to assist you in this important effort. These resource materials and our expert staff will be available in Meeting Room 6 at the Empire State Plaza (Concourse Level) throughout the day on January 27.

Please make your legislative appointments today.
HCA State Advocacy Day!

Tentative Agenda
January 27, 2014

8:00am – 9:00am
Registration – Empire State Plaza – Concourse Level, Meeting Room 6
HCA Staff will be available from 8:00am – 4:00pm in Meeting Room 6 to provide you with any assistance necessary, important updates and meeting material. Light refreshments and snacks will be provided throughout the day. Meals are on your own.

9:00am – 4:00pm
Legislative Appointments
Please schedule your legislative appointments as soon as you have registered to attend HCA’s Advocacy Day.

5:00pm – 6:30pm
Senator Kemp Hannon Fundraiser
In addition to HCA’s Advocacy Day on January 27th, we invite you to attend a fundraising reception for Senator Kemp Hannon. Senator Hannon is the Chair of the Senate Standing Committee on Health, the Assistant Majority Whip in the Senate Conference and Chair of the Health Budget Subcommittee. Regarded widely as an expert in health care public policy, Senator Hannon has worked to improve the quality of health care for all New Yorkers. The fundraising reception will be held at the HCA office located at 388 Broadway, 4th floor, in Albany, NY. Refreshments and hors d’oeuvres will be provided. Watch for more details in a special invitation coming soon. A $50 donation to “Citizens for Hannon” is requested.

Hotel Information
Hampton Inn and Suites
Chapel Street
Albany, NY
(518) 432-7000
HCA has arranged a group rate at the Hampton Inn and Suites of $145/night. Contact the Hampton Inn directly at (518) 432-7000 and reference Group Code C11. Early reservations are encouraged as the hotel is likely to sell out this evening.

REGISTRATION

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**Participant(s) will attend:**

_____ Advocacy Day on January 27 (No Fee)
_____ Hannon Fundraiser Reception @ $50 per person = $_______

Corporate and LLC checks are acceptable under NYS Election Law. 501 (c) (3) Organizations are prohibited from making political contributions.

Please make personal check payable to: Citizens for Hannon and mail to 388 Broadway, 4th Floor, Albany, NY 12207; or pay by personal credit card:

_____ American Express   _____ MasterCard     _____ VISA
(3 digit code on reverse) __________   Exp. Date ____/____/____

Card Number _______________________________________________
Cardholder’s Name ___________________________________________
Cardholder’s Address _________________________________________
__________________________________________________________
Signature ___________________________________________________

FAX completed form to (518) 426-8788